

20

CONFERENCE NUMBER



THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

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XVI

OCTOBER 1949

No. 4

The Association of Surgeons of India

11TH ANNUAL CONFERENCE

207, Poonamallee High Road,
MADRAS 7.
20-9-'49.

Dear Doctor,

The Eleventh Annual Conference of the Association of Surgeons of India will meet in Madras on the 29th, 30th and 31st of December 1949. In addition to the usual scientific discussions, visits round the city hospitals as well as an exhibition of medical and surgical equipment of various kinds are being arranged. A representative Reception Committee has been formed and His Excellency the Governor of Madras has consented to inaugurate the Conference.

We invite you to attend the Conference and help to make it a success.

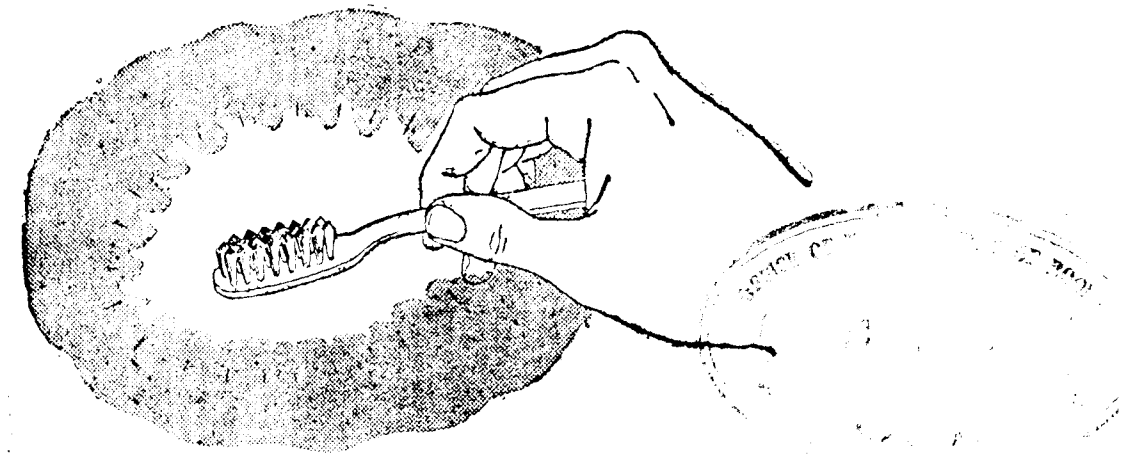
We trust that the information given in the annexures will be of assistance to you in planning your trip to Madras.

As it is desirable to make rail and hotel reservations as early as possible, we shall be thankful for a return of the annexures C and D after due completion at your earliest convenience.

Looking forward to welcoming you at the Conference,

Yours sincerely,
U. MOHAN RAU,
Hony. Secretary.

The MISCELLANY—October, 1949



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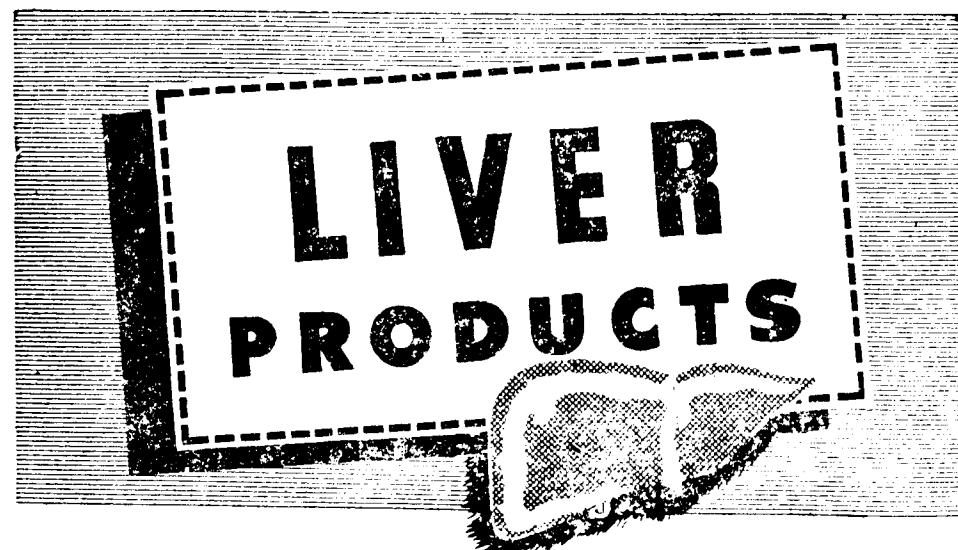
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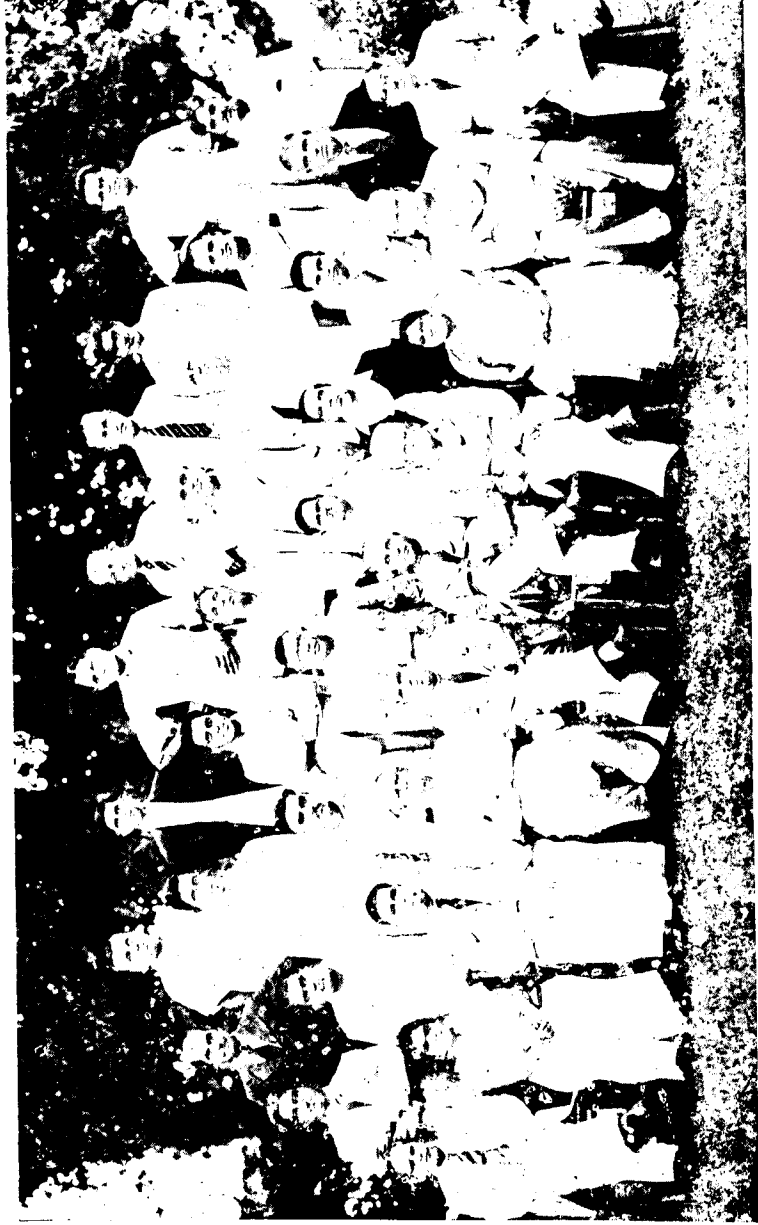
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THE MISCELLANY

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THE INDIAN MEDICAL ASSOCIATION

VOL. XVI]

OCTOBER 1949

[No. 4

ADDRESS DELIVERED

BY

THE HON. DR. T. S. S. RAJAN, *Minister for Public Health, Govt. of Madras*

at Annamalainagar on 8-10-'49

Inaugurating the IVth Provincial Conference of the I. M. A. and the 7th Provincial Conference of the A.I.M.L.A. at Annamalainagar on 8-10-49, The Hon. Dr. T. S. Rajan, said that he was glad to be there to inaugurate the two conferences but it was paradoxical why the licentiates should still keep up a separate individuality as they were a dying race. The closure of the medical school education in this province 10 years back had made the number of licentiates decline rapidly and there will not be any Licentiates after a decade or two. Moreover the Government of Madras who were the first to abolish caste distinction among medical men by abolishing medical schools in this province, have not only given gazetted rank to the Licentiates, but are also considering the unification of the Asst. Surgeons Class I, and Class II into one cadre. Under the circumstances he did not see any necessity for the existence of separate association for the Licentiates and all should be in one organisation. The lot of the Licentiates lies with medical profession as a whole.

He said that many are not probably aware of the fact that the province is in great shortage of medical personnel to administer relief in this province. The total number of allopathic practitioners in the province is about 8,500 and the number of practitioners of the Indian systems of medicine registered in both classes, A & B, is about 16,100 and for the population of 524 lakhs this works at (practitioners of Allopathic and Indian systems put together) one practitioner for over 6,000 of the population. It must also be pointed out that 127 allopathic dispensaries and 64 dispensaries of the Indian medicine are closed down for want of medical men to run the dispensaries. The total number of allopathic dispensaries are 1661 and that of Indian medicine 655. So nearly 10% of the dispensaries are not functioning. Besides these a number of posts in hospitals and dispensaries are vacant for want of medical men. The position in Public Health establishment, such as Health Officers, Sanitary

Inspector, Vaccinators etc., is also equally bad; having a vacancy of 20 posts among the Health Officers and 17 posts of Health Inspectors, 12 posts of Health Visitors and 88 posts of Vaccinators. Even among the posts which are not vacant, some are filled up by unqualified and untrained men—a very undesirable state of affairs.

The question arises as to how to make up this deficiency and how to raise the ratio of medical men to the population. The average output of medical graduates (allopathic) is only 250 and that of licentiates of Indian Medicine not more than 120 making a total of 370. Roughly calculating that the profession is depleted by about 170 per year due to death and about an equal number by retirement, incapacitation and migration, the production and depletion will be almost equal and there is no possibility of increasing the number medical men in the province to expand medical relief to the masses which is a vital necessity. If we take the qualified indigenous practitioners also in the list, the depletion will be about 490 while the annual output is only 370. This means that the number of qualified medical men is rapidly dwindling and hence there is clamour for adequate medical relief all over the province particularly in rural areas.

The only solution is the expansion of the output of medical training institutions. This can be achieved either by increasing the number of seats available in each institution or by a quicker manner of training medical students or a combination of both. On an average 1,200 candidates apply for admission into the allopathic medical colleges whereas the number of seats available is only 285. There is undoubtedly room for increasing the number of seats in the existing ones and though it is a difficult problem the Government is examining this aspect. The question of opening new allopathic medical colleges immediately is also not possible in the present financial position of the Government and shortage of material. However this question is also being considered by the Government. The possibility of training medical students by a shorter and quicker method without sacrificing standards and efficiency has to be explored. This means we have to prune the medical studies, give up unnecessary emphasis on subjects which may not be ultimately necessary and give greater facilities for specialising in individual subjects with a view to producing men of special capacity and talent needed for practice, consultations, teaching and research. This is a matter which requires deep consideration and medical men of experience should give their opinion for the guidance of the Government. He said that what he spoke on these lines on a previous occasion had been misunderstood and hoped that he now made himself clear.

He then declared the conferences opened and wished all success.

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October, 1949]

The Fourth South Indian Provincial Medical Conference I.M.A. The Seventh Madras Provincial Licentiates' Conference

ANNAMALAINAGAR, CHIDAMBARAM

ADDRESS OF WELCOME

BY

DR. NATARAJA JATAVALLABHAR,
Chairman, Reception Committee

Members of Reception Committee, Delegates, Ladies & Gentlemen,

It is my happy lot, though not quite deserving of the honour, to have been elected Chairman of the Reception Committee of this session of the South Indian Provincial Medical Conferences and to have thereby the opportunity and privilege of welcoming you to this town, an ancient seat of learning and religion to which a new town, symbolic of modern scientific and progressive thought, has been added in the shape of the Annamalai University in one the spacious halls of which we are now assembled. The antiquity of the holy Chidambaram shrine goes back to nearly 2,000 years and covers all the phases and stages through which our Hindu religion, philosophy and temple worship and all that the temple had meant for the social life of the people, had passed. Beginning as the nucleus Mulasthana Lingha shrine fostered by the famous Saint Patanjali who has been identified with the great Vedic figure of that name and also with Vyaghrapada developing after some centuries into the cult of the cosmic dance of Siva, in the beautiful Thillai hall, the temple has received, in successive generations and centuries, the hall-mark, cultural and architectural and the impress of successive dynasties that rose and fell in this land of Pallava, Chola, Pandya, Mediaeval feudatories, Vijayanagara, Nayak and Poligar. The temple is an epitome of the history at once of the spiritual and architectural, evolution of the land.

The temple has also witnessed in the successive stages of its history, the efficacy of the Saivite revived faith over Buddhism due to the great abilities of Manickavachaka, the vindication of the power of prayer and single-minded devotion of even the lowest Bhakta like the immortal Nanda, the triumph of Sekkilar, the author of the Peria-Puranam as against the Jaina rivalry, and above all the growth of the Saiva Siddanta philosophy by the labours of the Protestant reformer, Umapathi Sivacharya and his followers.

The temple had in its precincts lecture halls, schools for Vedic and secular learning, Natya salas and all other instruments of cultural growth as well as institutions of economic relief, poor feeding etc.

In the last two centuries, owing to the great anarchy that heralded the advent of British Rule and the indifference of that rule to our native institutions and culture, the temple fell into decline and would have lost all its importance but for the munificent

charities of philanthropists like Pachaiyappa Mudaliar, Manali Chinnaiya Mudaliar and above all of the 3 or 4 generations of the S.R.M. family of the Nattukottai Nagarathars who have practically renovated every old and ruined structure and provided on a splendid scale for the proper upkeep of worship and Ubayams. This is not alone. Diwan Bahadur Ramaswami Chettiar, the elder brother of Rajah Annamalai Chettiar, pioneered secular charities for this town like the starting of a well conducted and large High School and the provision of a protected water supply which has been of incalculable benefit for the health of the people. And the good work begun by Mr. Ramaswami Chettiar, was continued in even widening channels by his far-sighted brother, the Rajah Saheb, whose College started in 1920 developed into a University with a charter of its own 8 years later. The rapid extension of the academic and cultural activities of the University like the conduct of higher institutions of Oriental Learning, well established Music College, the provision of facilities for advanced research studies in Tamil music, history and antiquities and above all, the growth of Honours departments in the Science subjects supplemented by a well-equipped Engineering College and a Technological Institute, may be noted. All these activities took up a great deal of the time and energies of the Rajah Saheb who in fact, can be regarded as having treated this University as his first born son. May we hope that under the equally guiding and fostering care of his distinguished son Rajah Sir Muthiah Chettiar, this University will grow more and more and become the exemplar of unitary Universities in our country.

We are indeed happy that the Hon'ble Minister for Public Health has been able, amidst his multifarious pressing engagements, to be with us to inaugurate this conference. We are indeed grateful to him for having accepted our invitation.

The Surgeon-General with the Government of Madras has been pleased to accept our invitation to inaugurate the scientific session. We warmly welcome him to our midst.

The President of the Conference Dr. P. A. S. Raghavan, is an old comrade of ours who richly deserves the honour of being re-elected as President, for a second time, of the South Indian Provincial Branch. We welcome him and hope that during his period of office we would have many grievances redressed.

Dr. Nathamuni Naidu the President of the Licentiate Conference is a leading practitioner of Ambur who is also keen in the welfare of our Association. While cordially welcoming him on this occasion we hope and pray that during his term of office the amalgamation of the Licentiate's Association with the Indian Medical Association will be an accomplished fact and that there would be no necessity to hold Provincial Licentiate Conferences in future. We heartily welcome the delegates the visitors and the public who have responded to our invitation.

We are happy that the Hon'ble Dr. T. S. S. Rajan an illustrious colleague of ours is at the helm of medical administration as Minister for Public Health. Sir, you had the unique honour of abolishing the licentiate course and other provinces hailed it as a right reform and followed suit. We are indeed grateful to you for having abolished the caste system in our ranks.

In the United Provinces, we hear that a condensed course of three years is introduced to produce a large number of doctors in a short time. We understand that the Government in our Province is also contemplating to give training for about a year or two in the scientific system to medicine to Vaidyans and quacks and recruit them for service in the villages.

Sir, we feel that it is not a right step and that it is not conducive to the interest and welfare of the villagers. Those of us who are engaged in active practice are painfully conscious of cases that are badly handled by unqualified persons and that by the time they reach well equipped hospitals they are too far advanced and beyond any hope of recovery. Proper facilities must exist for early diagnosis and proper treatment of all sick patients irrespective of their status in life and their capacity to pay. It should be the first charge of the State to look after its citizens in regard to their health.

In England the National Health Insurance Scheme has assured each citizen of prompt medical aid with the benefit of consultation and treatment at the hands of experts for a nominal charge. Some such scheme suitably adopted for Indian conditions must be evolved to solve this problem. Again the medical relief at present is concentrated in towns and the villagers are served by L. F. Dispensaries which are too few in number considering the population and area. We are aware of villages in this district which have no dispensaries for a radius of 16 miles.

This defect could be remedied by opening up more dispensaries and manning them by qualified doctors.

The rural medical scheme though very good in its objects, has certain fundamental defects. Firstly the medical officer-in-charge has no prospects of getting out of the place to improve his knowledge or better his prospects. Having been accustomed to urban life, with all the facilities, the qualified medical men are reluctant to take up rural service. This ought to be remedied by provincialising the entire medical services.

PROVINCIALISATION ought to include all doctors in employ in Local Funds i.e., District Boards and Municipalities and the rural medical practitioners. If the entire service is provincialised there will be less discontent in the rank and file of the L. F. and Rural medical Practitioners due to disparity of their pay when compared to that of Doctors in Government service.

We are aware that the financial resources of the Government are very slender and they cannot afford to launch on such costly schemes. But we would humbly suggest that the Local Bodies might be compelled to contribute towards the pay of the Medical Officers under their employ. The finances of the province might, also be augmented by acquisition of trust and charity properties, chatram funds and properties of rich temples, and by nationalisation of the motor transport of the entire province.

Until such time that the entire service is provincialised the Local bodies, might be ordered to pay the same scale of pay as the Government are now paying to the doctors in their service.

HONORARY SYSTEM:—The honorary system must be expanded so that it may slowly replace the paid staff. That may bring about slight saving in the expenditure. The Honorary system prevailing in Great Britain in the big hospitals should be our aim.

MOBILE MEDICAL UNITS:—This could be carefully planned and staffed to serve the villages. Each unit should consist of at least one doctor, one midwife, a compounder and an orderly a fully equipped van with first aid set, common medicines, and emergency injections with facilities to transport cases. The unit should visit the village by turns, spot out early cases and send them to well-equipped institutions with letters of recommendations for treatment. It should look after pregnant women also and attend to anti-natal diseases. It should be combined a medical and health unit with facilities for propaganda and lectures with illustrations. We would humbly suggest that the ambulance cars and lorries in charge of the fire service sub-stations in the mofussil could be utilised for such service.

Such a type of work is both arduous and requires careful planning and arrangement. The success of the Mobile Medical Unit will largely depend on the enthusiasm of the team operating it and hence the team should be carefully selected and after a short training, should be entrusted with this work.

At present the Taluk H. Qrs. Hospitals and the Dt. H. Qrs. Hospitals are very much over-crowded and in many cases, understaffed and ill-equipped. It should be possible to provide each Dt. Hd. Qrs. Hospital with at least one specialist in the following subjects:—

Surgery, Medicine, Midwifery, Ophthalmology, E. N. T., Venereal disease etc.

The question of employing as Honorary staff suitable candidates with specialised training in the above subjects and who practise only that speciality might also be considered. Such a step would considerably reduce the expenditure. The District Medical Officer may be divested of all the administrative duties which could be vested in a lay secretary so that he may devote more time and attention for the hospital work.

LABORATORY: The Hd. Qrs. of each district must have a central laboratory wherein every type of investigation is done for a nominal charge or no charge. Private enterprise could also be stimulated by a small subsidy in the initial stages by the Government.

There should be small laboratory in each Taluk H. Qrs. manned by trained personnel for the examination of motions, sputum, urine, blood etc., Even here private enterprise could be encouraged by sending specimens for examination from Government institutions.

X RAY EQUIPMENT: This is a sad chapter in the history of the district. The X ray apparatus that is installed at the Government H. Qrs. Hospital, Cuddalore N. T., about a year back has not been equipped completely with the result, that there is no work done in the institute. Except an X-Ray-plant in the Danish Mission Hospital of Tirukoilur, and another at Chidambaram, at Dr. Rāṅgasami's clinic we are not

having this most necessary equipment for early diagnoses of disensis of diseases. Unfortunately private enterprise in this district is also lacking in this direction. We hope that in the near future, with your kind efforts, the X-Ray department of the Government Hd. Qrs. hospital Cuddalore, will start functioning soon.

THE TUBERCULOSIS PROBLEM: We are painfully aware of the magnitude of the tuberculosis problem. Slowly and steadily the incidence of this disease is increasing. Unfortunately we have no special T. B. hospitals or sanatorium in this district. Cases that are sent outside to the various sanatoria and to the T. B. Hospital at Madras but they are not able to secure admission due to over-crowding in those institutions. Even early cases are not able to secure proper treatment at the hands of the specialists. It is very necessary that we should have sanatoria built on the lines of the Perundurai Sanatorium which is a monument of private philanthropy and Government support. We hope and pray that the Government and Public of this district would join hands and launch a similar scheme to serve the Public of this district.

CANCER: Incidences of cancer in this district is as heavy as it is elsewhere. The pity is cases are not brought to well-equipped institutions in time where surgery by itself or surgery and radium could save the patients. A system should be devised by which early cases are promptly transported to institutions in time, so that they could be saved. We are happy to note that the Government under your able direction are launching a scheme to open up more treatment centres for this disease in mofussil areas. We hope young men and women doctors would take to this speciality and do research work.

LEPROSY PROBLEM: We have a heavy incidence of leprosy in this district. There has been no attempt at isolation of infective cases. There are two settlements in this district doing good work, one at Vadathorasalur, managed by a mission and another at Kandachipuram managed from Kasthur Ba funds. Here is a vast field for research work.

MALARIA AND FILARIA: Malaria and Filariasis are endemic in most parts of this district and offer good field for research work in these diseases.

NEW MEDICAL COLLEGES: More Medical Colleges could be opened avoiding heavy expenditure on buildings by utilising old medical school buildings at Tanjore, Calicut, etc. The question of having Medical colleges in the place of schools of Indian medicine should also be considered. Instead of imparting knowledge on the scientific system of medicine in a perfunctory manner as is done now in the School of Indian Medicine, knowledge that is useful should be imparted in the medical colleges as an additional subject in the indigenous system of medicines. After all what a patient requires is quick cure and restoration to normal health no matter how he is treated. To this end whatever is good in these system of medicine should be included in the curricula of the medical colleges.

Those who cry hoarse that the Indigenous systems of medicine would lose their individuality and suffer due to the impact of the scientific system of medicine are not

realistic to facts. Ancient system however good they were once are not complete and hence whatever is good in the modern system must be utilised. One cannot say that it has been existing in the village for centuries and serving the villages always with no necessity for the scientific system of medicine. The facts are otherwise. It will be a great folly to sit idle with folded hands when other nations are making such rapid strides in the field of medical research. It will be ruinous if we do not utilise those researches.

Nowadays it is necessary to think of global war and global warfare against diseases. The World Health Organisation is doing splendid work to Far-eastern countries and to India, but this does not touch the fringe of our problems. Our primary concern is food for the growing population and next comes medical relief.

One other matter in which our association feels strongly is that this association has not been represented in the legislature. We request you to use your good offices to secure for us a few seats in the Assembly so that when matters of medical relief and public health are discussed, our representatives could talk with vigour and authority.

In conclusion we would plead.

1. That there should be no lowering of standard in regard to medical education.
2. The synthesis of various systems of medicine for the benefit of the population may be done and subjects included in the course of the Medical Studies.
3. Provincilisation of the entire medical services.
4. Merit and experience should be the criteria of promotion in service.
5. The existing hospitals in the districts shall be staffed with specialists.
6. Institution of mobile medical units.
7. Increase the number of admissions to Medical Colleges and opening of more colleges.
8. To open up more village Health centres as has been done by the Government recently.
9. To give representation of I. M. A. in the legislature.
10. To stimulate research in scientific and indigenous system of medicine and to put down quackery ruthlessly.
11. To institute laboratories and X-Ray equipments in each District Head Quarters hospitals.
12. To encourage the honorary system by recruitment of suitable qualified private practitioners.

Our lists though appears formidable, is a very moderate demand that may not entail heavy expenditure on the part of the Government.

In welcome you to this historic town and to this University we hope that during your stay here, you will have a pleasant time. The Reception Committee have been

October, 1949]

ADDRESS OF WELCOME

trying their best in regard to arrangements. Deficiencies there will be and we request you to excuse us.

We have arranged an elaborate scientific session. We hope it will be useful and instructive to every one of us. We wish to thank all the lecturers who would be contributing for the success of the scientific section. We hope you will carry with you pleasant memories of this University and the Conference.

We wish to thank Raja Sir Muthiah Chettiar and the Vice Chancellor for allowing us to hold the Conference here in these spacious University buildings and for having afforded facilities for the same.

We thank the Registrar, the Bursar, the Wardens and the other staff of the University for their invaluable help.

We request you, Sir, to declare the Conference open.

CHAIRMAN AND MEMBERS OF THE
RECEPTION COMMITTEE.

Announcement

SOUVENIR OF THE FOURTH SOUTH INDIAN PROVINCIAL MEDICAL CONFERENCE, ANNAMALAINAGAR

This excellently got up book giving various details about the district of South Arcot and other useful information is worth possessing.

A few copies are still available for the members of the profession and the price of a copy is Rs. 2/-. Doctors desirous of securing one may address Dr. V. Krishnamoorthy, L.M.P., L.O., Cuddalore N.T.

Managing Editor.

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Fourth Provincial Medical Conference of The Indian Medical Association

ANNAMALAINAGAR 8-10-1949

Presidential Address of Dr. P. A. S. Raghavan, Z.M.B.E., Tiruchi

FRIENDS,

I thank you most sincerely for re-electing me as President of this Conference and the South Indian Provincial Branch of the I.M.A. There has not been much time since the date of my election for me to prepare any lengthy presidential address. Moreover, in my address at the last Provincial Conference held in Madras in October 1948, I covered a variety of subjects, and I do not propose to traverse the same ground again. So, with your kind permission, I shall touch upon a few matters of topical interest.

It is a happy augury that this conference is being inaugurated by the Hon'ble Dr. T. S. S. Rajan, the doyen of our profession. He gave his hearty support to Col. Bholanath, one of the founders of the I. M. A., when he toured the country about twenty years ago. Dr. Rajan has been a tower of strength to the Trichinopoly Branch, of which he is a life member, and contributed the maximum of clinical material as long as he was in practice. Opinion may be divided as to whether it is advisable to have a medical man as the Health Minister, but we, in this province have been demanding, since the formation of the Congress Ministry, that a medical man should be in charge of the portfolio, and we are glad that the right man been given the right job. His monumental work during the first Congress regime was the ushering in of the Public Health Act, the first of its kind in India. He brought credit to our Province as being the first to abolish the medical school education in the country. It is hoped that he would put up a strong case to amend the Indian Medical Council Act in such a way as to give due representation to the Licentiates and see that no compartment or schedules are created in the All India Register. We assure him of our whole-hearted support to all his schemes which we know will be in the best interests of the country and the profession.

It has been usual in conferences of this kind, side by side with scientific work, to pass a number of resolutions (on the medico-political matters) ventilating our grievances in service and in the matter of practice. But you would have observed that in conferences of recent years the scientific section absorbs most of our time and we spare but little time for medico-political matters. Even so, we are often criticized as always clamouring for more, not realising the difficulties of the Government or the critical situation in the country. It is usual for the Government to say that they are concerned with millions of people who are half-starved, half-clothed and badly housed and so they cannot be bothered about a handful of medical men, who must take care of themselves. To this, our reply is that unless we are improved, we cannot render satisfactory service to the masses. Hence we may be excused if we agitate a little to better our position.

October, 1949]

PRESIDENTIAL ADDRESS

11

We realise that the problems confronting the nation and the government are staggering, and it is becoming evident that it is beyond the ability of the Provincial and even the Central Government to cope with the situation, and it requires the combined efforts of global organisations such as the World Medical and World Health organisations to tackle the problems of poverty, disease and death. We, as medical men and as citizens of this country, are also over-awed by the magnitude of these problems but as constituents of the World Medical and Health Organisations we have also a duty to perform and thus contribute our mite to the solution of these problems. We, as individuals or as associations, can at best give suggestions to the powers that be and help them in the work they chalk out, to the best of our ability. But the main burden and the responsibility of preventing disease and giving medical relief is that of the Government, just as it is their responsibility to feed and clothe and house the masses.

HEALTH PROBLEMS

The ideal is to prevent illness and eliminate medical men altogether but as that cannot be achieved immediately or in the near future, it is the duty of State to provide the masses with some rational methods of treatment to overcome their illness in the shortest time possible. Our country is so large and medical personnel so short that it would be necessary to combine the preventive and the curative aspects in the same individual at least in the lowest level, i.e., the village unit. Our Provincial Government is giving effect to this part of the recommendation of the Bhore Committee by starting a number of Primary Health Units where the basic doctor would carry on preventive and curative treatment. The Bhore Committee has recommended the amalgamation of the two departments, Public Health and Medicine. But, our provincial Government, along with one or two other provinces, is not for such amalgamation. Anyhow, there is amalgamation at the highest level, the Ministerial level and at the lowest level, the Basic Doctor level, and how far from above and how far from below there should be integration should be decided in the best interests of the country and the department.

It is an undeniable fact that the majority of the people in our country suffer from preventable and curable diseases. As for the preventable diseases, I have already stated that it is the duty of the Government to take all measures to prevent diseases. As for the curable diseases, they are of two kinds, those that get cured of their own accord and those that require proper medication. Fortunately, the large majority of diseases are self-curing, and hence the masses, particularly in rural areas get cured without any treatment. Those that get treated for these simple ailments by qualified practitioners or quacks begin to have immense faith in these people and as quacks outnumber qualified practitioners a hundredfold and as their remedies cost next to nothing, the impression is created that a large number of people prefer indigenous treatment. The question then arises as to how we and the State are going to render some rational treatment to the masses and save them from the clutches of quacks and well-meaning but misguided friends and relatives who very often create complications even in simple diseases. The only method of tackling the problem is to educate the masses and supplement the recommendations of the Bhore Committee by starting more medical Colleges

to turn out more medical men and to start forthwith as many Primary Health Centres as possible. I would suggest that many hospitals and dispensaries in towns and cities may even be depleted of the paid staff and sent to the primary units. This staff may be replaced by honorary medical officers, and I am sure there are enough public spirited medical men, both young and old, who will gladly give this service. This seems to be the only way of tackling the problem and not by playing with life and death by implementing the recommendations of the Chopra Committee.

CHOPRA COMMITTEE

As you are all aware, the Government of India appointed a committee to enquire into the Indigenous Systems of Medicine in this country and advise the government on how to provide for research, scientific investigation, facilities for training, methods of State Control, and on how to increase the usefulness of these systems. An eminent medical man, Sir R. N. Chopra, I.M.S., (Retd.), was appointed as the Chairman and hence the committee is commonly called the Chopra committee. A perusal of the report and the comments thereon will show that the committee went beyond its terms of reference and spent more time in reporting on how to synthesise the modern and ancient systems of medicine and how to give mass medical relief, than on the points at issue. In both these directions they exhibit lack of understanding of the situation in the country and are only carried away by a sense of false nationalism and pseudo-patriotism. Their recommendations even on the points of reference do not reveal a grasp of the real state of affairs in the country. Let us consider the three aspects separately, to realise the impossibility of implementing their recommendations.

Mass Medical Relief

The committee has cut the Gordian Knot in its scheme to flood the country with doctors in six months. They have recommended that all the quacks in the country who number nearly three lacs, be given a six months training in medicine, surgery, midwifery, ophthalmology, public health etc., and be given certificates and be registered in a Government register. If this help is not sufficient for them to carry on their depredations in the country, the Government should subsidise them. The Committee has not bothered to find out if these people know at least the three R's and even if they can read and write the vernacular, whether anything could be taught in the short space of six months, I wonder whether this scheme is intended to serve the masses or to help these quacks.

Synthesis

It is strange that such an eminent scientist and medical man like Lt. Col. Chopra and his colleagues should think that the views of the largest section of the duly qualified practitioners of the modern system of medicine as represented by the Indian Medical Association and also the opinions of the qualified practitioners of the ancient system of medicine such as the Ayurvedics, the Unanis and the Siddhas, who have all declared that synthesis is only possible in the highest levels after research by those who are capable of appreciating the good in each system, can be adopted

only in the later stages. Instead of suggesting, that this method be adopted immediately, the committee has recommended that the hybrid system that was started 25 years ago in this Presidency, namely, that of giving training in a little of the modern system and a little of the ancient system, such as obtains in the School, now College of Indian Medicine, should be multiplied. It is an undeniable fact that the products of this institution practise only the modern medicine in a crude way as they are not well trained in this.

Improving the indigenous systems.

Though these half-baked protagonists of the so-called Indian Medicine declare that the systems such as Ayurveda, Unani, and Siddha, are God-given, perfect in themselves and need no addition from other systems of medicine, yet they do not practise it themselves. The committee forgets that the modern medicine is only developed from ancient medicine and suggests that all the subjects in modern medicine such as Anatomy, Physiology, Pathology, Biology, Medicine, Surgery, Midwifery, Ophthalmology, Radiology, etc., should be taught in the College of India Medicine along with the ancient systems, which, according to them, has accumulated the accretions of centuries due to stagnation. The committee calls this "synthesis" and labels it as "Indian Medicine." This is just like importing all the parts of an automobile, assembling them in the country, and calling the product 'Indian Made.' It is impossible to integrate the various systems which have totally different and opposing basic principles on diseases and their treatment. During the last 25 years of this experiment, the various indigenous systems have been kept in water tight compartments in the School of Indian Medicine as it has not been possible to synthesis even the indigenous systems. How is it possible to integrate two opposing systems such as the ancient and the modern? If a student is taught for three years the basis of modern medicine such as anatomy, physiology, pathology, biology etc., and then be asked to study the ancient systems of treatment, how is it possible to avoid chaos and confusion in his mind? Lt. Col. Chopra in his book 'Indigenous drugs of India' (1933) has stated that it would cause chaos and confusion in the students if they are asked to relate ancient theories to modern basic science. Has anything happened within this short period to make him change his ideas and sponsor a procedure which he then condemned? There is evidence to show that Lt. Col. Chopra and his team surrendered their conscience and judgment to a clique that sponsor the mixed system of medicine in Madras. In proof of this, it may be pointed out that the L. I. Ms. in their Conference in March 1949 not only extracted passages from the Chopra Committee report, which had not yet been published, but also stated that the committee found it difficult to come to any conclusion or draw up the report without the assistance of the L. I. Ms. and it was they that finalised the report. So, it is clear that the opinions expressed in the report are the views of the handful who represent the mixed-trained variety.

The University of Madras is now arranging to institute a five-year degree course in Indian Medicine, i.e., in pure Ayurveda, pure Siddha and pure Unani without the admixture of modern medicine. It is doubtful whether the advocates of the present mixed study as given in the College of Indian Medicine, Madras, would approve of this

decision. The opposition by our representatives is because the indigenous system are not founded on progressive modern scientific basis, that they have been static for centuries and that they will not come up to the present-day needs. They also feel it will be a waste of time and a drain on the slender finances of the country to sponsor a number of system of medicine. There is also the fear that this will be the thin end of the wedge to ultimately recognise the present system of combined teaching in the College of Indian Medicine, which has neither improved the old systems nor helped the new one.

The Hon'ble Dr. T. S. S. Rajan, our Health Minister, is a strong man and can be called the Sardar Patel of the South. He stated in his address at the Madras Medical College last month that he was baffled by the magnitude of the problem of medical relief and the paucity of qualified medical men in the country, and wondered if a cheap and short course of medical education could not be evolved to meet the great demand. At the same time he is against lowering the standards. To uphold high standards of medical education he was the first in the country to abolish the medical school course in the Presidency so early as 1937, even though it was then one of five years' course but not upto the University standard. This reform is now being adopted in all the provinces of the country. I wonder how cheapness and efficiency could go together. He is also rightly against compartmentalism in medicine, and is now trying to abolish the same in service and have only one grade of medical officers. Would not different standards of education perpetuate compartmentalism?

Our Health Minister at the Centre, Rajkumari Amrit Kaur, has condemned in no uncertain terms the lowering of standards even in emergencies (Calcutta Dec. 1948). She deprecated the tendency in certain provinces (Central Province) to have short and cheap medical education to cater to the masses. She declared that it would, in the long run, be costly to the nation.

MEDICAL RELIEF

As I said before, it is an admitted fact that diseases are rampant in the country and medical relief is absolutely inadequate and scarcely touches even the fringe of the population. The Government find that there is not enough money to start more medical colleges and produce more doctors. How are we going to tackle these problems? The following suggestions may be considered.

Diseases can be broadly classified as preventable and those which are now inevitable. They can also be divided into curable and incurable. To tackle the problem, four aspects have to be considered and the needful done.

Preventable diseases.

Diseases like malaria, filaria, smallpox, cholera, dysentery, plague etc., are preventable and should be tackled first. To prevent these, the standard of living has to be improved very much and good water supply should be assured and decent housing conditions provided. As these cannot be achieved in a day, other measures are preventing diseases have to be adopted immediately. They are educating the public to safeguard themselves against disease as far as possible by keeping their surroundings clean and by

mass inoculation against diseases for which proved and efficacious vaccines are available. Our anti-vaccinationists will protest against this suggestion, as for one thing, according to them, preventive inoculation is unsatisfactory and a failure, and for another, they are afraid that if Government concentrate on this aspect they will neglect other public health measures, under the complacency of having done their duty. As regards the first fear, it has been proved beyond doubt that inoculation is the one single measure to prevent the spread of some of these diseases in epidemic form. Regarding the fear that our government will neglect measures for improving the health of the nation, it is to say the least, distrusting our own leaders and suspecting that they will become negligent about their responsibility and that they are not capable of taking care of the masses. If there is any slowness in tackling the problems of health and disease, it is due the immensity of the problem and they very short time that has elapsed since they have taken charge of the administration of the country, as well as the unexpected events that have happened since then. In spite of these handicaps, our health matters are being tackled in the right way, and if there are some defects and drawbacks, they are unavoidable.

Curable Diseases.

Fortunately many of the diseases are self-curing or are curable and with the rapid advance of science and the discovery of Anti-biotics and Chemo-therapeutics more disease are being transferred to the list of curable diseases, then was the case a decade ago. For self-curing diseases, such as Influenza, smallpox, typhoid, etc., it would be enough if the patients are taught not to interfere with nature's process of healing by resorting to quack remedies and the advice of well-meaning but ill-knowing friends and relations and thus avoid complications. As for simple diseases which are curable by safe remedies, such as malaria, diarrhoea, scabies etc., the public health staff, i.e., the Sanitary Inspectors and Health Visitors may be taught to carry out the necessary treatment. They can also be taught how to prevent infections after injuries and by knowing first aid they can prevent serious diseases and deformities. They can also be taught to detect serious conditions and refer such cases to the nearest doctor. So the only possible quick and cheap method of carrying on preventive and curative measures to the masses in the villages, seems to be to increase the public health personnel a hundredfold with a training in the above matters. If the country is flooded with such people, it will help to reduce the incidence of disease and also give breathing-time to the Government to turn out fully qualified medical men. There will be no fear that these health staff would give up their jobs and start practice, as would be the case if all and sundry are merely labelled as doctors.

While on the subject of medical relief, I would like to digress a little and say a few words on the three great scourages, Tuberculosis, Leprosy and Cancer.

Tuberculosis.

Though tuberculosis is a more infectious and more dangerous disease than leprosy, there is no stigma attached to it as in leprosy, as it is not usually apparent to the naked eye. At one time it was even considered fashionable to have the disease.

Fortunately, tuberculosis is easily preventable and curable in a short time, if detected early. One most important method of preventing the spread of this disease is to take particular care of the sputum, collect it religiously and destroy it ceremoniously. This aspect of prevention has to be dinned into the ears of the public in season and out of season till it catches the popular mind. The other method of prevention is by vaccination with B.C.G. When this B.C.G. vaccination campaign was started in Madras last February, there was a tearing controversy for and against it. Those against it argued that vaccination of any sort was useless and dangerous. Others argued that vaccination of any sort was useless and dangerous. Others argued that vaccination is still in the stage of experiment and that we should not take risks with it but wait till it becomes established and fool-proof. This argument savours of selfishness. If we take no risks and do not contribute to research, we will always be followers and never leaders. Moreover, test and trial has proved its efficacy in the Scandinavian countries and in America, and now, France and England are making it compulsory. It is a well-known fact that sub-lethal doses of any infection create anti-bodies which resist a serious attack of the disease. Statistics reveal that a large majority of people have already received, naturally, such doses of the infection and have developed a certain immunity. It is only for those, who by tests, are found not to have had it, the protection artificially by vaccination is advocated. To date there have been no reports of harmful results by such vaccination. The Laubek tragedy is an accident due to a mistake, and that cannot be quoted as an argument against B.C.G. vaccination. Even with proved remedies like Penicillin and many common drugs, there have been fatal accidents, yet we have not rejected them.

Regarding treatment of tuberculosis by the sanatorium method, it gladdens one's heart to see that many districts are arranging to have their own sanatoria to cater to their needs, but I wonder if our approach to the problem by this method is the right one. It must be remembered that to construct a decent sanatorium of about 100 beds we require about 5 lacs of rupees and to maintain it would cost about Rs. 50,000/- per annum. A patient on the average requires about six months treatment in the sanatorium and assuming that the cure rate is 50% we cure 100 patients in a year. Out of these only a small belong to the upper middle class and the rest to the lower middle or poorer classes. When they are discharged cured, they go back to their old surroundings and worsened circumstances and so the disease recurs in many of them and they die. Moreover, we cannot have enough number of sanatoria to meet the needs of all the tuberculosis patients in the country. I think sanatoria are useful only for the richer classes and to those who can afford to have long treatment and a longer period of rest and rehabilitation and to serve as surgical and research centres. The poorer patients should be treated in their own homes and in their own surroundings, so that there will not be any difference between the place of their treatment and their usual residence. The very useful surgical proceedings like Artificial Pneumo-Thorax and Phrenic avulsion can be easily done in patients homes. Incidentally, this method of home treatment would also help to improve their houses and surroundings and inculcate in the residents of the locality a sanitary conscience and in contacts better preventive practices. Every

District Headquarters Hospital should have a special ward for treating cases of tuberculosis by the surgical methods, such as Thoracoplasty, Lobectomy etc.

Leprosy.

In the case of leprosy, institutional treatment would be more useful, and it would be availed of by the poorer class of leprosy patients, for the treatment of leprosy is more painful and prolonged. Along with it rehabilitation measures can be carried on in most cases. After discharge there is no great likelihood of recurrence of the disease, and the patients can carry on their avocations. Even here, there is great difficulty because the patients have to be kept away from their homes for a number of years. Able bodied leprosy patients, who are also the bread-winners, are not tempted to seek admission into the institutions. Since by experience it has been found that infection in leprosy occurs only by continuous and constant contact, particularly of children, and that contact is more intimate at nights it would be very useful to develop night segregation camps in villages where the incidence is high. Treatment can also be carried on in these camps. Establishment of such camps as at Polambakkam have caused a lowering of the incidence of the disease. Even if there is delay in taking treatment to the villages, much can be done by educating the patients and their families to observe night segregation of patients even in their homes and in isolating the patients bed, clothes, utensils etc.

Cancer.

We should congratulate the Government of Madras on their wise decision to start a wing in the General Hospital, Madras exclusively for the treatment of cancer by a team of doctors, who would also carry on research. We are also glad to hear that the Government propose to set apart wings and give facility for the treatment of cancer in the Stanley and Kasthurba Hospitals. It is a good news that these facilities would also be extended to some of the larger district hospitals to save patients the trouble of trekking to the metropolitan city. May we suggest that even before giving these facilities to the other hospitals in the city, at least three regional hospitals in the mofussil, say the Government Hospitals at Madura, Visakapatnam and one on the West Coast, be immediately equipped to give cancer treatment?

NATIONALISATION OF MEDICINE

The only way of tackling the problems of health and disease on a permanent basis is to nationalise medicine as has been done in England now. In India, fortunately for us, modern medicine is already partially nationalised, for this system has been widely administered through government agencies or through the local bodies. When the Workmen's State Insurance Scheme, which is now being worked out, is put into effect, another stride in nationalisation would have been taken. I realise this is not nationalisation in the proper sense as is being carried on in England, but because we have been moving in that direction almost ever since the western system was adopted in this country, and as it is only during the last 4 or 5 decades that the modern system has found sponsors amongst the private practitioners, it may not be very difficult to nationalise medicine in this country if only the money could be found

for it. It looks as if it would take ages to attain the millennium and in the present financial position of the country with the devaluation of the dollar, we do not know where we are. But, though wholesale nationalisation may not be possible in the near future, attempts should be made to make the Primary Health Centres, that are being started in all districts, serve such an ideal.

DOCTORS AND SOCIAL SERVICE

Our duty does not end by merely advising the powers that be to do this and that or criticising whatever is done by others. It is not enough if we merely attend to our professional work and feel satisfied that we have served humanity. Each one of us should do some social service for the public at large. It is usual for us to say that we are too busy and have no time to spare, and that others should take up such work. We as medical men are best fitted for social service. By experience and from the example of others, I realise that the busiest practitioners and the hardest worked official can always find time not only for recreation but also for such service if he is methodical in his work. Unless we place service above self, we shall not deserve to be called members of the noblest profession.

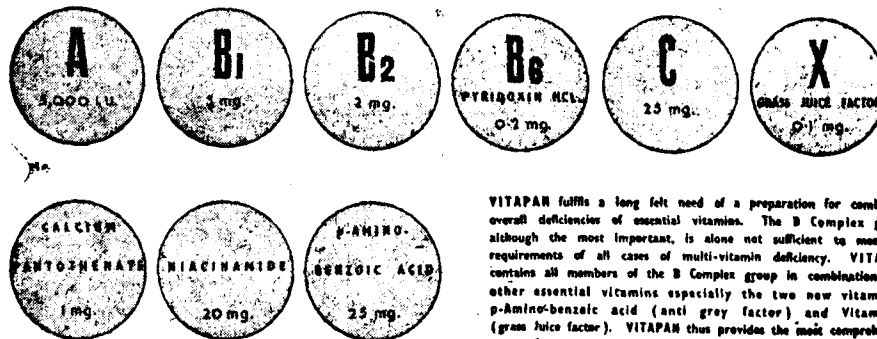
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October, 1949]

The Sixth All-India Obstetrics & Gynaecological Congress 1950

RECEPTION COMMITTEE

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B.A., M.B., F.R.C.S.(E.), M.R.C.O.G.

Hony. Secretary:

Dr. M. K. KRISHNA MENON, B.A., M.D.

Treasurer:

Dr. N. RAJASEKHARAN, M.B., B.S.

Government Hospital for
Women and Children

EGMORE, MADRAS,

11, August 1949.

Dear Doctor,

The Sixth All-India Obstetric and Gynaecological Congress is to be held in Madras in the first week of January 1950 under the auspices of the Obstetric and Gynaecological Society of South India. Delegates from all over India are expected to attend. The Congress will last for three days. In this connection a medical exhibition is also being arranged.

As conveners of the Congress it is our duty to see that the congress is a first class success. This is not possible without your help and co-operation. We therefore request you as a token of your help to enroll yourself as a member of the Reception Committee. The minimum subscription for membership is Rs. 15/- but we will be very thankful for a generous contribution.

Thanking you.

Yours faithfully,

M. K. Menon,

Hony. Secretary.

P. S.:—All Communications may please be addressed to: Dr. M. K. KRISHNA MENON, B.A., M.D. Hony. Secretary, All-India Obstetric and Gynaecological Congress, Government Hospital for Women and Children, Egmore, Madras.

RESOLUTIONS

Passed at the 4th and 7th Provincial Conferences of I. M. A.
and A. I. M. L. A. on 10-10-49

1. This Conference places on record its sense of deep sorrow at the passing away of Doctors S. K. Sundaram, S. Thambiah, H. M. Rao, Sambasivam of Madras, J. S. Victor, C. S. Venkataraman, C. S. Pandiaraj and T. P. Balaji Rao of Madura, Jayaraman of Tanjore, O. R. Balu of Trichy, D. Narayanaswami Pillai, S. D. Velukannu, T. R. Vaidyanatha Iyer and Narayanaswamy of South Arcot and resolves the same be communicated to the members of the bereaved family.

Moved from the Chair and passed all standing

2. This Conference notes with satisfaction the assignment of the Health Portfolio to a member of the profession and trusts that during the Hon'ble Dr. T. S. S. Rajan's tenure of office much will be done to improve the health of the people and afford greater medical relief.

3. This Conference conveys its congratulations and felicitations to Dr. V. Krishnamoorthy, L.M.P., L.O., Cuddalore for having been chosen as a member of the Senate, Madras University, by the Local boards of South Arcot District. A deserved and unique distinction for a member of the profession from the ranks of licentiates.

4. This Conference resolves that the integration of various systems of medicine is possible only on the highest level i.e. after research into the indigenous systems. Integration of various systems of medicine at lower levels as attempted in the School of Indian Medicine during the last 25 years has neither improved the indigenous system nor added anything to the modern system and the products of this school administer only modern medicine for which they are ill trained.

5. The suggestion of the Chopra Committee for the introduction of the six months training on public health and curative medicine such as surgery, midwifery, ophthalmology etc. is impossible, as the time is too short a period for even literates and much more so for illiterates. This Conference is of opinion that the only method of carrying medical relief to the masses is to implement the Bhoré Committee recommendations in full.

6. This Conference notes with satisfaction the opening of 21 Primary Health Centres and urges on the Government to open as many more as possible, in view of the urgency of the need of medical relief in the rural areas.

7. In the appointment of medical officers to these centres the claims of the Licentiates should be duly considered and preference should be given

to such of those Rural Medical Practitioners who are already serving in the locality within a radius of five miles.

8. This Conference suggests to the Government that one or more mobile medical units be attached to each taluk hospital from where the units, which should consist of a male and woman doctor, midwife and a male attender, can visit a number of villages a day, according to the prearranged programme announced beforehand to the villages concerned, to attend to simple ailments and bring back with them cases requiring hospitalization in the Taluk Head Quarters Hospital. The villages in the taluk may be visited once or twice a week and medical aid carried to the suffering villagers.

9. This Conference requests the Government of Madras to promote the deserving Licentiates for the posts of the Civil Surgeons and D. H. Os.

10. This Conference is happy to note that the unification of Civil medical services is under the active consideration of the Government of Madras and requests them to consider at the same time the provincialisation of the Local Board and Municipal medical services. Till provincialisation is achieved, the Government should insist on the Local Bodies and Municipalities to give the same scale of pay as obtaining in Government service just as they do in the case of Health, Engineering and other services.

11. This Conference requests the Universities of Madras and Andhra to permit candidates who have put in the requisite period of training in medical studies in colleges affiliated to other universities in India to sit for the M. B. degree examination.

12. This Conference is of opinion that it is possible to reduce the five years medical course to one of four years by judicious planning of holidays and syllabuses, without lowering the standards of education.

13. This Conference requests the Government of Madras that in order to meet the needs of the country, more medical colleges should be started immediately in various parts of the Province. This Conference suggests that the Government need not spend large sums of money on buildings but the existing buildings which lodged the medical schools in Madura, Tanjore, Calicut and Guntur may be utilised for new colleges. The standard of education should be of the present M. B. course, with intermediate in science as basic education. If there is any difficulty in the Universities giving recognition to these colleges for want of adequate buildings as per their requirements, this conference suggests to the Government that a college of Physicians and Surgeons, as in England, be constituted who will conduct examinations and issue diplomas to the products of these colleges. For purpose of practice and appointments in the Government and all other services these diploma holders should have the same facilities and status as University Graduates.

14. This Conference suggests to the Government that in order to provide adequate teaching personnel, full facilities be made available for post-graduate studies to all those who desire higher qualifications.

15. This Conference protests against the continuance of the Indian Medical Council Act of 1933 and request the Central Government to amend the Act forthwith in such a manner as to maintain an All India Register common for all qualified medical practitioners including licentiates where their names should be entered in an alphabetical order irrespective of the qualification they possess. There shall be two elected representatives on the council from each province which maintains a register for itself, of whom one shall be a Licentiate and one from the others for a period of 10 years. The powers and functions of the Indian Medical Council should be enlarged as to make it an advisory Council to the Ministry of Health on all matters of health. This Conference also requests the Government of Madras to recommend to the Central Government the above amendment.

16. This Conference suggests to the Government of Madras that the service of medical men should not be wasted on public health work but a separate course of 3 years on Public Health be instituted for filling up these health officers posts.

17. This Conference resolves to request the Central Association to press upon the Government of India the claims of the Licentiates for permanent commissions in the Army on a par with the graduates.

18. This Conference requests the Government of Madras to throw open more posts of Civil Surgeons to Women Medical Officers.

19. This Conference requests the Government of Madras to prohibit unqualified and un-registered medical practitioners (though qualified in medicine but not registered under Medical Registration Act) from issuing prescriptions or practice medicine.

20. In view of the grave financial situation of the country consequent on the devaluation of the currency this conference requests the members of the medical profession to limit to absolute necessity their purchase of drugs and other materials from the Dollar areas and also to encourage Indian made medicines as far as possible.

21. This Conference reiterates its previous resolution regarding the admission of students into Medical Colleges and that at least 30 per cent of admissions should be on merit alone without communal or regional considerations and also requests the Government to reserve a reasonable percentage of seats for the children of medical men, lest medical institutions started by them need not be closed down after them.

22. This conference thanks the Government of Madras for promising to include representatives of the Provincial Branches of the I.M.A. and A.I.M.L.A. in the formation of the committees intended for the purpose of formulating measures on medical and public health reforms but regrets to note that in the recently formed Tuberculosis Advisory Committee, representatives of the Associations were not included.

23. This Conference places on record the very excellent arrangements made by the Reception Committee for this Provincial conference and thanks everyone concerned for their efforts.

The Conference also thanks the authorities of the Annamalai University for affording all facilities for holding the conference in the University Buildings.

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Copies can be had from the Author

Dr. A. Viswanathan

Vengudi Village

Thimmarajampet Post, Dt. Chingleput

(Via Madras and Conjeevaram)

**Proceedings of the meeting of the Council of the South Indian
Provincial Branch of the Indian Medical Association held
at Annamalainagar on the 9th Oct. 49, at 6 p.m.**

Members Present :—

Dr. P. A. S. Raghavan	<i>President</i>	Tiruchirappalli.
„ A. K. Rajagopalan	<i>Hon. Secretary</i>	Madura.
„ D. V. Venkappa	<i>Jt. Secretary</i>	Madras
„ P. V. Sundaram	<i>Hon. Treasurer</i>	Tiruchirappalli.
„ A. M. Sivaraman		Madras.
„ R. Sankaran		„
„ P. B. Anangarachar		„
„ K. Ramarao		„
„ C. Ramarao		„
„ N. Chandrasekaran		„
„ Major N. Gangadharan		„
„ A. G. Leelakrishnan		„
„ T. S. Shetty		Coimbatore.
„ P. A. K. Nair		Chettinad.
„ S. Kantimathinathan		Tanjore.
„ K. G. Ramabhadran		Madura.
„ R. Ganesan		„
„ G. Joseph Gnanadickam		Tiruchirappalli.
„ Capt. S. S. Chary		„
„ S. Chandrasekaran		Negapatam.
„ S. Sankararaman		Cuddalore.
„ P. Vydinathan	(By invitation)	„
„ V. Krishnamurthy		„
„ C. Nathamuni	„	„
„ A. Jabbar	„	Madras.
„ C. H. Srinivasan	„	Karaikudi.
	„	„

Dr. P. A. S. Raghavan, the president was in the chair.

The following resolution was moved from the chair and passed all standing:—The council places on record its sense of sorrow at the passing away of the members (given in resolution No. 1 of the Conference) of the association, and requests the secretary to communicate the same to the members of the bereaved family.

The Hon. Secretary then read the minutes of the last Council meeting held at Kodaikanal on 22-5-49 and the minutes of the working Committee held at Tanjore on 24-9-49 and the same were approved.

The Hon. Secretary then read the annual report of the branch for the year ending 30th Sept., '49 and the same was approved with the suggestion that the name of the members that constituted the deputation that waited on the Hon. Rajakumari Amrit Kaur, Minister for Public Health, Government of India, New Delhi, may be mentioned. They are Dr. P. A. S. Raghavan, Lt. Col. T. S. Shastry, Dr. Joseph Gnanadickam and Dr. D. V. Venkappa.

The audited statement of accounts was passed.

The budget estimate for the year 49—50 subject to correction of clerical mistakes, and deletion of the item on travelling expenses to the members of the Working Committee, was passed.

It was resolved to pay travelling allowance to the President, Hon. and Jt. Secretaries and Treasurer when they travel on Association work (other than meetings of the Council.)

The letter from Dr. K. L. Narayana Rao, Hon. Secretary Madras Branch, as placed before the house. The president explained that the Hon. Provincial Secretary did the right thing in placing the letter before the Council instead of disposing of it off himself and this was no cause for complaint. The President also explained that the Council was the supreme body and it had power to elect a Working Committee as it did in Chettinad and there was no rule which required the Council to refer the matter to all the branches. The house approved of the statement of the President.

The Council decided that as its membership was not unwieldly and as no meeting of the council had been adjourned for what a quorum, there was no need for a Working Committee now.

The following office bearers were elected.

<i>President :—</i>	Dr. P. A. S. Raghavan of Trichy	} Already elected by the branches.
<i>Vice Presidents :—</i>	Dr. K. I. Vythilingam of Vellore	
	Dr. K. R. Kini of Mangalore	
<i>Hon. Secretary</i>	Dr. A. K. Rajagopalan of Madura.	
<i>Jt. Secretary</i>	„ D. V. Venkappa of Madras.	
<i>Hon. Treasurer</i>	„ P. V. Sundaram of Tiruchy.	

Members of the Central Working Committee:—

Dr. P. A. S. Raghavan of Tiruchy, Dr. D. V. Venkappa of Madras and Major Gangadaran of Madras.

With a vote of thanks to the chair and the organisers of the Conference the meeting terminated.

Indian Medical Association South Indian Provincial Branch MADURA

ANNUAL REPORT FOR THE YEAR 1948-49

LADIES & GENTLEMEN,

I have the honour to submit the following report for the year 1948-1949.

HEAD QUARTERS: The Head Quarters of the South Indian Provincial Branch during the year was located at Madura, the place of the Hony. Secretary.

The year began with 16 active branches and a total membership of 1219. The following are the 16 active branches:—

Bangalore	Chingleput	Coimbatore
Coenoor	Devanagere	Madras
Madura	Malabar	Negapatam
North Arcot	Ramnad	Salem
South Arcot	S. Kanara	Tanjore
Tiruchirappalli		

The branches of Tinnevelly, Pudukottah and Mysore were not working at the beginning of the year.

Pudukottah: Due to merger question and dislocation of medical men, Pudukottah branch was not functioning. Every member of the Medical profession there was uncertain about his or her future. I visited Pudukottah and convinced them on the need for the revival of the branch and restarted the branch at Pudukottah as a new one with 12 members. There are only a few practitioners there.

Tinnevelly: I paid a visit to Tinnevelly and a branch was started with a membership of 31 and it is hoped more members will be enrolled and the branch will be again active.

Mysore: In spite of repeated reminders and registered letters there was absolutely no response. Only one member has condescended to send his central fund contribution direct to the South Indian Provincial Branch.

Erode: The members of the medical profession there were anxious to have a separate branch of their own at Erode (in the Coimbatore District). There was once a local Association functioning there but now it is defunct. They are entitled to have a separate branch as Erode has got a Municipality of its own. I went there and met the members of the medical profession. A branch was started and office-bearers were elected and the branch has begun functioning from the second half of 1948-49.

The total number of active branches now is 19 and the number of members on roll is 1414.

October, 1949]

ANNUAL REPORT

27

The Provincial Branch held two Council Meetings during the year. The 1st meeting was at Chettinad on 19th February, 1949. Dr. T. S. Shetty was kind enough to be the host. The second meeting was at Koday on the 22nd May 1949. The Council of the South Indian Provincial Branch has a strength of 86 members. As is always the case, the attendance during the Council meetings is meagre. So in order to carry out the day-to-day administration, the Council of the Provincial Branch at the Chettinad meeting on the 19th February 1949 decided to have a Working Committee consisting of the President, the Hony. Secretary, the Joint Secretary and the Treasurer as Ex-officio members and 7 other members elected from among the members of the Provincial Council. The following were elected to be the members of the Working Committee.

Lt. Col. T. S. Shastry, I.M.S.	Madras
Dr. T. S. Shetty, M.D.	Chettinad
Dr. A. G. Leelakrishnan,	Coimbatore
Dr. S. Chandrasekaran,	Cuddalore
Dr. K. R. Kini,	Mangalore
Dr. Joseph Gnanadickam,	Tiruchirappalli
Dr. K. R. Hariharan,	Salem

The first meeting of the Working Committee was held at Thyagarayanagar at Lt. Col. T. S. Shastry's bungalow on July 6th. The second meeting was held at Tanjore on 24th Sept. 1949 when the election of the President and Vice-President were announced and other organisational matters attended to.

Members of the Working Committee of I.M.A.

At the last annual meeting of the Provincial Council at Madras, the following were elected to be the members of the Working Committee of I.M.A.

1. Dr. P. A. S. Raghavan
2. Dr. A. K. Rajagopalan
3. Dr. P. B. Anangarachari

Since we had on the rolls only 1219 members who had paid their central fund contribution in full upto September 1948, the Central Office of I.M.A. held that we were entitled to have 2 members only for the Working Committee of I.M.A., and refused to take in the 3rd member. So Dr. P. A. S. Raghavan and Dr. A. K. Rajagopalan the first two elected members were members of the Working Committee. Dr. P. A. S. Raghavan attended all the meetings of the Working Committee. As Dr. A. K. Rajagopalan could not attend the meeting of the Working Committee at Delhi on 3rd April 1949, Dr. Joseph Gnanadickam attended as a substitute member.

As per resolution No. 10 passed at the meeting of the Council held on 19th February 1949 at Chettinad, the President led a deputation to the Hon'ble Minister for Health, Government of India at Delhi on the 4th April 1949 with regard to the inclusion of Licentiates in the All India Medical Register. The Hon'ble Minister promised to consider the matter very favourably. The deputationists also met some members of the Constituent Assembly and they have promised to help in the matter.

The President and Joint Secretary met the Hon'ble Minister for Public Health, Government of Madras with regard to the various resolutions passed by the Provincial Council and also met the Vice-Chancellor, Madras University re: the condensed M. B. course for Licentiates.

Regarding the resolutions passed at the meeting of the Working Committee that at least 25 per cent of the total admissions should be by merit, the Government of Madras has replied that admission of students to the Medical Colleges on the basis of merit is considered and the best available candidates are taken from each community in each district and therefore the merit of the candidates is not overlooked. They do not consider it necessary to make a new reservation for admission of candidates based only on merit without reference to communal and district representations.

As for the reservation of seats for children of medical men the Government of Madras has replied that "their request cannot be complied with as this will conflict with the general principles of territorial and communal representation and of merit.

Regarding candidates possessing B.Sc. Pharmacy degree, the Government has replied that candidates possessing B.Sc., Pharmacy degree specialise only in one subject viz., Pharmacy, which does not form an integral part of M.B.B.S., course and hence they cannot be given preference in the matter of admission to the course.

Regarding Bogus Medical Practitioners, the Madras Medical Council has recommended to the Government the prosecution in this specific case and it is very regrettable to note the Government has not yet thought fit to sanction the prosecution.

There were lots of complaints with regard to the non-receipt and irregular receipt of journal of I.M.A. from many members of various branches. It is now rectified to a very great extent. In this connection, I would request the members to give their change of address, if any, to their respective branch and the Provincial Secretary.

My thanks are due to the retiring President for all the guidance he gave me, the Joint Secretary and the Hony. Treasurer for all the co-operation they gave me in the discharge of my duties. I am also thankful to the Editor of the Miscellany, the official organ of the South Indian Provincial Branch for giving due publicity to all the activities of the branches, which helped in increasing the membership.

I am also thankful to the Secretaries of all the local branches for their kind help and support they extended to me. I would request them to be prompt in their replies and I can assure them that this office is always at their service in the best interest of the profession. Last but not least I must express my thanks to the office assistants Mr. Venkatarathnam and Mr. Lakshminarayanan for their good and hard work. I have had most loyal and active support from them without which it would have been impossible for me to run the Provincial office.

Jai Hind!

Madura, }
25-9-49. }

A. K. RAJAGOPALAN,
Hony. Provincial Secretary.

Budget for 1949-50

Membership of the S. I. P. B.	...	1,500 members
Expected Provincial quota at Rs. 3/- from the Central Fund	...	Rs. 4,500/-
Contribution: from 1500 members	...	Rs. 300/-
Estimated increase of 100 members and the provincial quota:	...	Rs. 4,800/-
Total	...	Rs. 4,800/-

ESTIMATED EXPENDITURE

Postage & Stationery to both offices	...	Rs. 500/-
Pay of Treasurer's Clerk at Rs. 30 p.m.	...	360/-
Pay of Full time clerk for the Secretary at Rs. 50/- per mensem	...	600/-
Travelling allowances for office bearers	...	300/-
Contingencies	...	70/-
Auditor's fee	...	50/-
Cycle allowance for Clerks	...	120/-
Total Rs.	...	2000/-
Budget Balance	...	2500/-
Total Rs.	...	4,500/-

INDIAN MEDICAL ASSOCIATION

SOUTH INDIAN PROVINCIAL BRANCH—TRICHINOPOLY

Receipts and Payments Account for the year ended 30th September, 1949

RECEIPTS			PAYMENTS		
	Rs.	A. P.		Rs.	A. P.
To Opening Balance:—			By Salaries	595	0 0
Cash on hand	51	1 9	" Travelling Expenses	1,005	1 0
Cash with Bankers	3,795	11 3	" Printing and Stationery	280	13 6
" Interest	64	6 5	" Postage and Telegrams	270	15 9
" Central Fund contribution	8,934	15 0	" Bank charges	23	1 9
" Delegates' Fees	140	0 0	" Central Fund Contribution:		
			Remitted to Central Office	5,380	0 0
			" Typewriter	200	0 0
			" Advance:—to Secretaries	115	0 0
			" Bank Fixed Deposit	3,000	0 0
			" Closing balance:		
			Cash on hand	12	7 9
			Cash with Bankers	1,203	10 8
Total Rs.	12,086	2 5	Total Rs.	12,086	2 5

Tiruchi } (Sd.) M. S. Krishnaswami & Jagannathan,
5-10-49 } Chartered Accountants.
(Sd.) P. V. Sundaram,
Hon. Treasurer

(Sd.) A. K. Rajagopalan,
Hon. Secretary.
(Sd.) D. V. Venkappa,
Joint Secretary.

The Fourth Provincial Medical Conference I. M. A. and Seventh Provincial Conference of A. I. M. L. A.

ANNAMALAINAGAR

8th, 9th, & 10th Octr. 49.

A REVIEW

The Fourth Provincial Medical Conference of the I. M. A. and the 7th Provincial Conference of the A.I.M.L.A. which were held jointly at Annamalainagar were by all accounts a grand success.

Delegates and visitors who numbered over 400, started arriving in Annamalainagar from the evening of the 7th Octr., and there were many responsible organisers and volunteers of the conference present at the station for every train to receive the guests and escort them to the camp. A number of guests also arrived by car. The guests were very comfortably lodged in the palatial buildings of the University, the bulk of the visitors being accommodated in the Oriental College building. Distinguished visitors and visitors with families were given separate rooms in the Guest House. Boarding arrangements which had been made in the Hostel, were neat and clean and in spite of rationing difficulties sumptuous.

The opening of the conference took place in the Srinivasa Sastriar Hall at 11 a.m. on the 8th instant. Though there were more than 500 people who had gathered there, including some members of the staff and the public, only a small part of the hall was filled as the hall is of immense proportions and was tastefully decorated. The conference commenced with prayer all standing. In inaugurating the two conferences, the Hon. Dr. T. S. 3. Rajan, Minister for Public Health with the Government of Madras, delivered a very interesting and thought provoking address which lasted nearly an hour. It was attentively listened to by the audience. (A summary of the address is published in this issue). Dr. S. Nataraja Jatavallabhar, Chairman of the Reception Committee read his Welcome Address, and then formally proposed Dr. P. A. S. Raghavan, to preside and this was seconded by Dr. S. Chandrasekaran, the General Secretary of the Reception Committee, and unanimously approved by acclamation.

Dr. P. A. S. Raghavan then delivered a very impressive address which covered various problems of medical relief in the Province. As printed copies of the address were distributed, he omitted to read some portions and gave a gist of some other portions. The address was much appreciated.

Dr. C. Nathamuni Naidu of Ambur, President of the Licentiates Conference then read his Presidential Address, which covered the various problems of the Licentiates. With the reading of messages from various persons, wishing the conference success, the opening session ended at 1 p.m.

The scientific session commenced at 3 p.m. in the Gokhale Hall. Dr. A. S. Mannadi Nair, the Surgeon General, in opening the Scientific Session, stressed the need for such conferences where ideas, thoughts and experiences might be exchanged. He also impressed on the need for research and said every practitioner, whatever his quantity of work was, could, if he was methodical, contribute his mite for research. There were 3 lectures on various subjects during this session.

At 4 p.m. the Hon. Dr. T. S. S. Rajan, Dr. A. S. Mannady Nair, Dr. P. A. S. Raghavan and a few members went to the Municipal Office where they were presented with Civic Addresses. In his reply to the address, Dr. Rajan said that the primary function of a Municipality was to supply good drinking water, safe drainage and

decent houses. He was glad that the town had protected water supply due to the munificence of a philanthropic gentleman, Mr. Ramaswamy Chettiar. He also informed them that in the matter of drainage, their priority was advanced and that the Government had decided to complete all the drainage schemes in the province within five years. Dr. Mannady Nair in his reply thanked the Municipality for their address and invoked the blessings of Lord Nataraja for the well-being of all. In his reply, Dr. P. A. S. Raghavan said that it was but proper that Municipalities honoured medical men thus, because local bodies were very much concerned with doctors. He was also glad to note that in addition to there being a few doctors in almost all the municipalities in the provinces, doctors are and were Chairmen of many of the major municipalities and cited the example for Madras, where last year the Mayor was a doctor and the next year also there is likely to be a doctor, and the municipal councils of Coimbatore, Tiruchirappalli, Coonoor, Conjeevaram, etc. The Chidambaram Municipal Chair was adorned by a Doctor on a previous occasion, in the person of Dr. Nataraja Jatavallabhar, an eminent member of the profession. Doctors were essentially the sweepers and cleaners and that was no disparagement and according to Gandhiji it was the noblest service.

With a vote of thanks the function terminated.

It is a pity that the Civic Addresses were not presented in the conference place as was originally arranged as it was done at the First Provincial Medical Conference at Tiruchirappalli in 1945 as all the visitors could have participated in the function, particularly because the address was to Dr. P. A. S. Raghavan, the President and Members of the Indian Medical Association.

At 5 p.m. Dr. Manavala Ramanujam, the Vice Chancellor of the Annamalai University, declared open the Medical Exhibition organised along with the conference. He stressed the need for encouraging indigenous industries and encouraging indigenous medicines. He also announced that they were contemplating the opening of a Siddha College of Medicine in this University. The visitors then went round the various stalls which had been arranged in two rows on either side of the front of the Gokhale's hall, and were well decorated and illuminated. Then there was a Tea Party in the open lawns given by East India Pharmaceuticals and the visitors enjoyed a pleasant hour. Later in the evening there was a dance recital by S. Vitaldas, and Miss Chandrasekaran and music at night by Sri Vedavalli brought the days functions to a close.

Next day, the 9th Octr. was an arduous one, a number of lectures being crammed from 8 a.m. to 7 p.m. with short intervals for lunch and tea. It was a sort of condensed post graduate course. Many felt that it would have been better if there were fewer lectures and more time given for discussion. After 7 p.m. came the well needed relief and relaxation with excellent music by Chittoor Subramania Pillay.

The third days function was short, having commenced at 8 a.m. ended at 1 p.m., and though crammed with 5 lectures was not felt too boring as the visitors were expecting to go off in the afternoon. It was a good thing that the open session of the Conference to pass resolutions, which was fixed after lunch, was held before it, as otherwise there would have been only the President, the Secretaries and the organisers to pass important resolutions. Even so many did not give the open session that amount of interest which it deserves, as matters vitally concerning the profession are decided there. It is hoped that in future the open session would be fixed during the middle of the scientific session and more members would take greater interest in the medico-political aspects of the conference.

Thus ended another useful conference and the thanks and gratitude of all should go to the organisers of the conference, who under heavy handicap, made the conference a grand success.

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Spt. Amm. Aromaticus	... 40 m.	Ext. Cascara.	... 16 m.
Tr. Nux Vomica	... 16 m.	Ext. Hemidesmus Indicus and Syrup	
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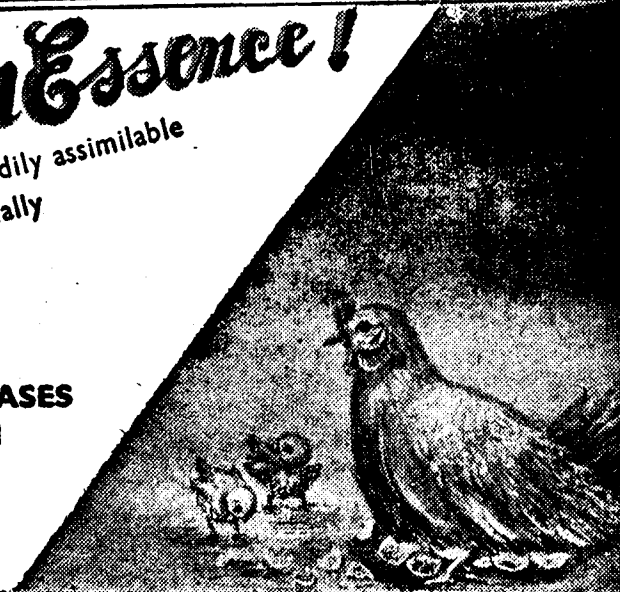


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In cases of allergy to atropine, or when a mydriatic is indicated for a long time, Lachesine may be used.

∴ ∴ ∴
Q fever is an acute specific bacterial disease of man characterized by high fever, head-ache and malaise and likely to be wrongly diagnosed as Influenza or Atypical Pneumonia.

∴ ∴ ∴
There is an institution in U. S. A. called "The Rapid Treatment Hospital."

∴ ∴ ∴
80 per cent of women in Denmark get the benefit of Wassermann Test in early pregnancy—for preventing congenital syphilis.

∴ ∴ ∴
At an evening party, there was a girl who had a thin chain on her neck, with a tiny golden air-plane, as pendant. One of the young men in the party was staring at it so much, the girl was tempted to ask "Do you like my little air-plane?" "As a matter of fact" he confessed hesitatingly "I was not looking at the plane. I was only admiring the landing field."

∴ ∴ ∴
The doctor was pleased to with patient.
"You look much better today."
"Yes, I obeyed the instructions on the bottle."
"What instructions?"
"Keep the bottle tightly corked."

∴ ∴ ∴
Family physician (after consultation): "Mr. Smith, I congratulate you most heartily."

Patient (Excitedly): "I will recover, doctor?"

∴ ∴ ∴
Family Physician: "Well—er! Perhaps not exactly that, but—er well after consultation we find that your disease is entirely novel, and if the post-mortem examination should prove this to be a fact, we have decided to name the disease after you."

∴ ∴ ∴
The eye specialist's consulting room was crowded.
"Is it always like this"? asked a friend.
"No, only when there is a bad film in our local theatre."

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Yours Sincerely,

(Sd.).....

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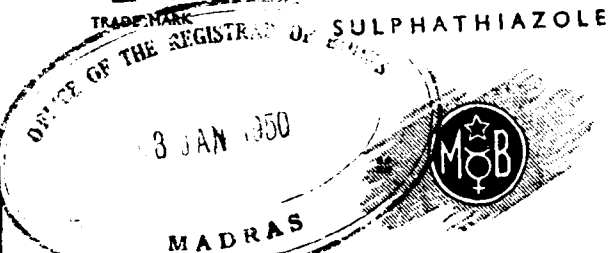


21 THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

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The Coimbatore District Medical Association

SILVER JUBILEE SESSION

1950

The Coimbatore District Medical Association which was founded in 1924, is celebrating its Silver Jubilee in the third week of March (17, 18, & 19th) 1950 in Coimbatore. Doctor Sir A. L. Mudaliar has kindly consented to inaugurate the celebrations.

This association is thus the oldest of the medical associations in the South. This has been one of the most active associations and it is the only one among its group that is having buildings of its own. Recently additional constructions have been put up for the original buildings, and the opening of the new buildings will be an additional feature of the jubilee celebrations.

The scientific side of the programme will include three symposia, on Fevers, Fractures, and Forceps. Distinguished specialists in these lines will be taking part in the sessions.

A health exhibition stressing the preventive aspect of medicine, nutrition, sanitation, etc., is being organised in conjunction with lectures on health in Tamil with a view to educate the public on these lines.

An attractive Souvenir will be published in commemoration of the Jubilee, and it will contain articles by eminent members of the profession and scientists of international repute on important medical and public health problems of the day.

A limited number of pages in the Jubilee Commemoration Souvenir are open for advertisements from leading manufacturers and dealers in medicines, drugs, surgical and all other requisites useful to the medical profession and their patients, and to medical and research institutions and clinics, both private and public.

Announcement

The Indian Radiological Association

The 4th Indian Congress of Radiology will be held in New Delhi on the 21st, 22nd and 23rd January 1950. Doctors who desire to attend the Conference may contact Dr. Ved. Prakash, D.M.R.E., 1, Barkhamba Road, New Delhi for arranging accommodation etc.

Barnard Institute,
G. H. Madras.

M. N. DASANNA,
General Secretary.

MISCELLANY—November, 1949

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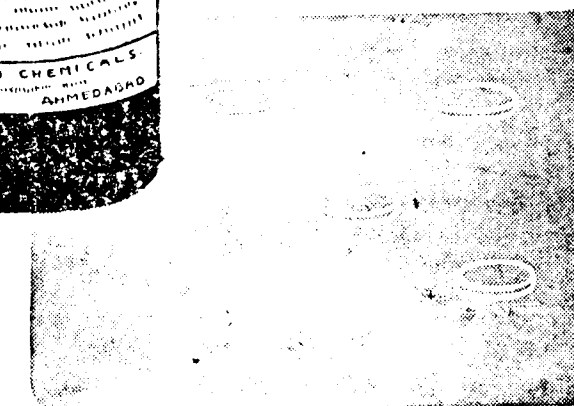
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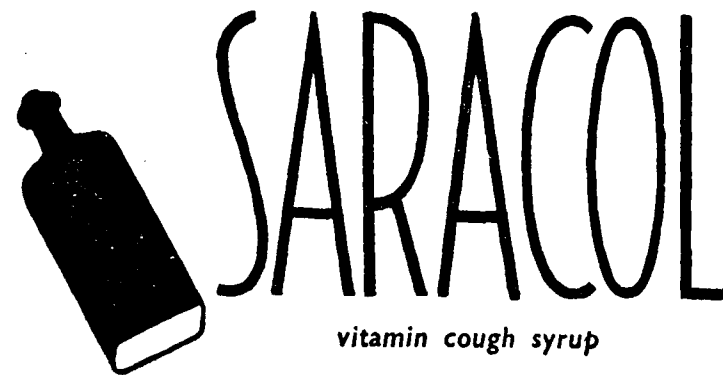
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Terpin Hydrate	0.4	"
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Sodium Benzoate	1.2	Gr.
Glycerol	30.0	"
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INDICATIONS.

Bronchitis, pneumonia, influenza, coughs, colds, whooping cough, asthma and all diseases of the respiratory tract.

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MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
THE INDIAN MEDICAL ASSOCIATION

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[No. 5

X-RAY THERAPY IN NON-MALIGNANT CONDITIONS

BY

DR. V. K. RANGANATHAN, M.B.B.S., D.M.R., *Trichy*

Ever since the discovery of x-rays and radium during the last part of the 19th century, a new therapeutic science has grown up and become firmly established as an essential procedure in the treatment of human ills. Recognition of the healing properties of these forms of radiant energy closely followed this discovery. But the early over-enthusiasm which at first regarded them as a panacea for every bodily ailment was only too soon followed by the inevitable reaction, a case of treatment being worse than the disease, which almost cast these agents into discard. At present however, thanks to the earnest perseverance of the clinician and in no small measure due to the work of the physicist in helping to understand the properties of x-rays, radiation therapy has fully justified its status as an efficient modality of treatment on a par with other therapeutic agents.

X-ray therapy is commonly associated with the treatment of malignant conditions. The value of x-ray therapy in cancer, either alone or combined with surgery, cannot be overestimated, but unfortunately more often than not, the type of case referred to the radiologist is far too advanced to effect a cure and at best it is palliation that is aimed at. In striking contrast to this present position of x-ray therapy in malignant conditions, there are

many non-malignant conditions in which x-ray therapy has a remarkable curative action either alone or as a supplementary measure.

The essential biological action of X-rays is one of cellular destruction. This destructive action is selective i.e. different types of cells react differently to x-rays. It is on this selective action depends its use in therapeutics.

The various conditions in which x-ray therapy is useful may be considered under the following clinical groups.

Dermatological Conditions:

Radiation therapy is an essential part of dermatologic practice. It is the method of choice in certain chronic intractable dermatoses like chronic eczema especially with marked hyperkeratosis, and a valuable adjuvant to other recognised methods of treatment in such conditions as dermatophytosis acne vulgaris and sycosis barbae where the possible recurrences are prevented. Acute furunculosis and carbuncles whether diabetic or non-diabetic respond very satisfactorily to x-rays. Since x-rays do not have any bactericidal effect, it is believed that in these acute conditions due to the action of x-rays the lymphocytes and leucocytes are destroyed liberating an endotoxin which is highly bactericidal. It is to this destruction of leucocytes and subse-

quent reduction in tension within the lesion, is due the almost dramatic relief of pain even after a couple of exposures in cases of carbuncle. Acute furunculosis is characterised by multiple pustules occurring most commonly in the back of the neck and axillæ. In the very early stage before there is actual suppuration, x-ray therapy arrests the inflammatory process and in the later stages it is only supplementary. In carbuncles, if treatment is started early the whole lesion resolves without leading to suppuration. Even otherwise there is early localisation and surgical interference is reduced to the minimum. Of course it has to be combined with other therapeutic measures such as penicillin, and insulin in case of the diabetic variety. In the treatment of keloid, the response to x-rays depends upon the duration of the condition as well as its size. Small keloids of recent origin respond better to x-rays than large ones of fairly long duration. To the latter type, surgical excision followed by a course of post-operative irradiation, after skin grafting if necessary, affords the best possible chance for a cure and prevention of recurrence. The epilating effect of x-rays is made use of in treating ring-worm of the scalp. This condition is due to a parasitic fungus which is firmly attached to the hair follicles. Although it is very sensitive to anti-parasitic ointments like Amoniater Mercury, the difficulty is that the drug cannot reach the parasite at its site of infection.

It is on this same property of epilation depends its use in the treatment of Sycosis Barbæ. Apart from this action, the X-ray has also a fungicidal effect to a certain degree. It is convenient to include Herpes zoster in this group since it is the skin lesion that is predominant clinically. Although in the majority of cases it passes off as a mild malady, in a few cases, the post-herpetic pain which is segmental in distribution is most excruciating and intractable. A few

exposures to the posterior nerve roots corresponding to the affected areas brings about a marvelously dramatic cessation of pain. Recently the son of a doctor was treated, with X-ray therapy for this condition and surprisingly, a single exposure completely stopped the pain. Other rare lesions of the skin that are benefited by X-ray therapy are Lupus vulgaris, seborrhoeic dermatitis and psoriasis. In psoriasis it is essential not only to expose the lesions themselves but also the corresponding posterior nerve roots, the rationale not being quite clearly understood. X-ray therapy has been successful in cases of venereal granuloma as an adjuvant to antimony therapy. But the advent of streptomycin has definitely changed a hitherto incurable condition into a comparatively benign and easily treated disease. Even after a course of streptomycin, the average dose being 10 grams given daily in 1 gram dose for 10 days, a course of X-rays prevents recurrence as also the formation of any keloid or cicatrix during the process of healing of the large granulating surface. Hæmangiomas either capillary or cavernous are most often congenital and consequently occur in children from birth. The best time to treat them is as early as possible after birth since those of shorter duration are more embryonic in structure and hence more sensitive to radiation therapy. Although there is no essential difference between filtered x-rays and filtered gamma rays from radium, radium is best suited for treating nævi on practical consideration and technique but where radium is not available x-rays may be used with equally gratifying results.

Diseases of the Respiratory System:

X-Ray therapy in lesions of the tonsils may be considered first. In chronic tonsillitis with recurrent acute exacerbation of follicular inflammation, surgical removal of the tonsils is the rational and recognised method of

treatment. The modern trend in considering the tonsils as a focus of chronic sepsis is that the foci are not only in the crypts but also in the tonsillar bed. Hence it is quite rational to irradiate the tonsillar bed after tonsillectomy. If for any other reason surgery is out of question irradiation offers an equally effective method of treating the condition. In those cases of tonsillar hypertrophy, where due to the enormous size there is mechanical impediment to respiration, X-ray therapy brings about a rapid retrogression in the size. On the same principle is based the radiation treatment of those cases of deafness that are due to an over growth of lymphoid tissue round about the internal opening of the Eustachian tubes. The problem of the adult carrier in the control of diphtheria is one of great importance in preventive medicine. Irradiation effectively destroys the foci in the tonsillar crypts.

Pulmonary conditions requiring x-ray treatment may be broadly classified into two groups. (1) The infectious group and (2) The non-specific affections.

Whooping cough, unresolved pneumonia, Lung abscess, persisting empyemic sinuses and actinomycosis come under the first group.

Whooping cough though a malady of childhood may sometimes affect adults also. The spasmodic cough is due to pressure irritation on bronchi and pathologically numerous enlarged lymphoid nodules may be found in the mediastinum. X-ray therapy offers a means of rapidly relieving this condition in a painless and harmless manner. Even in those cases where a cure is not effected the paroxysms are rendered less severe and spaced far between.

Unresolved Pneumonia: Clinicians quite often find cases of lobar pneumonia which pass on uneventfully to the stage of crisis but instead of proceeding to a total healing stage, linger on with mild temperature, con-

tinued malice and persistent signs of consolidation. The infective process in the lung does not go on to complete resolution but remains as an unresolved pneumonia manifesting itself at any time from the 4th to the 10th week. At this stage the histological picture indicates incomplete disintegration of leucocytes and fibrin. Although the exact rationale is not known it is believed that irradiation destroys the sensitive leucocytes and hastens the completion of this arrested or dormant process. With x-ray therapy the response is often rapid and complete.

Lung Abscess: Radiation therapy is recognised as an essential part in the treatment of lung abscess and combined with penicillin, it offers a very reasonable and fair chance to complete cure. In the very rare condition of pulmonary actinomycosis, in addition to iodides, x-ray treatment is the only hope for a cure.

Non-specific conditions: The three important affections under this group are asthma, bronchiectasis and persistent cough in children. *Asthma:* From the standpoint of irradiation asthma cases may be classified into two (1) infections and (2) allergic when seizures can be traced to some protein sensitiveness. The allergic substance should be determined and desensitisation carried out. Many cases however react allergically to so many substances that irradiation becomes the method of choice. By far the best results are obtained in those cases which present a clinical history of chronic bronchitis of many years duration and in whom the apparent pathogenesis is a sensitivity to bacterial infections. Often the improvement is quite startling, the paroxysms diminishing in number and intensity, eventually disappearing. The primary reaction may be an activation of the paroxysms but fortunately this complication lasts only for a short time. Recurrences after the initial satisfactory response are quite likely

to occur within four to five weeks after the first cure, but the severity of the attack is strikingly diminished. Treatment should be reinstituted giving slightly larger doses. Several refractory cases are known but these are not the rule.

Persistent Cough in Children:—X-ray treatment is of definite value in the treatment of children with persistent cough of no definite aetiology. This is especially valuable since sometimes symptoms are not alleviated by any therapeutic means. The effect may be due to action on the peri-bronchial lymphoid tissue or sympathetic nervous system.

Diseases of the Lymphatic system and the blood dyscrasias:—

The two chief conditions of non-malignant lymphadenopathy are tubercular adenitis and Hodgkins disease. In combination with streptomycin we can almost say that the problem of tubercular glands is solved. The treatment of Hodgkin disease for the most part consists of arsenicals, blood transfusions, surgery and irradiation. Surgical excision of localised nodes with or without irradiation seems definitely to have influenced the duration of life of some cases of genuine Hodgkin disease. But the majority of cases seem not favourable for surgery and as a measure of at least prolonging the life, x-ray therapy stands unrivaled.

Of the blood dyscrasias, hæmophilia, polycythaemia varie, purpura, splenic anæmia, pernicious anæmia and leucemias form a group of conditions where x-ray therapy has its value provided its limitations are understood. The action of x-ray in hæmophilia is not properly understood. While not always successful, it has no negative effect and irradiation of the spleen and the sternum has definitely helped in some cases and it is very worthy of a trial in the treatment of this condition which has to date proved refractory to any mode of therapy.

While the treatment of pernicious anæmia is primarily medical, in some cases irradiation has proved beneficial. The sternum, spleen and long bones are treated. The action is not understood but perhaps there is direct stimulation. The treatment is harmless and well worth a trial.

Polycythaemia may be primary or secondary as a compensatory reaction. While there is a definite indication for x-ray therapy in the former condition, it is definitely harmful in the latter and a correct diagnosis is an essential prelude to x-ray therapy. The entire hæmopoietic system is subject to irradiation in rotation.

Splenic anæmia is supposed to be due to an over active spleen and upto recent years splenectomy was the treatment of choice. But since irradiation of the spleen gives an equally good result by starting the destruction of R. B. Cs, it offers a safer and equally efficient method without the mortality associated with surgery.

Irradiation of the spleen in purpura has given encouraging results. In leucemia whether lymphoid or myelogenic, radiation treatment is the only known method of prolonging the life, in helping to get over the extreme feeling of exhaustion which is a concomitant feature and in some cases to relieve the extreme bony pains which is the result of reactive periostitis subsequent to sub-periostial deposits and myelogenic activity. It is the only effective method of reducing the blood count. In those cases where priapism is a troublesome symptom due to the infiltration of the cavernous tissue with myeloid cells a few exposures to the penis relieves the condition.

X-ray therapy in endocrinology and gynaecology:

Disease of the thyroid: In simple hyperplasia of the thyroid with very little enlargement of the gland but

marked symptoms of increased cellular activity surgical intervention might prove a difficult procedure because of the small gland encountered and the difficulty in assessing how much of the gland has to be removed and in such cases irradiation may well control the symptoms.

Toxic Goitre: Discussion of toxic goitre nowadays centres round the place of thyouracil in treatment. At a meeting of the Medical Society of London, the balance of opinion was against thyouracil as compared with surgery. Its drawback are the risk of idiosyncrasy, persistence of the tumour and the need for protracted treatment. In a follow up of over 1000 cases, the condition after withdrawal of the drug was satisfactory in only 10 % and when the drug was resumed toxic reaction became more frequent. Mention was made of cases in which it has not only proved ineffective but actually dangerous. Some patients get worse with treatment, some are intolerable and a pregnant woman treated with thyouracil may bring forth a child with a large thyroid and above all there is a possible, though unproved, risk of carcinomatous change. The trouble with thyouracil is that it has no direct action on the gland. It acts by depriving the gland of iodine and this in some cases may actually stimulate it to a greater activity. The consensus of opinion was that it is of some value in those cases with acute symptoms where other methods could not be thought of immediately. Pre-operative treatment may prejudice surgical chances, for after this treatment there is often torrential hæmorrhage at operation.

Either surgery or irradiation or medical procedures retain the same level of importance. Bed-rest, high caloric diet, sedatives and Lugol's iodine must be administered under the same criteria as would be observed ordinarily. Irradiation has advantages

over surgery from several aspects. The fear of operation is eliminated. There is no pain or shock. Serious heart complications which may not prove rapidly amenable to preoperative procedure should dictate immediate institution of therapy. Irradiation shows no mortality directly from the procedure and scars and keloids are avoided entirely. Conditions where irradiation assumes a secondary role to surgery are (1) When pressure symptoms due to enlargement may be distinctly aggravated after the first few exposures and where it is desirable to produce a quick response. In highly toxic cases it may be employed as a preoperative procedure to reduce the toxicity and lessen the bleeding during operation. The one disadvantage with irradiation is that a tumour mass is slow to retrogress and the exophthalmos hardly shows any recession. In some cases however treatment with x-rays directed at the eye muscles themselves has given good results.

In **Osteitis Fibrosa Cystica**, where there is hyperparathyroidism with distinct alterations in blood chemistry, irradiation of the parathyroid has been known to result in a healing calcification of the cysts with repair of the condition.

Either direct or indirect irradiation of other organs such as ovaries has a remarkable effect in certain conditions of the breasts both acute and chronic. In acute mastitis the breasts are directly irradiated with very good results. Non puerperal lactation can be effectively controlled by irradiation. Depression of the ovarian function by irradiation of the ovaries is a very effective therapeutic measure in certain gynaecological conditions like menorrhagia, metrorragia and suitable cases of uterine fibroids where direct treatment to the tumour is also essential. As a single therapeutic measure radiation therapy is unsurpassed in the treatment of menopausal syndrome where symptoms are

very annoying and distressing. It is a safe and certain method of inducing artificial menopause.

Diseases of joints and bones: Somewhat encouraging results have been obtained in some cases of osteoarthritis and spondylitis deformans. In the latter condition radiation therapy is the chief therapeutic agent employed and there is also dramatic relief of pain and diminution of the muscular spasm, with the arrest of otherwise progressive condition. In the treatment of Brodies abscess it has been tried with much benefit.

In chronic osteomyelitis it helps the formation and separation of sequestrum with the production of healthy granulating tissue.

[Paper read at a meeting of the Tanjore District Medical Association on 24-8-'49.]

X-ray therapy in the relief of pain.

In many conditions where pain is a very intractable symptom not yielding to any other treatment, radiation therapy offers a means of giving quick and sure relief. Among such conditions may be mentioned sciatica, brachial neuralgia, lumbago and supraspinatus syndrome.

Lastly mention must be made of those conditions where x-ray therapy is used with some benefit, the effect has not been always constant. Used within 72 hours of onset it is reported that the actual paralysis has been arrested in Bell's Palsy, followed by rapid recovery. It has also been used with advantage in certain ocular conditions including tubercular lesions.

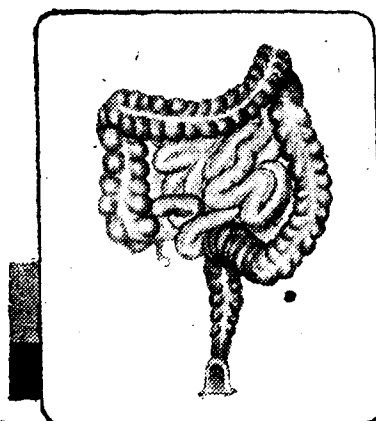
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November, 1949]

ASSOCIATION NOTES

BANGALORE BRANCH

President: Dr. M. N. Mahadevan
Vice-President: Dr. T. K. Dayalu
Secretaries: Dr. M. Sirsi
 Dr. N. S. Alasingarachar
Treasurer: Dr. M. Kothandaraman

The Annual General Body Meeting of the Bangalore Branch of the Indian Medical Association was held at Thippagondanahalli on the 16th October 1949.

The following members were duly elected to the respective offices for the year 1949-50.

President:

Dr. M. N. Mahadevan, M.B.B.S., D.T.M., M.R.C.P., (Ed).

Vice-President:

Dr. T. K. Dayalu, B.A., M.B.B.S.,

Secretaries:

Dr. M. Sirsi, M.B.B.S., D.T.M.,
 Dr. N. S. Alasingarachar, L.M.P.

Treasurer:

Dr. M. Kothandaraman, M.B.B.S.

Executive Committee Members for 1949-50

1. Dr. L. S. Doraiswamy, B.Sc., M.B.B.S.
2. Dr. M. S. Mekhri, B.Sc., M.B.B.S., D.O.M.S.

3. Dr. M. A. Narasimhachari, B.Sc., M.B.B.S.

4. Dr. P. T. A. Chatte, L.M.P.

5. Dr. M. Sivaram, B.A., M.B.B.S.

6. Dr. K. Rama Rao, B.Sc., M.B.B.S. Members for the Central Council of the Indian Medical Association.

1. Dr. K. S. Ramanna.

2. Dr. H. Krishnamurthy, B.Sc., M.B.B.S.

Members for the South Indian Provincial Council of the Indian Medical Association.

1. Dr. K. R. Pai, L.M.P.

2. Dr. M. A. Rao, M.B.B.S.

3. Dr. S. S. Jayaram, M.B.B.S.

All further circulars and other correspondences may be made to the following address:

Dr. N. S. ALASINGARACHAR,
 Hon. Secretary,
 Bangalore Branch of I.M.A.
 Gandhinagar Dispensary,
 Bangalore City.

COIMBATORE BRANCH

President: Dr. C. Nanjappa
Vice-President: Dr. N. Krishnaswamy
Hon. Secretary: Dr. A. G. Leelakrishnan
Associate Secretary: Dr. S. Ganapathi
Hon. Treasurer: Dr. T. V. Sivanandam
Committee Members: Dr. P. N. Ramaswamy
 Dr. T. K. Subramaniam Dr. R. Saradambal
 Dr. C. V. Ramaraj Dr. G. A. Chandrasekharan

The monthly clinical meeting of the Association was held at 6 p.m. on Saturday, the 27th August 1949, in the Association premises with Dr. C. Nanjappa, the President in the chair. 50 members were present.

After tea and reading of the minutes of the last meeting, the recommendations of the managing committee as regards the coming silver jubilee celebrations and of the jubilee committee with the following members were approved:

President:

Dr. C. Nanjappa.

Vice-President:

Dr. N. Krishnaswamy.

Honorary Secretary:

Dr. A. G. Leelakrishnan.

Associate Secretary:

Dr. S. Ganapathy.

Honorary Treasurer:

Dr. T. V. Sivanandam

Members:

Dr. C. S. Ramaswamy
 „ S. V. Swarnambal
 „ G. A. Chandrasekharan
 „ L. K. Muthuswamy
 „ S. Dorairaj
 „ K. N. Sengottayyan
 „ Mrs. R. Saradhambal
 „ T. K. Subramanian
 „ B. S. Viswanathan
 „ R. G. Iyer
 „ Shankunni Kallat
 „ R. Narasimmayya

Exhibition:

Dr. L. Munuswamy

Benefit Performances and Variety

Entertainment:

Dr. Y. P. Vasudevan
 „ T. V. Sivanandam
 „ C. V. Ramaraj

Souvenir and Publicity:

Dr. A. G. Leelakrishnan
 „ S. V. Subramanian
 „ K. N. Ramanathan

Scientific Section:

Dr. P. K. Kalyanaraman
 „ M. P. Pai

Decorations:

Dr. P. N. Ramaswamy
 „ S. R. Srikantan

Then the recommendation of the managing committee to fix a scale of pay for the association peon viz. Rs. 40-2/2/50 plus cycle allowance of Rs. 5/- from September 1949 was unanimously approved.

The other recommendation of the managing committee that in view of the increase in the C.F.C. from Rs. 6/- to Rs. 8/ per head per year from October 1949 onwards, the subscription payable by non-resident members be increased from Rs. 9/- to Rs. 10/- per head per year was unanimously approved.

The following members were then unanimously elected for the office of the President and three Vice-Presidents of the I.M.A. for the year 1950.

President:

Lt. Col. T. S. Shastry

Vice-Presidents:

1. Dr. V. Govindan Nair
2. „ D. K. Sabesan
3. „ P. Kutumbiah

The following members were then elected for the office of the President and three Vice-Presidents of the South Indian Provincial Branch of the I.M.A.

President:

Dr. U. Krishna Rao

Vice-Presidents:

1. Dr. C. S. Ramaswamy
2. „ N. Velappan

Then Dr. R. Sundararajan, M.B.B.S., addressed gathering on "Prescribing Spectacles." A short discussion followed in which Drs. K. Narayanan and D. Sundareswaran took part.

After a vote of thanks to the lecturer and the host Dr. N. Krishnaswamy, the meeting terminated at 8-30 p.m.

* * * * *

The monthly clinical meeting of the Association was held at 6 p.m. on Thursday, the 22nd September 1949 in the Nurses hall of the Head-quarters

Hospital, Coimbatore, with Dr. C. Nanjappa, the President in the chair. Sixty five members were present.

After tea and reading of the minutes of the last meeting, the Secretary announced amidst cheers that Dr. A. L. Mudaliar has agreed to inaugurate the Silver Jubilee of our Association on the 17th and 18th of March 1950.

Members who were desirous of attending the 4th provincial medical conference at Annamalaiagar were requested to contact the Secretary so that they could represent our Association as delegates at the conference.

Then the following two resolutions proposed by Dr. K. V. Subramanian, L.M.S., B.Sc., and duly seconded were passed unanimously.

1. "Resolved unanimously that in view of the highly technical nature of the subject and the terms and expressions of the various branches of Medicine, Surgery, Midwifery, etc., and the impossibility of having equivalent expressions in any other Indian language, the Association is of the opinion that the medium of instruction in Medical education shall be only in the English language."

2. "That in view of the essential nature of the work carried out by doctors and the growing volume of duties, the present supply of petrol is very inadequate even for half the month. Hence the Association requests that immediate orders be passed for grant of extra supply of petrol as heretofore for Medical Practitioners."

The following members then demonstrated a few of their interesting cases.

1. Dr. N. Subramanian;

- (a) Two cases of congenital heart disease.
- (b) Rheumatic heart disease.
- (c) Progressive muscular atrophy.
- (d) Tumour abdomen.

2. Dr. C. N. Santhanam:

- (a) Glandular enlargements.
- (b) Pernicious anæmia.
- (c) Aneurysm of the abdominal aorta.

3. Dr. C. R. Subbarathnam:

Meningo myelitis.

After a short discussion and a vote of thanks to the doctors who demonstrated the cases, to the host Dr. T. V. Sivanandam, and the D.M.O. and the Matron for permission to use the nurses quarters for the function, the meeting terminated at 8-40 p.m.

MADRAS BRANCH

President: Dr. K. C. Nambiar

Vice-Presidents: Dr. P. Natesan
 Dr. K. Narayanamurthi

Secretaries: Major N. Gangadaran
 Dr. A. M. Sivaraman

Treasurer: Dr. R. Sankaran

Vice-Presidents:

Dr. P. Natesan
 Dr. Narayanamurthi

Secretaries:

Major N. Gangadaran
 Dr. A. M. Sivaraman

Treasurer

R. Sankaran

At the Annual General Body Meeting of the Madras Branch of the Indian Medical Association held on Monday the 31st October, 1949 at the Madras Medical College at 6-30 p.m. with Dr. K. C. Nambiar in the chair the following Office bearers were elected:

President:

Dr. K. C. Nambiar

Executive Committee Members :

1. Dr. M. R. Bail
2. Major N. Chandrasekaran
3. Dr. N. A. Iyengar
4. Dr. K. L. Narayana Rao
5. Dr. G. D. Valiath
6. Dr. D. V. Venkappa
7. Dr. K. V. Swami
8. K. Rama Rao
9. P. T. Ragavachari
10. P. Krishnaswamy
11. C. S. Krishnaswamy
12. P. S. Srinivasan

Central Council Members :

1. Dr. U. Krishna Rao

2. Dr. V. Samuel
3. Dr. Lt. Col. T. S. Sastry
4. Rao Bahadur Dr. T. S. Tirumurthy

Provincial Council Members :

1. Dr. M. R. Bail
2. Major N. Chandrasekaran
3. Dr. Damodara Doss
4. Dr. U. Krishna Rao
5. Dr. C. Rama Rao
6. K. Rama Rao
7. R. Sankaran
8. A. M. Sivaraman
9. Lt. Col. Sastry
10. Rao Bahadur Dr. T. S. Tirumurthy
11. Dr. D. V. Vengappa

MALABAR BRANCH

President : Dr. N. Achuthan
Vice-President : Dr. P. B. Menon
Secretaries : Dr. A. P. Kunhiramanunni
 Dr. C. V. Narayana Iyer
Treasurer : Dr. N. Govindan

Secretaries :

Dr. C. V. Narayana Iyer
 Dr. A. P. Kunhiramanunni

Treasurer :

Dr. N. Govindan

Committee Members :

Dr. Mrs. V. Krishnan
 „ Dr. R. Hermen
 „ A. G. Nair
 „ K. R. G. Kurup
 „ A. B. Dass
 „ P. V. Karunakaran Nair

For the Central Council :

Dr. C. V. Narayana Iyer and Dr. N. Sundaram were elected and for the Provincial Council Dr. A. P. Dass, Dr. M. Krishnan and Dr. C. K. Karunakaran. Letters wishing the function success from Hon'ble Dr. T. S. S. Rajan, Secretary, S. I. P. Br., Secretary Coimbatore Br., etc. were read. With a vote of thanks by the Secretary the function ended.

At the Annual General Body Meeting of the Malabar Branch held on 13-9-49

The following office bearers were then elected.

President :

Dr. N. Achuthan

Vice-President :

Dr. P. B. Menon

the following resolutions were unanimously passed.

1. Resolved to inform the authorities concerned that the Malabar Branch of I. M. A. views with serious concern that the adoption of the Chopra Committee Report will be detrimental to the interest and progress of the scientific system Medicine. Any attempt to combine the Scientific system with the Indigenous system will result in a mutilated system of treatment or a hybrid. The adoption of the said report will bring into being an inferior class of Medical Practitioners whose services will be dangerous to the Public especially in villages.

2. Resolved that the recent cut in petrol has greatly affected the Medical Men in discharge of the duties and hence request the Government to exclude medical men in active practice from the recent cut.

A meeting of the Malabar Branch of I. M. A. was held on Saturday 29-10-1949 at 5 p.m. at the Women and Children Hospital, Calicut. Dr. N. Achuthan presided.

The President welcomed Dr. K. Rama Menon, the New District Medical Officer

to the Association. After the minutes of the last meeting was read the following resolution was unanimously passed.

“While thanking the Government for removing the Caste distinction among the classes of Civil Assistant Surgeons and raising their status, scale of pay, etc. the Association request the Government that the same be done in the case of local fund and municipal medical officers.”

It was resolved that since the Association is purely a professional body not to send a representative to the Aikya Kerala Conference at Palghat. The letter from the Secretary Malabar branch of Provincial Welfare Committee was read and recorded. Circulars from I. M. A. and amendment to rules were read and recorded. A few interesting cases were demonstrated. Dr. K. Rama Menon appealed for co-operation among all and help the early starting of a Tubercular Sanatorium in Malabar. Earlier, the members were treated to refreshments the host being Dr. K. R. G. Kurup, Feroke.

N. B. The Secretary, South Indian Provincial Branch Mathurai is kindly requested to forward the above resolution to the proper quarters.

MADURA BRANCH

President : Dr. P. Vadamalayan
Vice-President : Dr. A. Balakrishnan
Secretary : Dr. K. G. Ramabhadran
Treasurer : Dr. A. S. Annamalai

The monthly meeting of the Association was held at 5 p.m. on Saturday the 17th September 1949, in the Erskine Hospital, Mathurai. About 60 members attended. After tea the meeting commenced with Dr. P. Vadamalayan in the chair.

The minutes of the monthly meeting held on 20-8-'49 were read by the Hony. Secretary and adopted.

The general opinion of the house was to postpone the meeting to be held

at Palni in October to a later month. Dr. A. K. Rajagopalan proposed and Dr. K. G. Ramabhadran seconded that Dr. Chamanlal Mehta be elected by this branch for the presidentship of the Indian Medical Association carried unanimously.

The following 4 names were proposed and seconded for the three vice presidentships:—

Dr. P. Kutumbiah of Vellore proposed by A. K. Rajagopalan, Seconded

by Dr. K. Ramachandran.

Dr. T. S. Thirumoorthy, Madras proposed by Dr. K. Rama Menon, seconded by Dr. Thirugnanam.

Dr. V. Govinda Nair, proposed by Dr. A. N. Menon, and seconded by Dr. D. Nainar.

Dr. P. A. S. Raghavan, proposed by Dr. Doraiswamy, seconded by Dr. K. S. Narayanan.

As there were 4 names for the three posts a secret ballot was held and the votes were counted and declared as follows:—

- Dr. P. Kutumbiah—46 votes
- Dr. T. S. Thirumoorthy—49 votes
- Dr. V. Govinda Nair—26 votes
- Dr. P. A. S. Raghavan—27 votes

Dr. Thirumoorthy, Dr. P. Kutumbiah and Dr. P. A. S. Raghavan were declared elected by the branch for the three vice-presidentships.

The circular of the General Secretary of the Provincial Conference were then read.

The following persons were elected as delegates to the forthcoming South Indian Provincial Conference to be held at Annamalainagar:—

1. Dr. K. Ramachandran
2. „ M. S. Krishnamoorthy
3. „ Vijayaraghavan
4. „ K. G. Ramabadrán
5. „ K. S. Narayanan
6. „ A. K. Rajagopalan
7. „ A. S. Annamalai
8. „ N. Krishnamoorthy

As the branch could elect 12 delegates the Secretary was authorised to circularise the absentee members and include 4 others as delegates among these willing to attend the conference.

Dr. A. Narayana Menon, Dr. A. K. Rajagopalan, Dr. K. Balasubramaniam, Dr. K. G. Ramabadrán, and Dr. K. S. Krishnan paid tributes to Dr. K. Rama Menon, District Medical Officer, Mathurai, on the eve of his transfer to Calicut. They spoke about the qualities of his head and heart and praised his services

to the profession, the Association and the public. Dr. P. Vadamalayan, the President, associated himself with the encomiums paid by the members and garlanded Dr. Rama Menon, who replied thanking the individual members and the Association for the kind sentiments expressed.

At the request of Dr. Miss A. Thomas, the lecture on Ectopic Pregnancy scheduled for the evening was postponed to a later meeting.

Dr. K. S. Krishnan, Hony. Surgeon, Erskine Hospital, demonstrated the specimen of a huge Mega Colon he excised in one stage from a patient aged 35. He gave the signs and symptoms of the case and the conditions that necessitated this resection. The patient however, after 6 days of comparatively uneventful post operative period succumbed on the 7th day after operation.

Dr. K. Ramachandran, Dr. K. A. Kalyanam and Dr. T. R. Muthurangam took part in the discussion that followed. The President was of the opinion that an one stage resection of the large bowel was a serious operation with a very high mortality and should not be resorted so.

After a vote of thanks by the Hony. Secretary the members adjourned to the adjacent lawn to see the following films:—

1. Skin Grafting—A demonstration of Techniques.
2. Partial Gastrectomy for a case of Castro Jejunal Ulcer.
3. Perineal Prostat-tectomy.

The films were lent by the kind courtesy of the United States information Service, Madras and were appreciated.

The meeting ended at 8 p.m.

The monthly meeting of the Madura Medical Association was held at 5 p.m. on Saturday the 29th October 1949 in the Erskine Hospital Mathurai. Sixty members attended.

After tea the meeting commenced with Dr. P. Vadamalayan in the Chair.

The minutes of the previous monthly meeting held on 17-9-49 were read and adopted.

The Hony. Secretary then welcomed Dr. A. Umapathi Mudaliar, the new District Medical Officer. He then gave particulars about the dates and venue of the Conference of the Association of Surgeons of India, the All India Obstetrics and Gynaecological Congress and the Annual Conference of the Indian Medical Associations. The sense of the house was taken for holding the next meeting at Palni. The managing committee was authorised by the house to go into the suggested amendments to the rules of the Indian Medical Association and give suitable recommendations.

The Hony. Secretary then gave in brief the highlights of the recent South Indian Provincial Conference held at Annamalainagar.

The president introduced Dr. A. Thomas, the lecturer of the evening to the members.

Dr. Miss Thomas then gave a most interesting and instructive lecture on Ectopic Gestation. She illustrated her lecture with case reports of various types of cases met with by her during her medical career and was listened to with rapt attention by the members. She dealt in detail about the classification in general and in the various age groups, the theories about the Etiology of the condition and also about its pathology. She described in detail about the various modes of the termination of a tubal pregnancy. She enumerated the important points in the diagnosis of the condition and discussed the differential diagnosis. She pointed out the difficulties usually met with in the diagnosis of Ectopic pregnancy and illustrated this with actual case reports of cases examined and treated by her. Regarding the treatment she said that it was purely surgical and must be

resorted to immediately a suspicion as to the diagnosis was made. She also gave comparative statistics from American and Indian literature on the subject.

An interesting discussion followed the lecture. Dr. Umapathi Mudaliar mentioned from his experience the very high incidence of Ectopic Gestation among the working classes of Calicut. Dr. K. Ramachandran quoted recent literature for leaving the placenta alone in cases where it was not easily removable after an operation for removal of fœtus in Ectopic Gestation. The President in his concluding remarks said that a case with vaginal bleeding combined with pain and evidence of a Pelvic Hæmatoma as disclosed by a diagnostic puncture in the posterior fornix must almost always be a case of Ectopic Pregnancy.

After a vote of Thanks by the Hony. Secretary the gathering adjourned to the adjacent lawn where the following films were screened:—

1. The Story of D. D. T.
2. Your Children's Ear.
3. Triumph over deafness.

The films were very instructive and were much appreciated and were lent by kind courtesy of the British Information Services.

The gathering dispersed at 8-30 p.m.

The monthly meeting of the Association was held in the Temple Town of Palni on Sunday the 27th November 1949. 30 members of the profession attended.

The bulk of the members from Mathurai reached Palni by train on the 26th night and were received at the station by the local doctors and accommodated in the R. M. K. Hall. After the morning bath and breakfast the members went up the hill to the temple, where a special Abhishekam to Lord Subramania was performed and prasadam distributed.

The meeting commenced at 10-30 a.m. in the R. M. K. Hall with Dr. P. Vada-

malayan in the Chair. Dr. V. S. Natarajan, Municipal Health Officer, Palni, sang the prayer. The minutes of the previous monthly meeting held on 29-10-1949 were read by the Hony. Secretary and adopted. The Secretary then announced that arrangements would be made shortly for distribution of journals to the mofussil members especially for towns like Palni, Dindigul and Periakulam where there were a number of members. The president then introduced the lecturer Dr. A. Umapathy Mudaliar to the audience.

The lecturer gave a masterly survey of the more important and common abdominal emergencies. He dealt first with the symptom of pain and explained how it had to be evaluated according to the intensity, location, the nature of the pain and association with rigidity, or otherwise. He dealt in detail with the conditions producing intestinal obstruction such as Intussusception, Volvulus, new growths in the bowel etc., and emphasised that the Surgeon's responsibility lay in the proper diagnosis of the obstruction much more than in treatment. He said that in obstruction large turpentine enemas should be tried and repeated twice if necessary before operation. In dealing with acute appendicitis he said that he always preferred a proper right paramedian incision which would enable the surgeon to survey the damage better and penicillin and sulphanamides had greatly reduced the risk of spreading the infection. He also discussed the optimum time factor for operation for acute appendicitis, perforated Peptic ulcer, he said, was very common and closure of the perforation and stitching a piece of omentum over the closure and maintenance of continuous suction by Ryle's Tube was found highly satisfactory. He mentioned paralytic Ileus in post-operative abdominal emergencies and continuous suction by Ryle's Tube and

repeated injections of morphia were more successful than other methods of treatment.

The lecture was followed by a discussion in which many members took part. Replying to a question, the lecturer said that the treatment of perforation need not always be an immediate operation. The present trend was that the expectant medical treatment was being adopted more and more.

The President, in his concluding remarks, emphasised that every doctor in his out-patient practice should arrive at a diagnosis in all cases of pain abdomen only after a proper examination of the patient.

Dr. Varadarajulu, Assistant Surgeon, Palni, demonstrated a few cases. The first was a woman aged 70 with strangulated Femoral Hernia (Richter's type). He described the operative procedure he adopted in that case. The patient had an uneventful recovery. He then read the case report of a case of Atresia of the cervix discovered during labour in a third para for whom Caesarean section was performed. A case of an inflammatory swelling in the right cheek of 10 months duration in a eleven months old baby and a case of bilateral T.P. with laryngeal involvement treated successfully with streptomycin were demonstrated and discussed.

The Hony. Secretary proposed a vote of thanks to the lecturer and to the members of the profession in Palni and the Municipal Health Officer for the excellent arrangements and all those who helped in making the function a grand success.

The members were then treated to a sumptuous lunch and each member was given a small tin of Panchamrutham and a packet of vibhoothi. The members dispersed after tea in the evening.

NEGAPATAM BRANCH

President: Dr. C. H. Venkateswaran.
Vice-President: Dr. J. Y. Arthur.
Secretaries: Dr. S. S. Chariar.
 Dr. S. Ganapathy.
Treasurer: Dr. T. S. Varadhachary.

The Monthly meeting of the above association was held on 24-9-49 at the Government Hospital Negapatam. 12 members were present. Dr. Mrs. Mathew was "At home" to the members. After the minutes of the last meeting were read by the Secretary, Dr. S. S. Chariar, the following members were elected to attend the 4th S. I. Provincial Conference at Annamalaiagar (1) Dr. S. S. Chari, (2) Dr. S. Ganapathy and (3) Dr. T. S. Varadhachary.

The following resolution moved by Dr. S. Ganapathy and seconded by Dr. S. T. Thyagaraja Pillai was carried unanimously "This association requests the Government not to give effect to the proposal of the Surgeon-General contained in his letter No. R 69845-II-49 dated 23-8-49 to appoint a separate Medical Officer for vaccination and

inoculation of the sea borne passengers at the port of Negapatam as it is detrimental to the interests of the private medical practitioners and infringes on the rights and privileges besides adding to the financial burden of the Government. Further, this association vouchsafes for the regular and correct working of the Emigration Medical Syndicate Negapatam consisting of 13 private Medical Practitioners of this place started long ago for the specific purpose."

After that, Dr. (Major) Gangatharan M.B.B.S. of Madras gave an interesting lecture on "Anæsthesia in General Practice."

With the President's concluding remarks and with a vote of thanks by the Secretary, the meeting came to a close.

NILGIRIS BRANCH

President: Col. A. J. D'Souza.
Vice-President: Lt. Col. J. C. Bharucha.
Secretary: Capt. A. Balasubramanian.
Jt. Secy. & Treasurer: K. P. S. Nambiar.

The Second Annual Meeting of the Association was held at 12 noon at the Lawley Institute, Ootacamund on 6-11-49. Col. A. J. D'Souza presided.

At the request of the members present, the demonstration of the films was taken up first. The following films kindly loaned by the United States Information Services, Madras were screened.

1. Plastic and Reconstruction surgery of the hand.
2. Subtotal Gastrectomy for Gastrojejunal Ulcer.

The films were very much appreciated by the members.

The members then adjourned to a sumptuous lunch provided by the Association (covers were laid for 60 people including guests of members).

The business meeting was convened at 2-45 p.m. The minutes of the previous meeting were read by the Secretary and confirmed. The annual report for the year 1948-1949 as well as the accounts for the same period were unanimously adopted along with a vote of thanks to Capt. A. Balasubramanian, Hony. Secretary of the Association for the year 1948-1949.

After some discussion it was resolved to fix the rate of subscription for the

year 1949-50 at Rs. 30/- per member for annum subscriptions being payable half yearly or yearly by all members of the Association.

The amendment to the rules of the I.M.A. vide circular No. 45 49-50 were considered and the Hony Secretary was authorised to make a suitable reply to the same.

The following office bearers were elected unanimously for the year 1949-50.

President: Col. A. J. D'Souza, I.M.S. (Rtd.), Bramley Lodge, Ooty.

Vice-President: Lt. Col. J. C. Bharucha, I.M.S. (Rtd.), Bideford, Ootacamund.

Hony. Secretary: Capt. A. Balasubramanian, M.B., B.S., Pasteur Institute, Coonoor.

Joint Secretary & Treasurer: Dr. K. P. S. Nambiar, Cantonment Hospital, Wellington Town.

Committee Members:

Dr. H. C. Berlie, Longleat, Coonoor.

Dr. I. G. K. Menon, M.B., B.S., Pasteur Institute, Coonoor.

Dr. (Mrs.) C. G. Herbert, Government Lawley Hospital, Coonoor.

Dr. N. S. Menon, L. F. Dispensary, Kundah-Bridge.

Dr. K. Rajamannar, L.M. & S., D.M.O., Govt. Headquarters Hospital, Ooty.

Major T. D. Jeevarathnam, Modern Pharmacy, Ooty.

Rao Sahib Dr. A. Achyuthan, View Charming, Ooty.

Capt. F. W. Perriera, Govt. Hospital Kotagiri.

Representatives for the Central Council:

Dr. I. G. K. Menon, M.B., B.S., Pasteur Institute, Coonoor.

Representatives for the Provincial Council:

Col. A. J. D'Souza, Bramley, Lodge, Ootacamund.

Capt. C. N. Narayanan, Padma Vilas, Ootacamund.

Capt. Delemose, Cordite Factory Hospital, Aruvankadu.

The meeting terminated with a vote of thanks proposed by Capt. A. Balasubramanian to the Secretary of the Lawley Institute, Ootacamund for providing the lunch and placing the Institute at their disposal for holding the meeting; to the United States Information Services, Madras for the loan of the films and Major Fosberry, Kotagiri for screening the same in his own projector and to the members and their guests for attending the function and making Annual Report a success.

The Nilgiris District Medical Association was inaugurated in June 1937 by Lt. Col. T. S. S. Shastri at Government House, Ootacamund. During the period 1943 to 1947 it was in suspended animation consequent on the active members of the Association leaving the station either on military service or on civil transfers. It was revived on 1st October 1947 when the medical men in this District met to bid farewell to Col. A. I. Cox, I.M.S. an able and popular District Medical Officer of this district on the eve of his retirement from service. The Association became a branch Indian Medical Association at its meeting held on 26-10-1947 after which date it was renamed the Nilgiris District Branch of the Indian Medical Association.

The first annual meeting of the Association was held on 15-9-1948 when the following office bearers were unanimously elected for the year 1948-49.

President: Col. A. J. D'Souza.

Secretary: Capt. A. Balasubramanian.

Joint Secretary: Capt. C. N. Narayan.

Committee Members:

Major T. D. Jeevarathnam.

Dr. (Mrs.) A. Cherian.

Dr. H. C. Berlie.

Capt. F. W. Perriera.

Dr. K. P. S. Nambiar.

Capt. N. Vanchinathan.

Representative to the Central Council:

Dr. I. G. K. Menon.

Representative to the Provincial Council:

Col. A. J. D'Souza.

Dr. (Mrs.) H. B. Francis.

Dr. H. C. Berlie.

It was with a certain amount of terpidation that I took over the duties from the Secretary of the Association

for the year 1947-1948, Dr. I. G. K. Menon, who is now back with us, on the eve of his departure to overseas on a travel Fellowship granted by the Government of India. At the outset I thank you all for having elected me to this office the duties of which were new to me. I hope I have not fallen far short of your expectations, as the standard set up by my predecessor, with his experience in and understanding of the duties of the office were certainly of a very high order.

The meetings held during the year were as under:

DATE	VENUE	SUBJECT	NAME OF SPEAKER
1. 16-10-1949	Pasteur Institute, Coonoor.	Treatment of Chronic Arthritis.	Dr. K. P. S. Nambiar.
2. 20-11-1949	Taj Mahal Hotel, Ootacamund.	Comments on an Abdominal Case.	Lt. Col. K. S. Fitch.
3. 28-11-1949	Pasteur Institute, Coonoor.		A meeting to bid farewell to Dr. I. G. K. Menon on the eve of his departure to overseas.
4. 22-1-1949	Military Hospital, Wellington.	Eosinophilic Lung.	Capt. P. S. Sebra.
5. 25-2-1949	Pasteur Institute, Coonoor.	Tuberculous Meningitis (Presentation of a case with postmortem findings.)	Dr. H. C. Berlie and Dr. P. V. Kurian.
6. 19-3-1949	Taj Mahal Hotel, Ootacamund.	Common Emergencies in Surgery.	Dr. P. V. Rajamannar.
7. 23-4-1949	Pasteur Institute, Coonoor.	Disease of the Eye Caused by Nematodes.	Dr. (Miss) M. P. Jeffery.
8. 24-5-1949	Taj Mahal Hotel, Ootacamund.	Problem of Prolonged Pyrexia.	Dr. N. F. Lilauwalla.
9. 18-6-1949	Pasteur Institute, Coonoor.	Medical Emergencies.	Dr. N. F. Lilauwalla.
10. 28-7-1949	Pasteur Institute, Coonoor.	Demonstration of films:	
		1. Blood transfusion.	Kindly loaned by British information Services, Madras.
		2. Your Health.	
		3. Defeat Diphtheria.	
		4. Surgery in Chest Diseases.	

DATE	VENUE	SUBJECT	NAME OF SPEAKER
11. 20-8-1949	Staff College, Wellington.	Demonstration of film. Polio-Diagnosis and management.	Kindly loaned by British information Services, Madras.
12. 17-9-1949	Taj Mahal Hotel, Ootacamund.	Problems in General Practice. & Organisation of a Health Centre.	General Discussion Dr. U. Krishna Rao.

The attendance of members at the meetings have been very satisfactory particularly in view of the distances involved, the drastic cut in petrol rations and the vagaries of the weather peculiar to the district. The members have evinced a keen interest in the activities of the Association as seen by the number of papers so readily contributed by them at the meetings and the standard of discussion attained at the same.

The membership of the Association has shown a rise from 47 at the beginning of the year under review to 60 now.

The financial position of the Association is satisfactory as will be seen from the balance sheet. I would warn members against attaching an undue weightage for the closing balance of the year for it has to be confessed that the association has during the period under review been living on its own resources without any contacts with the leading members of the profession outside the district.

The response of our members to the appeal for Dr. Venkappa's Fund has been very satisfactory and the amount realised so far has been remitted to the Convenor of Dr. Venkappa Fund Committee as shown in the balance sheet.

Our thanks are due to the Regional Officer, British Information Services, Madras and the Public Affairs Officer; United States Information Services, Madras for forwarding for the use of the members of the Association

complimentary copies of medical literature and their respective film catalogues.

Let me thank the Regional Officer of the British Information Services, Madras for having readily loaned us films and the authorities of the Staff College, Wellington and the Sunday School Union, Coonoor for screening the same at the meetings.

The association not having a house of its own owes a deep debt of gratitude to the Director, Nutrition Research Laboratories, Coonoor, the authorities of the Staff College Wellington and the Manager of the Taj Mahal Hotel, Ootacamund for having readily placed their buildings at our disposal for our monthly meetings on more than one occasion.

It is no exaggeration to say that the Association is very much indebted to the Director, and Staff of the Pasteur Institute, Coonoor particularly the non-members of the Association in that Institution for their ready help in the various details connected with the meetings of the Association such as office work, arrangement of teas and theatre facilities etc.

Our thanks are due to Dr. N. F. Lilauwalla, G. R. Medical College, Gwalior and Dr. U. Krishna Rao, Madras for attending our meetings and taking an active part in the same.

It will be a grave omission on my part were I not to mention the ready help and co-operation I have had from our President and other office bearers of the Association.

I take this opportunity for thanking you all for the help you have so readily rendered me in connection with the smooth working of the Association more often at no small amount of personal inconvenience.

RAMNAD BRANCH

President: Lt. Col. M. A. Parthasarathy.
Vice-President: Dr. T. S. Shetty.
Secy. & Treasurer: Dr. S. Sundaresan.
Jt. Secretary: Dr. K. Venkataraman.

Minutes of the meeting held at the Municipal Hall, Virudunagar on Saturday the 29th October 49 at 5 p.m.

The members on arrival were entertained to Tea by Dr. S. N. Ganapathi M.B., B.S. Civil Asst. Surgeon Virudunagar. The meeting commenced under the Presidency of Lt. Col. M. A. Parthasarathy F.R.C.S. District Medical Officer. The minutes of the 2 previous meetings held at Swedish Mission Hospital Trippattur, and New Palace Sivaganga, were read and adopted. The Secretary appealed to the Doctors present to enrol themselves as members and strengthen the Association.

An exhaustive paper on "Malnutrition in General Practice" was read by Dr. S. N. Ganapathi, which was supplemented by the President in his concluding speech.

The Secretary proposed a vote of thanks to the Municipal Council for giving the use of the Hall, for the meeting, to Dr. S. N. Ganapathi for inviting the Association to have its meeting at Virudunagar, and for having stood as the Host, and the meeting terminated.

The members were entertained to a nice Dinner by the Host, and were taken to at Talkie.

SOUTH ARCOT BRANCH

President: Dr. S. Sankararaman
Vice-President: Dr. Nataraja Jata Vallabhar
Secretaries: Dr. N. Ramachandran
Dr. V. Viswanathan
Treasurer: Dr. S. Mahendranatha Singh

The Annual Meeting was held on 30-10-49 at Government Head Quarters Hospital, Cuddalore, the Vice-Chairman Dr. Sankararaman presiding.

The Secretary Dr. C. Seshachalam Naidu read the Annual report mentioning the various activities of the Association, thanking the various lecturers of the year. The Association took pride in having creditably managed to conduct the Annual Provincial Medical Conference at Chidambaram. A resolution opposing the enhancement of Central Fund contribution was unanimously passed.

The following office bearers were elected for the ensuing year:—

President: Dr. S. Sankararaman
Vice-President: Dr. Nataraja Jata Vallabhar
Secretaries: Dr. N. Ramachandran
Dr. V. Viswanathan
Treasurer: Dr. S. Mahendranatha Singh
Executive Committee: Dr. C. Seshachalam Naidu

Dr. S. Narasimham
Dr. Mrs. Kurian
Dr. S. Chandrasekharan
Dr. C. S. Swaminathan

Central Committee:

Dr. S. Chandrasekharan
Dr. V. Krishnamurthy

Provincial Council:

Dr. S. Chandrasekharan
Dr. S. Narasimhan
Dr. A. Ramadoss

British Empire Leprosy Association:

Dr. K. G. Satagopan

After tea Dr. V. S. Subramanian, F.A.C.S., M.Sc. Hony. E. N. T. Surgeon, General Hospital, Madras, gave an interesting and useful lecture on common affections of the Nose, Sinuses and their treatment having dealt with the Anatomy and physiology of the Nose and Sinuses. He dwelt on the functional importance and emphasized that functional importance of the structure should be maintained during the treatment and that no oily nasal drops or patent nasal drops should be injudiciously prescribed as they may all interfere with the function of the Nasal Mucosa. He demonstrated Prætz's method of treating Sinuses infection using 1% Ephidrin Hydro Chloride in normal saline. He said that this method was simple and efficacious. He concluded his lecture by reference to Allergic Rhemtis and causes of Nasal block. The lecture was very useful for private practitioners.

The next lecture was by Dr. N. Ramachandran, M.B.B.S., Hony. Asst. Surgeon,

Government Head Quarters Hospital, Cuddalore, on Infantile Diarrhoea and vomiting. He spoke on some recent advances in Bactriology and treatment with Chemo Therapy like Sulpha Drugs, Streptomycin and Anti-Histamine Drugs. This lecture aroused great enthusiasm among the members, for discussion. The meeting then terminated after Presidential Address.

* * * * *

The above association met in the premises of the Head Quarter Hospital Cuddalore under the Presidentship of Dr. S. Sankararama Iyer, M.B.B.S., on 19th November, 1949 at 4-30 p.m.

The minutes of the last meeting were adopted.

The Association placed on record its appreciation for the services of the out-going office bearers. Then a few resolutions were adopted.

There was a lecture by Dr. S. Sankararama Iyer on Anæmias.

The lecturer dealt in detail about the classification, ætiology, clinical picture and diagnosis. He emphasised on the importance of Hæmatological findings and gastric analysis before launching on treatment proper. He outlined that Transfusion of blood is the only measure to tide over the crisis in severe degrees of anæmia.

The members participated in a lively discussion on points of practical importance. The meeting came to a close with a vote of thanks to the lecturer. The members were entertained at tea by Dr. S. Sankararama Iyer.

CHANGE OF ADDRESS

DR. S. GOPALAN, M.B.B.S., of Trichy posted as Sub Asst. Surgeon in Dindigul.

DR. V. R. SRINIVASAN, B.Sc., M.B.B.S., of Trichy posted as Dist. Health Officer in Nilgiris.

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

GLYCOSURIA—Alexander Lyall, M.D., F.R.C.P.—*The Practitioner*, July 1949.

The discovery of a reducing substance in the urine, whatever the nature of the case, puts a new aspect on the examination and care of the patient concerned. Two main questions immediately arise. Is the reducing substance glucose, and if so does it mean that the patient is suffering from diabetes mellitus? These questions must be answered at the earliest possible moment. The answer to the first question presupposes the knowledge that other reducing substances may be found in the urine from time to time. These comprise certain drugs including rhubarb, senna, drugs of the antipyrine group, drugs excreted in combination with glycuronic acid, e.g. chloral, chloroform, and occasionally salicylates and iodides. If the presence of any drug is suspected in the urine it may be tested for, but the easiest method is to get a further sample of urine the next day when the urine is free of such complications.

Sugars in the urine—Sugars other than glucose may occur in the urine but practically the only sugar of consequence in this respect is lactose. This occurs only during pregnancy, usually not before the 7th month, and in lactation. It can be recognized as being non-fermentable by yeast. Glucose is, however, commonly present in the urine during pregnancy and often in the earlier months. If a reducing substance is found in the urine in a pregnant woman it is wise to have the fasting blood sugar determined. If this is normal, the condition can be watched and if necessary a full sugar tolerance test carried out later. Temporary renal glycosuria of pregnancy is a common condition but it must be kept in mind that diabetes may have its onset during pregnancy or even during lactation.

The other reducing sugars which may occur in the urine are laevulose (fructose), only rarely, as a metabolic abnormality, pentose or arabinose, and galactose. Laevulose and galactose may commonly be found in the urine of patients while under observation in hospital, since these sugars are sometimes given by mouth in

tests for hepatic function. Their renal threshold is low and they invariably appear in the urine if taken by the mouth. On occasions reducing sugars may be found in the urine as artefacts: when abnormal patients, usually with some medical training, add these substances to samples of urine for their own obscure reasons. These unusual sugars occur so rarely that in most clinics search for their recognition is instituted only when a bizarre type of glycosuria occurs which is not easily explained by the usual methods. In the great majority of cases a definite reducing substance found with Fehling's test or Benedict's test is glucose. Exton (1936) found that in 97 per cent. of samples the sugar was glucose if the concentration was over 1 per cent.

Is diabetes present?—Let us suppose that the reducing substance is glucose and that it is in fact glycosuria which is found. The second question must now be answered. Is the patient diabetic or not? Certain broad principles may help in a decision. If the amount of sugar is large the patient probably has diabetes. If symptoms or signs suggestive of diabetes, e.g. loss of weight, thirst, polyuria, nocturia, pruritus, are present, the diagnosis of diabetes is almost certain. If Rothera's test for acetone is positive, diabetes of moderate severity can be diagnosed with practical certainty.

The only exception to this rule is when a patient has had a starvation ketosis for some other reason, e.g. acute abdomen or hyperemesis gravidarum, and has already been treated with glucose. Temporarily the urine contains both glucose and acetone. If Gerhard's ferric chloride test for diacetic acid is positive there is severe diabetes in the stage approaching diabetic coma. The only precaution necessary here is to exclude the presence of previous treatment with aspirin or its compounds or with salicylates, which simulate this test.

The specific gravity of the urine may help. If the amount of sugar is large the specific gravity is usually about 1030 and may be up to 1044. This never occurs except in diabetes. But with copious

polyuria and when the normal constituents of the urine are in great dilution, the specific gravity of the sample may not be higher than 1016 or 1018. So that a sample of urine within the normal range of specific gravity may still be diabetic.

Milder degrees of diabetes may show only slight glycosuria or even transitory glycosuria and here the diagnosis may remain in doubt, since no symptoms or signs may be elicited. Generally speaking, the chance finding of glycosuria in a young adult when no symptoms of diabetes are present or suspected, is likely in nine cases out of ten to be due to one of the types of simple glycosuria. Thus, in a series of investigations of 381 young adults showing glycosuria which was discovered accidentally on medical examination for the Services, 41 were found to be diabetic, 112 to have high normal curves, and 234 to be examples of renal glycosuria (Lyll, 1946).

When symptoms have aroused suspicion of the presence of diabetes, and glycosuria is found the chance is reversed. Glycosuria in both sexes over forty-five years of age is nearly always diabetic. In an individual who has previously passed medical examinations for the Services, a life insurance, or appointments, and when a new finding of glycosuria occurs, it probably means diabetes. When an individual has a previous record of glycosuria on several occasions over a few years, the glycosuria is almost certainly of a harmless type, especially if no dietetic or other treatment has been instituted.

Glycosuria in various conditions—Glycosuria is found in association with a large number of conditions in routine practice or in hospital patients. No classification could be exhaustive, but glycosuria is a universal or usual finding in the following states besides diabetes mellitus:—

- Haemochromatosis or diabetes bronze.
- Hepatic diabetes of the obese in later decades.
- Renal glycosuria.
- Renal glycosuria of pregnancy.
- So-called alimentary glycosuria.
- So-called psychical glycosuria.
- Certain surgical conditions, including gross sepsis, e.g. cellulitis, carbuncles, and septic gangrene; severe traumatic injuries; acute pancreatitis; head injuries, and cerebral haemorrhage.
- After anaesthetics, especially chloroform and ether.

- After administration of adrenaline.
- In coal gas asphyxiation.
- After administration of intravenous glucose saline.
- Thyrotoxicosis, frequently.
- Hyperpituitarism and fully developed acromegaly.
- Cushing's syndrome and suprarenal tumour.

In the presence of clinical signs of obesity, pigmentation, acromegaly or Cushing's syndrome, glycosuria usually means associated diabetes. In the presence of severe sepsis, cellulitis, carbuncle, and septic gangrene, glycosuria also usually means associated diabetes, but in a proportion of these cases, even though hyperglycaemia be present, this may be transitory and disappear or be much ameliorated on suitable treatment, drainage and healing of the septic foci. In severe injuries, or some head injuries, temporary hyperglycaemia is present but is seldom followed on recovery by permanent diabetes. Nevertheless, permanent diabetes may be sequel to a head injury such as a fall from a motor bicycle. After the administration of anaesthetics, adrenaline, glucose-saline, and coal-gas, glycosuria is usually transitory. It is not uncommon to find temporary hyperglycaemia in young adults after operation for a gangrenous appendix. When obvious exophthalmic goitre is present, glycosuria usually means a temporary elevation of the blood sugar due to thyroxin stimulation, although occasionally true diabetes and thyrotoxicosis coexist. The more usual type of glycosuria is controlled after treatment with thiouracil.

In a recent instance in a male patient aged forty-four years referred for glycosuria, there were signs of exophthalmic goitre with tachycardia, loss of weight, sweating, enlargement of the thyroid gland, and basal metabolic rate plus 38 per cent. A glucose tolerance test gave the following figures for the blood sugar: 100, 156, 206, 181, 117, mg. per cent. After treatment with thiouracil the sugar tolerance test showed: 100, 140, 133, 109, 100 mg. per cent., and there was no glycosuria.

Blood sugar estimations—In all cases of glycosuria estimation of the blood sugar is essential in making a definite diagnosis. For this purpose capillary blood may be taken by finger prick into suitable solution, but it is much more convenient to take a sample of 2 ml. of oxalated blood and transport this to the laboratory. If the blood sugar is high, say above 250 mg. per cent. or higher, a diagnosis of diabetes is certain and suitable steps must be taken

for treatment. If the blood sugar value is normal in the fasting state, then the presence of diabetes can be practically excluded. Values between 130 mg. and 180 mg. per cent. found up to two hours after a previous meal, leave the diagnosis in doubt.

In most instances it is essential to carry out a full *sugar tolerance test*.

The patient has no food from 8 o'clock on the previous evening. Samples of urine are collected on waking and before the test is started. The latter sample is a true fasting sample, and even in renal glycosuria may be the only sample of urine found completely free of sugar. If this sample contains sugar, diabetes is probable, the only exception being renal glycosuria with very low values of the renal threshold for glucose. A sample of fasting blood is taken and the patient is given 50 g. of glucose in 3 to 4 ounces (85 to 114 ml.) of water. Samples of blood are taken at intervals of 30 minutes for two hours and samples of urine are collected at similar intervals. The sugar content of the blood samples is determined by one of the usual methods (Maclean, Hagedorn-Jensen, Nelsen, Folin-Wu) and a curve constructed. Normally the blood sugar does not exceed 170 mg. per cent. and the highest value occurs in 30 minutes. Thereafter the curve returns towards normal fasting value, and reaches this level or just below it within 120 minutes. The greater majority of normal persons show fasting blood sugar values below 100 mg. per cent. Only occasionally is this exceeded in the elderly patient.

The following curves with marginal notes illustrate the types of blood sugar in various conditions.

Glycosuria in diabetes under treatment—It is important in the continuous control of the diabetic patient under treatment to be aware of the significance of recurrent glycosuria. No diabetic patient under treatment should show acetone in the urine. In ideal circumstances the same should apply to glycosuria, but this degree of normality can seldom be achieved permanently in the severe diabetic under insulin therapy. In the milder obese diabetic in the later decades treated with a low calorie diet and limited carbohydrate, the urine should remain free of sugar, but when insulin dosage over 20 to 30 units daily is in use, permanent aglycosuria is not easily maintained, without risk of hypoglycaemia.

In establishing initial control of the diabetic state, it is essential to realize the

time relations of glycosuria to the type of insulin in use.

With a single morning dose of *protamine zinc insulin*, and when the patient is taking an adequate diet, say with 120 mg. of carbohydrate, the first sample of urine which should become free of sugar is that passed immediately before breakfast next day, the overnight sample having first been voided. When this sample is found to be free of sugar on several consecutive days, care must be taken in further increase of insulin to avoid hypoglycaemia at this time. In patients under good control with this type of insulin, this sample of urine should always be free of sugar.

With a single morning dose of *globin insulin*, the first sample of urine to become free of sugar is that passed about 5 to 6 p.m. the bladder having been previously emptied at about 3 to 4 p.m. When this occurs the diabetic state is coming under control and further modification must be conducted with care. With two doses of soluble insulin (at 7:30 a.m. and 6:30 p.m.) the samples of urine which will first show no sugar are those passed at 12 noon and 12 midnight, the bladder having been emptied an hour previously.

With various combinations of insulin, e.g. protamine zinc insulin plus soluble insulin as one injection, or protamine zinc insulin in the morning and soluble insulin at night, the timing becomes more complicated. An alteration in the renal threshold for glucose would produce considerable modification. With a rise in the threshold, such as commonly occurs in diabetes of long duration, glycosuria could be more easily abolished. When the renal threshold for sugar is low it may be much more difficult to render the urine free of sugar. This occurs occasionally in diabetes, and if an attempt is made to render the urine free of sugar by increasing the dose of insulin, hypoglycaemia is likely to occur first.

In the untreated case of diabetes the daily amount of sugar passed in the urine may be large, 2009 or over. In the successfully treated case on insulin, the sugar lost in the urine should not exceed 209 daily, an insignificant drain on metabolic resources.

Illustrated Blood Sugar Curves

URINE FASTING				BLOOD SUGAR				URINE AFTER TEST			DIAGNOSIS AND REMARKS
G. per cent.				Mg. per cent.				G. per cent.			
				Time in Minutes							
Sugar	Acet-one	Albu-min	Fast-ing	30	60	90	120	Sugar	Acet-Albu-min		
0	0	0	85	150	130	110	85	1.0	0	0	No symptoms. Renal Glycosuria
0.5	trace	0	85	120	110	90	65	2.0	trace	0	Hypoglycaemia. Renal glycosuria with very low threshold
0	0	0	100	220	187	152	122	1.0	0	0	No symptom. Mild diabetes.
0	trace	0	90	200	167	130	100	2.5	trace	0	Thyrotysicosis. Not diabetic
1.5	+	0	170	280	358	312	287	3.5	trace	0	Diabetic symptom. Moderately severe diabetes.
trace	0	0	150	220	230	160	154	2.0	0	0	Obese. Hepatic diabetes. No diabetic symptoms.
3	+	trace	200	383	400	382	296	5.0	+	trace	Thyrotomic signs. Severe diabetes and thyrotonicosis.
3.5	++	+	250	380	412	380	300	5.0	++	+	Severe diabetes in the renal charges
0	0	0	85	158	132	110	80	0	0	0	Normal.

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November, 1949]

GOVERNMENT OF MADRAS

Education and Public Health Department

G.O. Ms. No. 4427, Public Health, dated 15th Dec. 1949

ABSTRACT

Associations :—Indian Medical Association—South Indian Provincial Branch—Resolutions passed at the Fourth Provincial Conference—Orders passed.

READ :—

From the President, South Indian Provincial Branch of the Indian Medical Association, dated 24—10—49.

Order : The President, South Indian Provincial Branch of the Indian Medical Association is informed that the Government have considered the resolutions passed at the Fourth Provincial Conference of the Association and that they pass the following orders :

1. *Promotion of deserving licentiates to the posts of Civil Surgeons and District Health Officers* :

The suggestion is already being carried out in practice in respect of deserving candidates.

2. *Provincialisation of local board and municipal medical services.*

It is the policy of Government to take over gradually all Local Fund hospitals in the Taluk Headquarters as a first step and this is being implemented. As financial, working and other conditions vary greatly and in view of financial stringency the Government consider that it is not a feasible proposition to insist on local bodies to pay the same scales as Government or to provincialise the medical services under the local bodies.

3. *Reduction of medical course to four years :*

The Government have given very careful consideration to the suggestion and have come to the conclusion that the balance of advantage lies in leaving this as they are.

4. *Opening of more Medical Colleges* : The Government have already taken up the question of reviving the Mathurai Medical College Scheme.

5. *Facilities for post-graduate studies* : Certain facilities already exist in this Province for post-graduate studies and those who want to avail themselves of these facilities are at perfect liberty to do so. The Government have also taken up the question of training an adequate number of medical officers either in this country or abroad, to fill up the teaching posts and to keep a reserve of men for such posts.

6. *Appointment of more Women Medical Officers as Civil Surgeon* : The question will be considered by the Government.

7. *Reservation of seats in Medical Colleges to children of medical men and for admission on merit* : The attention of the President of the Association is invited to G. O. 2443, Public Health, dated 7—7—49 and he is informed that the Government regret their inability to pursue the suggestions.

(By order of His Excellency the Governor)

(Sd.) T. M. S. MANI,
 Additional Secretary to Government.

GOVERNMENT OF MADRAS

EDUCATION AND PUBLIC HEALTH DEPARTMENT

Memorandum No. 90967 A.I/49-1 P.H. dated 16th December 1949

Sub: Indian Medical Association—South Indian Provincial Branch—Certain resolutions—orders passed.

Ref: From the President, Indian Medical Association, South Indian Provincial Branch, letter dated 24-10-1949.

With reference to his letter read above the President Indian Medical Association, South Indian Provincial Branch, is informed as follows:—

(1) *Resolution (4) passed by the Association*:—The question of integration of the various systems of medicine is under the consideration of Government.

(2) *Resolution (5)*:—The six months' training given to Village Vaidyas relates only to the general principles of medical and public health matters.

(3) *Resolution (7)*:—The question of appointing licentiates in medicine in the Primary Centres is under consideration.

(4) *Resolutions (6) and (8)*:—As a measure of retrenchment the Government have ordered that the 21 primary centres sanctioned during the current year should not be started and that the proposal to start mobile medical units should be deferred.

(Sd.) T. GOVINDA MENON,
Deputy Secretary to Government.

GOVERNMENT OF MADRAS

PUBLIC WORKS (INFORMATION AND PUBLICITY) DEPARTMENT

PRESS COMMUNIQUÉ

Dated Fort St. George, the 7th November 1949

In July last, the Ayurveda Tamil and Ayurveda Telugu sections in the College of Indian Medicine were amalgamated. This amalgamation has been objected to in certain quarters on the ground that Ayurveda cannot be taught in English, there being no appropriate words to explain some of the technical terms in Ayurveda. The Government wish to make it clear that the Sanskrit text-books in Ayurveda have not been abolished. The Sanskrit texts are explained in English, where necessary, as most of the students cannot clearly understand Sanskrit and as the students can follow the explanation in English possessing as they do, at least the Intermediate qualification. Further, the amalgamation does not prevent the teachers from using Telugu or Tamil in explaining the text and the students from using the translation of the Sanskrit texts in Telugu or Tamil. The advantages in the amalgamation are that besides providing a uniform standard of teaching for the class as a whole, it obviates unnecessary expenditure on the maintenance of a larger number of Professors than is needed. It ensures efficiency in teaching and economy in the use of public funds.

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

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ODDS & ENDS

Dr. Seldom, the dentist, has named his new farm, "Tooth Acres".

∴ ∴ ∴

Investigation is going on to check the accuracy of the statement that there are at present 150,000 cases of Neurosis in Denmark. It is said every third patient is a mental case.

∴ ∴ ∴

According to a new law in France, a properly qualified subject of a foreign state may practice medicine, by order of the Minister for Public Health. One of the requirements is knowledge of medicosocial laws applicable to France.

∴ ∴ ∴

A woman decided to have the shape of her nose altered, so she called on a plastic surgeon.

"How must will you charge to alter the shape of my nose?"

"A hundred guineas, madam."

"A hundred guineas!" she exploded. "Isn't there something less expensive?"

"Well," replied the surgeon "You could try walking into a lampost."

∴ ∴ ∴

Heard on the phone. "Doctor, my wife has dislocated her jaw".

Doctor: "I shall come immediately."

"Oh, no hurry, any time next week or later will do."

∴ ∴ ∴

Doctor (after examination) "Madam, you have a constitution of iron."

Obese patient: "I have often wondered what makes me so heavy."

∴ ∴ ∴

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If drugs could save
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God wots enough
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While still they tries
On other folks
Their silly jokes.

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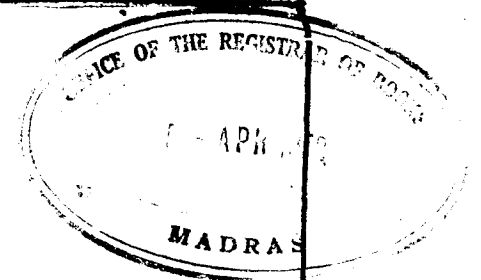
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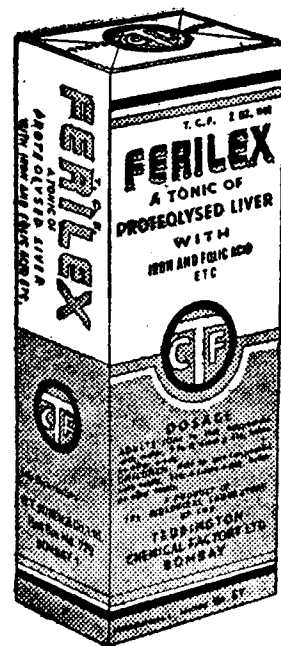
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[No. 6

MASTOID SURGERY—ITS PRESENT STATUS

BY

MAJOR P. G. K. MENON,

Head Quarters Hospital, Mangalore

In recent years special study and research on the temporal bone have improved our knowledge regarding the diagnosis, prognosis and treatment of suppurative and nonsuppurative conditions of the ear. Discharge from the ear, disturbances of equilibrium and deafness are the well known symptoms of ear disease. A patient usually seeks aid for his discharging ear and also when he finds that he is losing his balance; but for the solitary symptom of deafness he usually seeks aid at a very late stage. It is our common experience that when an individual's eye sight is a little blurred he rushes at once to his medical officer but the same individual will calmly lose the hearing in one ear and only seeks advice when the second ear is becoming definitely affected. The ears are complementary to each other and so it follows that a patient can be quite comfortable until he has lost about (60%—70%) of his hearing.

The majority of patients seeking aid for deafness in our hospitals give a clear history of discharging ears from childhood. The fact was noted also in the late war when some of us in charge of ear, nose and throat centres have found that wastage of men power in the armed forces was considerable, it may be they have been admitted and trained in the armed forces only later to be

boarded out and often pensioned at the expense of the State. It is clear therefore that the treatment of discharging ears should start early from the very onset and that our aim should be to get back the hearing of the patients to as near the normal as possible; and proper mastoid surgery is certainly of great help in eliminating sepsis and restoring hearing in our ear cases.

The mastoid part of the temporal bone, at birth, consists only of the mastoid antrum, and the mastoid process; the mastoid air cells are still undeveloped. The mastoid process grows downwards from the antrum and assumes the adult type in the third to seventh year. It is worth remembering that the mastoid antrum is not an isolated cavity within the temporal bone but part of the middle ear tract or cleft formed between the squamo zygomatic and petromastoid portions of the temporal bone. Any infection of the tympanic cavity is liable to involve the whole cleft. In fact a mastoiditis exists in every case of acute suppurative Otitis Media in that the mucosa lining the antrum and at least some of the periantral cells are affected. This is resolved by the treatment for the suppuration of the middle ear and drainage by a mastoid operation is not usually needed.

Three types of mastoids are described and the structure of these different types decides the course, influences the symptoms, signs, and treatment of mastoiditis as a complication of Otitis Media.

1. *The cellular Type*—The whole bone is formed of cellular spaces which are lined by mucus membrane. The cortex is very thin in this type of mastoid and therefore in acute infections oedema and sub periosteal-abscesses tend to be an early sign. It is these types of cases that we see commonly in the out-patients of our hospitals.

2. *The Diploic Type*—The interior of the mastoid is filled with cancellous bone similar to that found between the inner and outer tables of the cranial bones. The early signs of mastoiditis tend to be later in appearance than in the cellular variety.

3. *The Sclerotic Type*—There is complete absence of cells in this variety and in an infection of the mastoid, pus cannot find its way through the dense surface. In a virulent infection it is easier for the pus to pass through the walls of the antrum and thus infect either the middle or posterior fossa of the skull. The following case summary is illustrative of this point.

A male aged 12 was admitted in the Wenlock Hospital on 25-2-1949, with history of ear discharge and tenderness behind the left ear for about a week. Weber laterised to the left. Child curls up in bed. Cortical Mastoidectomy was done on 26-2-49 under general anaesthesia and antrum drained. A Sclerotic Mastoid was found at the operation. The child was found irritable even after the operation. 27-2-49 L. P. done and turbid fluid under pressure found. 28-2-49 patient suddenly developed fits involving right arm and right side of the face, and completely unconscious. 1-3-49 the patient was operated under general anaesthesia. A left sub-dural abscess was drained and pencillin injected.

The patient eventually was discharged cured from the hospital.

Indications for Mastoidectomy in Otitis Media (Acute)

- (A) Within ten days.
1. Acute Otitis Media with neck rigidity in children.
 2. Severe initial deafness in the beginning of acute Otitis Media.
 3. Profuse Otorrhæ with Reservoir test. (If within 20 to 30 minutes after cleaning by syringing and mopping, secretions are detected oozing into the meatus through the perforation with pulsation, it is from the Mastoid Antrum and cells and not from the narrow middle ear itself).
- (B) 10th day to 2nd week.
4. In case of suppurative Otitis Media after spontaneous perforation or Meningotomy if a headache or earache persists or increases.
 5. Temperature persists or increases.
 6. Mastoid tenderness persists or increases.
- (C) 3rd week onwards.
7. Swelling over the Mastoid process above or in front of the ear. This may be Zygomatic Mastoid or an Extra dural abscess perforating through the Squama of the temporal bone; swelling may be in the neck-Bezolds Abscess.
 8. Sagging of the Postero Superior wall of the meatus usually associated with purulent discharge. It means that the suppuration is extending forwards. It may be present for weeks with an earache.
 9. Positive Reservoir Sign.
 10. Acute Otitis Media with serous Labrynthitis.
 11. Grandingo's Syndrome—Acute inflammation of the ear with Homo-

lateral External Rectus palsy and pain behind the eye. It is due to oedema or inflammation spreading along the middle cranial fossa to the 6th nerve or Gasserian ganglion.

12. Acute earache with facial palsy. The nerve lies in the inner and upper wall of the middle ear in its bony canal—the aqueductus Fallopii. The canal takes a curved course just above the oval window before passing vertically downwards in the anterior and deep part of the mastoid process to emerge at the stylo mastoid foramen. Dehiscences in the bony wall just above the oval window occur in some cases so that the nerve is only covered by mucoperiosteum and therefore can be subjected to pressure in the middle ear. As a result facial paralysis is occasionally seen as a complication of acute Otitis Media. Also the vertical portion in the deep part of the Mastoid may be in very close proximity to some of the Mastoid cells and paralysis coming on in a suspected Mastoiditis gives a direct indication for immediate operation.
13. Acute ear with intracranial complications—Meningitis or Extra dural abscess.
14. Acute ear with diarrhoea and vomiting in children.
15. Acute ear with congenital Atresia of the meatus.

In chronic discharging ear the usual signs that call for surgical interference are:

1. Impairment of hearing.
2. Offensive discharge.
3. Marginal or Attick perforation.
4. Granulations and polypii in the ear.
5. Facial Paralysis.

Radical Mastoidectomy should be limited to cases where there is a very

foul smelling discharge or where endocranial complications like meningitis, lateral sinus thrombosis and brain abscess are threatened.

Can the serious intracranial complications mentioned above be avoided by the administration of antibiotic drugs? No doubt these complications are now very rare indeed after the advent of Sulphanamides and Pencillin. Before the introduction of these powerful drugs the prognosis of these cases was always considered grave. But these drugs will not by themselves and unaided cure infective diseases produced by certain organisms except perhaps in the earlier stages of invasion. Graham Brown in his conclusions based on 25 years practice of Mastoid surgery says (1944) "When pus has begun to form in bone or soft tissues, the inflammatory process may be retarded with the so called making of symptoms but not to the point when resolution can effect a healing of these abscesses. Most of us have had similar experiences and we have been taught that these drugs cannot replace surgical treatment when an undrained necrotic process is present." Recently a case was referred to me of Otitis Media for which he had intensive pencillin therapy with the result that although his discharge completely stopped he had unilateral deafness on that side.

I do not propose to go into the different techniques of the operations on Mastoid except to mention that in chronic discharging ear with an acellular Mastoid the infected middle ear and antrum could be cleared by an endaural approach to the temporal bone as standardised and perfected by Dr. Lampert of New York.

So far regarding the suppurative surgery of temporal bone which is bound to decrease in proportion to the prophylactic measures against the incidence of the aural disease increases.

Non-suppurative surgery of the temporal bone is now being done extensively

in all the advanced countries. Operations on the labyrinth are done to restore equilibrium to the unbalanced as in Meniers disease and also to give hearing for the deaf as in Otosclerosis. For the proper performance of operations on these small and delicate areas special experience, special equipment, special time are highly essential. Special experience by working on the cadaver before undertaking this sort of work, special equipment such as a Binocular dissecting microscope giving 5 to 10 diameters of magnification while working and diathermy to control

local bleeding, and special time in the sense that these operations should or could never be undertaken as a routine operation or as part of long list. Let us hope that this type of specialised surgical aid will be within the reach of ordinary man and woman in our country also in the not too distant future.

References:—

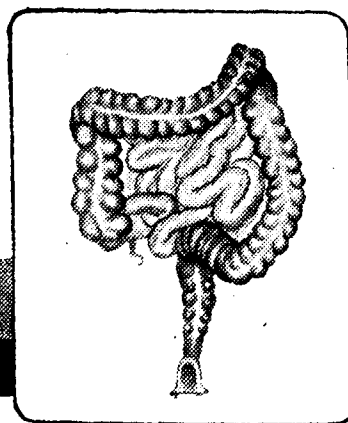
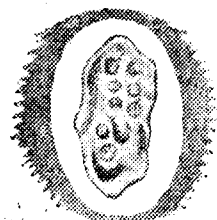
1. Acute Otitis and Mastoiditis—N. Asherson
2. Acute Mastoiditis Diagnosis and Treatment—J. Douglas MacLaggan.
3. Acute Otitis Media—W. M. Morrison

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December, 1949]

HEALTH MINISTER ON VILLAGE VAIDYA SCHEME

Ramnad 21-12-'49

Presiding over the 19th annual meeting of the Indian Medical Association, Ramnad District Branch, Dr. T. S. S. Rajan, Minister for Public Health, reminded the members of the medical profession of what H. E. the Governor General Sri. C. Rajagopalachariar had recently said in Madras that the Government was nothing but a 'Social Service League' and said that the present Government should be considered a 'Social State' and everyone should render his service to humanity in terms of freedom. The Minister said that he was actively connected with the Medical Association ever since he was a practitioner at Trichinopoly, and was very much pleased with the enthusiasm of the group of medical men taking an abiding interest in its growth. Medical Associations were not popular gatherings. They were meant for a definite purpose of not only doing work for the well-being of the profession but also for humanity in its larger sphere.

Medical men, wherever they lived should be honest and should serve the people in a true spirit of service.

The Minister pointed out that medical service based on monetary consideration without regard for human life, should not be their sole aim, but they should on the other hand serve the suffering human beings. In this connection he pointed out that even Mahatma Gandhi had a sort of dislike for the profession on the ground that the system of modern medicine was beyond the means of average villager. The Minister instanced how even today foreign missions were serving here with the same enthusiasm without any bias to cast, creed, or community, in medical aid.

Dr. Rajan referred to the service that was being done by the World Health Organisation in India, and said that a limb of the World Health Organisation had been started in Trichinopoly as a Cholera Investigating Research Station.

He informed the gathering that during a short space of the last three months, there were about 15,000 cholera deaths in the Province.

They must bow their heads in shame he added, and he was the Health Minister of the Province. But what could he do except appeal to them to investigate the matter to wipe out the epidemic in toto. The World Health Organisation was helping the Government in this direction. A batch of silent workers were touring villages in Trichinopoly and Tanjore District to study the cholera situation and conduct experiments.

The Minister referred to the great pioneering work started by Dr. Venkataraman of Madura for the last 13 years to find out the missing link in the epidemiology of cholera and how his work and sacrifice was being recognised by the W.H.O. A scientific and sensible investigation was necessary to wipe out this dangerous epidemic from the soil.

Referring to the proposal to open a Medical College in Madura, Dr. Rajan said that he welcomed it. He added that the scheme was mooted long before the Great War, and had been dragging on through investigations by Commissions and finally postponed on the plea of finance. But he would tell them that the monies spent on Commissions if only had been utilised properly, two new Medical Colleges could have been built long ago. Dr. Ramasubramanyam,

of Madura had come forward to work out this scheme offering his free service for running the Medical College if only the Government was prepared to help him with a few lakhs of rupees. Whatever the Government might say to this, the Andhras had got their medical College, but those in Tamil Nad missed getting one.

Important things of this kind were either ignored or postponed, while the wonderful "Village Vaidya Scheme" was being discussed in the Legislature and he, as Minister for Medicine, had to defend the Scheme. The Government said that it would make such Vaidyars into Doctors within six months.

The Government had opened four or five centres in this Province with a strength of 65 candidates in each of them. Though they would get certificates from the Government, the Government would not promise any appointments for them. This Province, he added, was very poorly equipped with medical men and therefore the need for instituting such a scheme.

The Minister deplored that knowledge was being denied to prospective entrants to the Medical College on communal grounds.

—Mail, 24-12-'49.

Announcement

INDIAN MEDICAL ASSOCIATION (CENTRAL OFFICE)

Ref. 59/49-50.

HONORARY SECRETARIES,
All Provincial Branches,
Indian Medical Association

DEAR SIR,

I have been instructed by the Working Committee to enquire from you if any member is willing to go as an additional delegate at his own expense, to the British Commonwealth Medical Conference to be held at Brisbane, (Australia) on 16th, 17th and 18th May, 1950.

It may be mentioned here that Dr. S. C. Sen has been elected as a delegate and in case he is unable to go, Dr. H. Hukku will be the delegate.

An early reply will be appreciated.

Yours faithfully,
(Sd.) S. C. SEN,
Hony. Secretary.

"HANGING BRIDGE"
FAIZ BAZAAR,
DARYAGANJ
Delhi, 6/9-1-'50

December, 1949]

ASSOCIATION NOTES

COIMBATORE BRANCH

President: Dr. C. Nanjappa
Vice-President: Dr. N. Krishnaswamy
Hony. Secretary: Dr. A. G. Leelakrishnan
Associate Secretary: Dr. S. Ganapathi
Hony. Treasurer: Dr. T. V. Sivanandam

The monthly clinical meeting of the association was held at 6 p.m. on Saturday the 22nd October 1949 in the association premises with Dr. C. Nanjappa, the president in the chair. 58 members were present.

After tea and reading of the minutes of the last meeting, the secretary announced about the forthcoming All India Medical Conference at Allahabad in December 1949 and members intending to participate in the Conference as delegates, were requested to send their names to the Secretary early.

The President then requested Dr. M. P. Pai, M.B.M.S., to address the members on "Surgery for the practitioner". The lecturer dealt briefly on the treatment of the infections of the hand, treatment of wounds and burns, early diagnosis of malignancy, treatment of anal infections, tubercular adenitis and sinuses, diagnosis of acute abdominal conditions etc. In the discussion that followed Drs. K. V. Subramaniam, C. V. Ramaraj, C. N. Santhanam, S. V. Appaji and R. Sundararajan took part.

After the president's concluding remarks and vote of thanks to the lecturer

and the host, Dr. S. Ganapathy, the function terminated at 8-30 p.m.

The monthly clinical meeting of the Association was held at 6 p.m. on Saturday, the 26th November 1949, in the Association premises with Dr. N. Krishnaswamy, the Vice-President in the chair. 65 members were present.

After tea and reading of the minutes of the last meeting, the President requested Dr. Miss A. K. Verghese, M.B.B.S., to address the members on "Ectopic Gestation". The lecturer dealt at length with the various types of ectopic pregnancy, the ætiology and diagnosis of the condition. She stressed the necessity of immediate laparotomy once the diagnosis is established.

Dr. C. R. Thiruvengkatam, M.B.B.S., A.D.M.O., supplementing the speaker, stressed the importance of blood transfusion in the treatment of ectopic gestation.

After a vote of thanks to the lecturer and to the host, by Dr. A. G. Leelakrishnan, M.B.B.S., the function terminated at 8-30 p.m.

MADURA BRANCH

President: Dr. P. Vadamalayan
Vice-President: Dr. A. Balakrishnan
Secretary: Dr. K. G. Ramabhadran
Treasurer: Dr. A. S. Annamalai.

The monthly meeting of the Association was held at 5-15 p.m. on Saturday the 17th December 1949 in the Willis F. Pierce Memorial Hospital, Mathurai. 65 members attended. The Superintendent

and staff of the W.F.P.M. hospital and the American Mission hospital for women and children were at home to the members.

The meeting commenced at 5-45 p.m.

with Dr. P. Vadamalayan in the chair. The minutes of the previous monthly meeting held at Palni on 27-11-1949 were read by the Hony. Secretary and adopted.

The Hony. Secretary then introduced the new members and announced that a souvenir was being got ready for the annual conference to be held in February 1950. He then read out the notice regarding the Annual Conference of the Indian Medical Association at Allahabad. The request of the secretary of the Ramnad District Medical Association for holding a joint meeting at Mathurai every alternate month was discussed and approved. Dr. T. V. Venkatesan invited all the members to attend the Erskine Hospital Clinical Society meeting to be held on the 21st December and read out a list of cases to be demonstrated.

Dr. E. S. Chellappa, Medical Superintendent of the W.F.P.M. Hospital next demonstrated a case of Duodenal ulcer for whom he had done vagectomy and gastro enterostomy. He described in detail the operation and showed the F.T.M. result both before and 3 weeks after the operation. He was of opinion that vagectomy should always be coupled with gastroenterostomy even though there was no stenosis, since the muscle tone was diminished after vagectomy and stasis was likely to occur in the stomach. Dr. K. Ramahandran and Dr. P. Vadamalayan took part in the discussion that followed.

Dr. Chellappa then began his lecture on the treatment of Pulmonary Tuberculosis in a General Hospital. He enumerated the various problems facing a general hospital in regard to the admission and treatment of T. P. patients and the need for a thorough examination and a proper diagnosis before admission. As regards prognosis he found by experience that a bilateral non-cavity lesion had a better prognosis than an unilateral lesion with cavity.

He also mentioned the important complication worsening the prognosis such as Diabetes, Enteritis etc. Regarding treatment, he said, that injections of Gold and Phrenic avulsions and compressions were being given up in his hospital. During the year 16 cases were treated with streptomycin with dramatic improvement in some cases. One of his cases developed vertigo and some dimness of vision after only 15 gms. of streptomycin.

He then demonstrated five cases of Thoracoplasty done by him in his Hospital during the past two years and illustrated them with case reports and skiagrams before and after operation.

Dr. K. Balakrishnan supplementing the lecturer said that a small percentage of his cases developed toxic symptoms only after a long treatment with streptomycin and cleared up within three months after the drug was stopped. Recently in some cases he was combining P. A. S. with streptomycin and found that the temperature in these cases came down to normal more rapidly than with streptomycin alone.

The president and others who took part in the discussion said that none of their cases exhibited lasting toxic symptoms after streptomycin. The president also mentioned the remarkably rapid curative effects of streptomycin in a few cases of bone tuberculosis and tuberculosis of the testis.

The Hony. Secretary proposed a vote of thanks to Dr. Chellappa and the staff of the mission hospitals for arranging this meeting in their premises and being the hosts of the evening.

The members then adjourned to the spacious lawn inside the hospital where the following films, kindly lent by the British Information Services, were screened.

1. YOUR CHILDREN'S TEETH.
2. YOUR CHILDREN'S SLEEP.
3. YOUR CHILDREN'S EYES.
4. SCABIES MITE.

The gathering dispersed at 8-30 p.m.

SOUTH KANARA BRANCH

President: Dr. A. G. Nambiyar
Vice-President: Dr. A. F. Coelho
Secretary & Treasurer: Dr. K. R. Kini
Jt. Secretary: Dr. B. R. Hedge.

Proceedings of the Annual General Meeting held on 12-11-1949 at 5 0 P.M. at the Wenlock Hospital, Mangalore.

Present:- (1) Dr. U. P. Mallya-President and 34 others.

The Honorary Secretary read the messages of greetings from sister institutions.

1. Consideration of the Annual Report and Audited Statement of Accounts for the year ending 30-9-1949.

"Resolved that the Annual Report and Audited Statement of Accounts for the year ending 30-9-1949 be adopted."

Proposed by Dr. A. F. Coelho and seconded by Dr. M. R. Shetty—passed unanimously.

2. Consideration of alterations to Byelaws.

"Resolved that in view of the increase in the rate of Central Fund Contribution from Rs. 6/- to Rs. 8/- per year per member, the following alterations to the respective Byelaws be adopted with effect from 1-10-1949.

Byelaw No. 8:- In clause (b) substitute Rs. 2/4/- per month for Rs. 2/- per month.

In clause (c) substitute Rs. 6/- per half-year for Rs. 5/- per half-year.

Byelaw No. 9:- In clause (b) substitute Rs. 8/- per member for Rs. 6/- per member and Rs. 4/- for Rs. 3/-."

Moved from the chair and passed unanimously.

3. Consideration of the Budget for 1949-1950.

The Honorary Secretary then placed the budget for 1949-1950 before the meeting and moved for its consideration and adoption.

"Resolved that the draft budget is approved and adopted"—Proposed by

Dr. M. Rangappa Kamath and seconded by Dr. A. F. Coelho—passed unanimously.

4. Election of Office Bearers and Executive Committee.

"Resolved that the following Office Bearers be elected for the different offices.

President:- Dr. A. G. Nambiyar—Proposed by Dr. U.P. Mallya and seconded by Dr. A. F. Coelho—passed unanimously.

At this stage Dr. U. P. Mallya, the retiring President vacated the chair and Dr. A. G. Nambiyar the newly elected President occupied the chair.

Vice President:- Dr. A. F. Coelho—proposed by Major W.E. Mascarenhas and seconded by Dr. M. R. Shetty—passed unanimously.

Honorary Secretary & Treasurer: Dr. K. R. Kini,—proposed by Dr. A. F. Coelho and seconded by Dr. Miss M. Thankamma—passed unanimously.

Honorary Joint Secretary: Dr. B. R. Hedge—proposed by Dr. M. Umesha Rao and seconded by Dr. K. Nemiraj Alva—passed unanimously.

Members of the Executive Committee:-

1. Dr. M. R. Shetty,
2. Dr. M. Rangappa Kamath,
3. Dr. S. Gopalakrishna Rao,
4. Dr. P. G. K. Menon,
5. Dr. C. P. Kamath,
6. Dr. K. B. Shetty,
7. Dr. Mrs. L. Saldanha and
8. Dr. J. Subba Rao—proposed by

Dr. A. F. Coelho and seconded by Dr. M. Umesha Rao—passed unanimously.

5. Election of Representatives to the Central Council and the S. I. Provincial Council.

"Resolved that the following members do represent this Branch on the respective Councils.

Central Council:- 1. One of the Honorary Secretaries, 2. Dr. U. P. Mallya.

S. I. Provincial: Branch Council:-

1. One of the Honorary Secretaries,
2. Dr. M. V. Shetty,
3. Dr. K. B. Shetty
4. Dr. M. D. Adappa,
5. Dr. M. R. Shetty,
6. Dr. U. P. Mallya and
7. Dr. M. Rangappa Kamath—proposed by Dr. C. P. Kamath and seconded by Dr. A. F. Coelho—passed unanimously.

6. Consideration of the question of contribution to the Tuberculosis Sanatorium at Moodashedde by the Association.

“Resolved that this Association views with great satisfaction that the Government have decided to open a Tuberculosis Sanatorium at Moodashedde for which the foundation stone has been laid already and contribute its own collection in the form of an endowment, the ear marking of which will be decided later on. The members are authorised to make voluntary contributions from the public and remit the same to the Honorary Secretary with their own contribution. The draft scheme prepared by the Honorary Secretary is approved and the Executive Committee is authorised to carry out the scheme and incur all expenditure such as purchase of collection boxes, printing of receipt books, pamphlets etc., for the implementation of the scheme. The collections shall be kept open for a period of six months at present”—proposed by Dr. U. P. Mallya and seconded by Dr. A. F. Coelho—passed unanimously.

7. Consideration of resolutions from members.

The following were considered:—

- (1) Letter from Dr. M. G. R. Sampi-geethaya, Karkala, regarding the fixing of clinical meetings on days other than Saturdays to enable some moffussil

members to attend such meetings at least for some meetings.

(2) The following resolution from Dr. B. R. Hedge—“In view of the fact that three members of this Association are also members of the local Municipal Council which convenes its meetings on 2nd and last Saturdays of every month this Association resolves that the meetings of the Association be held as far as possible on any day other than the two Saturdays mentioned above so as to enable the members in question to attend the meetings of this Association as well as the Council.”

Both the resolutions being on the same subject, the question was considered and after discussion it was decided to avoid Saturdays as far as possible.

8. “Resolved that Dr. K. R. Kini be congratulated on his being elected as Vice President of the South Indian Provincial Branch and this Association is very gratified at the result”—Proposed by Dr. A. F. Coelho and seconded by Dr. M. R. Shetty—passed unanimously.

9. “Resolved that this meeting places on record its appreciation of the services rendered to the Association by the retiring office bearers and members of the Committee and offers its thanks to them for the efficient way the work was carried on successfully in the past year”—Proposed by Dr. C. P. Kamath and seconded by Dr. A. F. Coelho—passed unanimously.

The Managing Director, Sri S. M. Nadakarni of the Chemo Pharma Laboratories Ltd., Bombay then gave an exhibition of the following films specially brought by him for review by the members.

- (1) Experiments in the Revival of the organisms.
- (2) Post Partum Haemorrhage
- (3) Reflexes

The films were very much appreciated by the members.

The newly elected President then appealed to the members to take more interest in the Clinical Meetings.

With a vote of thanks proposed by the Honorary Secretary to the members present, to the Managing Director of the Chemo Pharma Laboratories Ltd. and to others who participated in the function the meeting terminated.

* * * * *

Report on the working of the South Kanara Branch of the Indian Medical Association for the fourth year ending 30—9—1949.

The Branch Association has completed its fourth year.

Membership. The year opened with a membership of 69 of whom 35 were Resident and 34 Non-Resident. During the year 5 Resident members and 6 Non-Resident members joined. One Resident member became Non-Resident as he has temporarily left Mangalore. There were 3 resignations under byelaw 11 (c). Thus the total membership on the rolls at the end of the year was 77 of whom 37 were Resident and 40 Non-Resident.

Finance. The rates of subscription continued to be Rs. 2/- per month for Resident members and Rs. 5/- per half-year for Non-Resident members, the Entrance Fee being Re. 1/- for each new admission. Out of a total demand of Rs. 1327-12-0 including last year's balance, a sum of Rs. 1282-4-0 was collected leaving a balance of Rs. 45-8-0 at the end of the year. Current expenses including Rs. 465/- being the Central Fund Contribution, having been met, a balance of Rs. 1327-7-5 is left over. A sum of Rs. 947-8-0 has been invested under byelaw 9 (c). The Branch places on record its grateful thanks to Sri. A. Umanatha Rao, B.A., G.D.A., R.A., for auditing the accounts without any remuneration.

Meetings. Eight General Meetings were held during the year including the Annual General Meeting Col.

S. L. Bhatia, Surgeon General to the Government of Madras met the members at one of the meetings. The Association offers its grateful thanks to the lecturers.

Management. At the Annual General Meeting the old office bearers except one, were re-elected. The new member elected was Dr. P. G. K. Menon in place of Dr. P. N. R. Setty. Dr. K. R. Kini and Dr. V. R. Bhat were elected to the Central Council and Dr. S. N. Alekal, Dr. K. N. Nayak, Dr. M. R. Shetty and one of the Honorary Secretaries were elected to the Provincial Council to represent this Branch in the two different bodies. The Committee met three times to transact business.

Journals. The Branch besides getting the Journal of the Central Association both for itself and for the members individually, has been getting the following Journals:— 1. Practitioner, London, 2. Clinical Journal, London, 3. British Medical Journal, 4. Journal of the American Medical Association, 5. Indian Medical Gazette, 6. Antiseptic Madras and 7. The Medical Annual. The Journals were circulated as usual.

Library. The Library continues to be used by the members.

Habitation. The Branch places on record the continued co-operation of the District Medical Officer and his staff both for their courtesy and help in holding its meetings at the Government Head Quarters Hospital and the Lady Goschen Hospital.

Members' Activities. The Association congratulates the following members on their respective elections:—

Dr. K. R. Kini, on his election as Vice-President of the Provincial Branch.

Dr. K. Nagappa Alva, Dr. K. K. Hedge, Dr. K. B. Shetty, Dr. S. Champa and Dr. U. Shesha Rao on their election to the District Board.

Conclusion. The work of co-operation with the public health authorities

in the District could not be started in the year under report. Steps are being taken to do so in the coming year. A report of the work will be placed in the next Annual Report.

List of General Meetings held in 1948-1949.

1. Recent Advance in Leprosy Dr. R. G. Cochrane M. D., F. R. C. P. (Lond.) D. T. M. & H. Honorary Director Leprosy Campaign 1-11-1948.

2. Annual General Meeting 20-11-1948.

3. To meet Col. S. L. Bhatia, Surgeon General to the Government of Madras 25-1-1948.

4. Post partum Haemorrhage—Dr. Miss M. Thankamma, M.B.B.S., D. G. O. Demonstration of Trilene apparatus—Courtesy of Imperial Chemical Industries 12-2-1949.

5. X-Ray Diagnosis and treatment of Disease—Dr. K. B. Shetty, D. M. S. D. M. R. 19-3-1949.

6. Public Health Work and the General Practitioner—Dr. K. R. Kini, M. B. B. S. 25-6-1949.

7. Tonsillectomy—Dr. H. V. Adappa 20-6-1949.

8. Peptic Ulcer—Dr. A. G. Nambiar M. R. C. S., L. R. C. P. 24-9-1949.

TRICHY BRANCH

Vice President: Dr. R. Kalamegam
Secretary: Dr. V. K. Ranganathan
Treasurer: Dr. T. V. Sundaram

A monthly meeting of the Association was held on Saturday the 23rd July 1949 in the premises of the Bishop Heber High School, Trichinopoly. About 50 members were present. After Tea kindly provided by Dr. A. Dharma Rajan, the Secretary on behalf of the Managing Committee announced the resignation of the Vice-President Dr. G. Joseph Gnanadickam with regret and the election of Dr. R. Kalamegham as Vice-President. The meeting commenced with the nomination of one President and three Vice-Presidents for the Provincial Branch.

Moved from the Chair, the following resolution was passed unanimously.

"This Trichinopoly Branch of the Indian Medical Association strongly feels that the new rule of the Madras University raising the age of admission to Medical Colleges from 16 years 6 months to 16 years 8 months (a difference of 2 months) greatly handicaps those brilliant students, who, joining the intermediate at 14 years 6 months, pass the intermediate at 16 years 6 months and thus having to lose one

valuable year before entering the Medical College and so this Association requests the University to cancel the new rule."

After the introduction of the lecturer by the Chairman, Dr. N. R. Subramanyam, M.B.B.S., Tanjore gave a very interesting talk on 'Management of Amoebiasis' which was followed by the usual discussion.

After the vote of thanks to the lecturer, the Chairman Dr. R. Kalamegham, the host of the evening and the authorities of the Bishop Heber High School, the meeting terminated.

* * * * *

The monthly meeting of the Association was held on Saturday the 20th August 1949 at 5-30 P.M. in the premises of the Bishop Heber High School, Trichinopoly with Dr. R. Kalamegham the Vice-President in the Chair. About 50 members attended. After the final election of Dr. P. A. S. Raghavan as President of the South Indian Provincial Branch the meeting commenced after the Tea kindly provided by Dr. B.L.J. Mathu-

ram, Asst. Dist. Med. Officer, Trichy. Dr. K. Rama Menon, F.R.C.S. Supdt., Erskine Hospital, Madura dealt at length on the various aspects and problems of surgery in our country, which was followed by a very lively discussion in which many members took part.

After a vote of thanks to the lecturer, the host of the evening and the authorities of the Bishop Heber High School, the meeting terminated.

* * * * *

A monthly meeting of the association was held on Saturday the 15th Oct. 1949 at 5-30 P.M. in the premises of the Bishop Heber High School,

Trichinopoly with Dr. R. Kalamegham, the Vice-President in the chair. About 50 members attended, including 5 visitors from Coimbatore.

Dr. N. C. Subramanyam, B.A., M.B.B.S. T. D. D. was At Home to the members. After Tea, the Chairman introduced the lecturer Dr. P.K. Kalyanaraman, M.B.B.S. of Coimbatore to the members. The lecturer delivered a lecture on 'The Pneumonias' which was followed by a discussion in which many members took part.

After a vote of thanks to the lecturer, the host of the evening and the authorities of the Bishop Heber High School, the meeting terminated.

TANJORE BRANCH

President: Dr. Janab Mohamed Ismail
Vice-President: Dr. T. M. Pillai
Secretaries: Dr. N. R. Subramanyam
Dr. P. V. Kalyanasundaram.

The monthly meeting of the Tanjore District Medical Association was held on 28th August 1949 at 4-30 P.M. in the Medical School Buildings, Tanjore.

In the absence of the President, Dr. P. Narayana Rao the Vice-President of the association occupied the Chair. 32 members attended the meeting.

After Tea provided by Dr. V. Rajagopalan, M.B.B.S., R. M. Hospital, Tanjore the meeting commenced with reading of the minutes of the last meeting by the secretary which was adopted.

Report on streptomycin published by the Expert Committee of the W.H.O. was read out to the members for information.

Election of office bearers for 1950 for presidentship and Vice-Presidentship of S. I. P. Branch I. M. A. from among the nominations received was conducted. The following were elected.

1. *President:*—Dr. P. A. S. Raghavan.
2. *Vice-Presidents:*—Dr. J. Y. Arthur,

Negapatam, Dr. P. Vadamalayan, Madura.

For the office of President and Vice-Presidents of I.M.A. central for 1950 (from among the nominations received) the following were elected.

1. *President:*—Lt. Col. T. S. Shastry
2. *Vice-Presidents:*—Dr. P.A.S. Raghavan, Dr. D.K. Sabesan, Madras, Dr. T. S. Tirumurthi.

After election of office-bearers for the Indian Medical Association an interesting paper on "X-ray therapy in non-malignant conditions" was read by Dr. V. K. Ranganathan M.B.B.S., D.M.R., Trichinopoly.

He pointed out the use of X-ray therapy in various ailments of the body and its successful results in many cases in non-malignant conditions.

A discussion followed to which the lecturer answered suitably. The President of the day pointed out the necessity of having X-ray therapy facilities in at least all head quarters Hospitals in our Province.

A vote of thanks was proposed at the end of the lecture by the secretary the lecturer for the useful lecture that he has given and to Dr. V. Rajagopalan for the sumptuous tea provided.

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After Tea provided by the Secretary, the monthly meeting of the Tanjore District Medical Association (Branch of I.M.A.) commenced with 42 members on 18-9-49 at 4-30 P.M. in Medical School Buildings. Dr. P. Narayana Rao, Vice-President of the Association presided over the proceedings in the absence of Dr. Md. Ismail, the President.

The Minutes of the last meeting was read out by the Secretary and was adopted.

Information was given to the members regarding the forth coming 4th Provincial Medical Conference at Annamalainagar from October 8th to 10th.

The following were elected to attend the conference as delegates:—

1. Dr. T.M. Fillai, Tiruvadi
2. Dr. N.R. Subramanyam, Tanjore
3. Dr. N. Ramanathan, Tanjore
4. Dr. P.V. Kalyanasundaram, Tanjore
5. Dr. P.A.K. Nair, Tanjore.

An interesting paper on "Streptomycin in the treatment of Tuberculosis" was then read by Dr. N.C. Subramaniam, B.A., M.B.B.S., T.D.D., of Tiruchirappalli. He pointed out the usefulness of this drug in selected conditions of tuberculosis and pleaded that this should be used only as an adjunct to other accepted surgical and sanatoria regime. The Lecture was followed by a demonstration of X-ray films before and after treatment with streptomycin.

Since the subject was dealt very elaborately by the lecturer, there was left very little for discussion.

The days proceedings closed with a vote of thanks, to the lecturer for the interesting lecture and to the Secretary for the Tea.

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December, 1949]

All India Medical Conference of the Indian Medical Association—Allahabad

XMAS WEEK 1949

A Review

The annual festival of the Indian Medical Association was held during the last week of December 1949, in the holy place of ancient Prayag, the main part of it now being called Allahabad. Prayag has been famous from the times of the Epics and Puranas as the place where Sri Rama crossed the Ganges and where Bharadharaja Muni established his hermitage and now made renowned by Malavya, Sapru and the Nehrus. Even in these days it attracts millions of pilgrims from all over India for a dip in the Holy Sangham, the meeting point of the Ganges and the Jumna. In spite of all these, the conference attracted to Allahabad a meagre gathering of only about 400 doctors more than half of whom hailed from the United Provinces and the others from the surrounding provinces of Bihar, Central Provinces, with a sprinkling from Bengal and Bombay and a few from Delhi. Madras presidency was represented by just half a dozen. The reasons for this poor attendance was due to the fact that various specialist conferences were being held in different parts of the country either simultaneously or at slightly different times, unlike in the previous two years when all the conferences were held in the same place about the same time, as in Calcutta and in Bombay. The advantages of having all the conferences in the same place about the same time is obvious. It will enable doctors to make one pilgrimage a year and attend as many conferences as possible. It would also enable general practitioners to intermingle with the specialists and vice versa and benefit each other. The good beginning made during the last two years of meeting at the same place has unfortunately been broken up and it remains to be seen when it would come to pass again. The Indian Medical Association should be the central forum from which must radiate the various specialists organisations, and the I.M.A. must concern itself largely to Medical-political matters which are common to all doctors and to the general practitioners in particular. It was a pity that the Licentiate Conference did not meet jointly at Allahabad and is meeting separately in Vellore, but let us hope it will not be ere long before the two All India Associations will merge into one.

The climate of Allahabad, as most of the North Indian cities, was very cold and this was one of the reasons which deterred many from South India from venturing a trip to the North. Since these conferences are more often held in the North, it would be better held in March or April when the climate will not be in extremes.

More than half of those that visited the conference found friends to be their hosts and the rest stayed in the camp and a few in hotels. The camps were not ideal or uncomfortable; but the charges were rather very heavy ranging from Rs. 10/- to 12/- per day for the season or for a day respectively. One felt it was exorbitant to pay Rs. 2/- for a cup of tea with a slice of bread, a sweet and a spoon of savoury. Lunch and dinner at Rs. 3-8-0 and 4/- was too high especially for those who could not relish the menu. The system of charging for food started in Bombay in 1947 before which all visiting doctors were the guests of the Reception Committee or some of the pharmaceutical and

other firms. It seems some feel that it is degrading to accept the hospitality of manufacturers and hence the payment system was introduced. The logic is understandable, especially when larger conferences and congresses are held where board and lodge is provided by the Reception Committee. The Reception Committee in Allahabad was particularly well off, as in addition to the Reception Committee membership fee, it received a grant of Rs. 3500/- from the Municipal Board and Rs. 2500/- from the U. P. Government for the purposes of the conference. In this connection it is gratifying to note that the Allahabad branch of the I.M.A. is uniquely fortunate in having the privilege of sending a representative to the Local Municipal Board.

The Scientific sessions were of the average type as there were not many top ranking specialists to participate in the same, yet there were some useful and interesting papers. There was over-crowding of the programme but as some failed to turn up there was fair scope for discussion. It is a pity that the open conference where resolutions are considered in the interests of the profession as a whole, are still not well attended nor is much interest taken in them. Only a few who are fond of hearing their own voices not caring whether it interests others, jump up to the mike to speak on all resolutions.

The exhibition which was arranged on a large open ground had provision for about 40 stalls but only 22 stalls had been occupied by the usual medical firms who displayed their wares in various fashions. A small canteen in the exhibition grounds was having brisk sales throughout the day in fruits, cakes, biscuits, hot tea and coffee. The most interesting section of the exhibition was the stall occupied by about 20 children between the ages of 10 to 15 of the Deaf and Dumb School, Allahabad, who were learning to talk and also hear through vibrations by placing the hand on the speaker. A boy aged about 15 has improved so much that on the opening day of the conference he read aloud a printed welcome speech in Hindi, which was very much appreciated.

On Wednesday the 28th Dec. the Allahabad Municipal Board gave a Civic Reception at 9 a.m. The notice and invitation for this function was a bit intriguing, for it said the Municipal Board would give a Civic Reception to distinguished medical men. Though 'Men' embrace women, who was 'distinguished' had to be decided by each. However, cars and buses carried about a hundred doctors from the conference place to the Municipal Office grounds where under a decorated pandal, the Chairman of the Municipal Board read and presented addresses to the President and some of the past Presidents who attended the conference and there were about half a dozen of them. All the addresses were printed in one large sheet of paper in English on one side and in Hindi on the other side. The address also were printed in separate sheets for being presented to the individual presidents, and was read in Hindi. Except one past president who hails from U. P., Dr. S. K. Chowdry, the rest, Dr. Jivaraj Mehta and Dr. Chamanlal Mehta from Bombay, Col. Amirchand from Punjab and Dr. R. A. Amesur of Sind, had to reply in English as they were not conversant with Hindi. Anyway it was a nice item in the programme of the conference.

The usual medical films and entertainments added to the lighter side of the conference for those who could brave the cold of the nights. The members of the Reception Committee and the volunteers who met the delegates for all the trains, were kind and courteous. Thus went off another conference and let us see what Sholapur has to give us in Dec. 1950.

December, 1949]

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

THE MODERN TREATMENT OF EPILEPSY—Dr. A. J. M. Butler, M. D.—*The Practitioner*—November, 1948.

The treatment of idiopathic epilepsy depends mainly upon the use of anticonvulsant drugs, but other measures to raise the physical and mental well-being of the patient may first be considered.

General Measures—Employment :—

The usual rules of healthy living, often forgotten, need not be enumerated here but, in the case of the epileptic, the desirability of a regular routine, work, hobbies and physical exercise, requires emphasis. As regards occupation, the employable epileptic is to-day fortunate in being entitled to a certificate as a "disabled person" (obtainable from the rehabilitation officer at the local employment exchange) and, when this has been completed by a doctor, may be able to obtain suitable employment. The improvement in his general condition because of contentment in his work and the increased self-respect that it brings are often paralleled with a reduction in the number and severity of his fits. The electro-encephalogram has, within recent years, confirmed the impression of many observers that epileptic convulsions are less apt to occur when the mind is active and busy. For this reason, the child epileptic too, should, if at all possible, be kept occupied and not unnecessarily prohibited from attending school.

Various diets have been given extensive trials by different workers. Of these, only the *ketogenic diet* requires special mention. In intractable cases which do not respond well to drugs, the diet is well worth a trial, and this is especially true of child epileptics. In practice, however, even in an institution, it is found difficult to control because most adult patients subjected to it find it distasteful, are tempted to supplement their diet with forbidden foods, and finally state quite firmly that they would rather have their fits than the diet.

The same applies to treatment of epilepsy by *dehydration*, that is, the production of a negative fluid balance in the patient by reducing fluid intake to about one pint daily and administering diuretics, cathartics and diaphoretics. Advocates of this treatment have claimed a fair proportion

of good results. Patients, however, are unwilling to persevere for long with the irksome restriction of liquid intake and one can feel some sympathy with their occasional surreptitious visits to the nearest source of drinking-water. Nevertheless, one part of this treatment is always worth remembering in any case of epilepsy, namely, the morning dose of salts, especially in patients who are taking bromides. This simple measure often results in a significant reduction in the number of fits. Alcohol should be taken sparingly, if at all, for a single heavy dose of spirits may precipitate a fit, and, heavy beer drinkers, whilst they may not become intoxicated, do "hydrate" themselves and so are pre-disposed to fits.

Electrical convulsion therapy, has its use in epilepsy. Thus, in cases in which the patient's seizures are at fairly regular and therefore predictable intervals, an artificially induced convulsion may be desirable, and desired by the patient, since it can be arranged immediately before the expected attack as an "out-patient" treatment in the safety of a hospital bed instead of occurring without warning in front of a bus. In cases also in which there is an associated psychosis, improvement in the patient's mental condition may be obtained. Some workers maintain, in addition, that electrical convulsion therapy reduces the frequency of major attacks (Caplan, 1946).

Psychotherapy, in skilled hands, will, by resolving conflicts and raising morale, ameliorate the lot of a proportion of epileptics, but most psychiatrists would disclaim any special powers in influencing the incidence of the patient's convulsive seizures.

Surgical procedures are often valuable in cases of traumatic epilepsy and in convulsions due to intracranial tumours, but are not advocated in idiopathic epilepsy.

Drug therapy—Although the treatment of idiopathic epilepsy by drugs is largely empirical, guidance may be obtained from a study of the familial and personal history of an individual epileptic, his peculiarities of physique and temperament, the nature and number and possible periodicity of his fits, and the time of day at which the fits ordinarily occur.

Fortunately, when an encephalogram (E.E.G.) is available the patient's particular type of epilepsy may be more accurately diagnosed and the most suitable drug, or drugs, thus selected for treatment (Symonds, 1948). The E.E.G. may confirm a diagnosis of true *grand mal*; or it may reveal that what appeared to be *petit mal* is, in fact "minor *grand mal*". In both cases, phenobarbitone, alone or with epanutin, will probably be more appropriate than other drugs. Again, the E.E.G. may disclose a pattern of waves found in patients who suffer from so called psychomotor attacks. Such patients have phases of mental confusion and disordered behaviour with or without convulsive movements. They are often difficult and dangerous patients and usually evoke less sympathy than perhaps they deserve. In their case, as a rule, epanutin produces the best response. Should the E.E.G. demonstrate true *petit mal*, then, in our present-day knowledge, the patient is not likely to respond to any other drug than tridione. Even with the help of the E.E.G., however, it may be found that observation over many months is necessary before the drug, or combination of drugs, is discovered which will best control the patient's fits and, at the same time, produce no marked toxic effect. A record of fits should therefore be kept, indicating whether they are major or minor and at what time of the day or night they occur. Concurrently, a record of the drug or drugs employed should be made.

Occasionally, a slight alteration in the treatment effects a dramatic improvement. To select a single example:—

A patient aged sixteen was for a time the storm-centre of St. David's Hospital (an epileptic colony), the ringleader in almost every mischievous enterprise, destructive, insolent, insubordinate and foul-mouthed. During eight months of consistent misbehaviour he had 128 fits. Several drugs were tried without beneficial effect when a suitable combination of drugs was, at last, discovered, his behaviour improved almost at once. During the following eight months only five fits occurred and he became obedient, reasonable well-behaved and comparatively industrious.

Cases of this kind, which could be multiplied, encourage the perhaps illusory hope

that, given time and observation, almost any case of epilepsy could be greatly benefited.

It may be convenient, in discussing the drug treatment of epileptics, to consider the various types of cases that are common. First of all, the patient who has very infrequent fits, say, about once a year or at even longer intervals, requires no special medicinal treatment at all and, in any event, will probably be unwilling to take medicine all the year round in order to prevent an occasional attack. Secondly, there is the type of patient whose fits are all nocturnal. As he is in bed he is not likely to fall and hurt himself. If, however, these nocturnal fits are severe and occur more often than once or twice a year, and especially if they are sometimes accompanied by biting the tongue and passing water then the patient may be greatly benefited by phenobarbitone, one or two grains nightly. A third type of patient is he who has groups of fits, perhaps four or five occurring within forty-eight hours, at intervals of a few months. This type of man often knows himself, or it is obvious to those who are familiar with his peculiarities, that he is on the point of having a series of attacks. He may be irritable and depressed, or complain of giddiness, or uncomfortable abdominal sensations, or headache. When such warnings are manifested, then sodium bromide, three times a day in 20 grain (1.3 gm.) doses, plus phenobarbitone, also three times a day in 1 grain (65 mgm.) doses, may be successful in averting the series of fits or, at least, in preventing all but a mild attack. But probably most important of all is to give 3 grains (0.2 gm.) of calomel at night followed by 60 grains (4 gm.) of magnesium sulphate in the morning.

A more common case history is that the patient has three or four attacks of *grand mal* in a month all the year round and a large number of attacks of *petit mal*. In such a case, phenobarbitone, epanutin (soluble phenytoin), bromides, rutonal (phenylmethylmalonylurea) and other drugs may all be tried, alone or in combination and in various doses. In addition, tridione (3,5,5-trimethyloxazolidine-2,4-dione) may be helpful for the *petit mal*.

Phenobarbitone, used alone or in combination with other drugs, is still the most generally useful anticonvulsant. In a sur-

vey (Butter, 1945) of 375 cases of idiopathic epilepsy, observed in patients for periods ranging from six months to five years, it was found that phenobarbitone and epanutin were being used with good effect in the following number of cases:—

	NUMBER OF CASES	PERCENTAGE OF 375 CASES
Phenobarbitone, used alone or in combination with other drugs	278	74.1
Epanutin, used alone or in combination with other drugs	85	22.6

Therefore for those patients who have several fits every month throughout the year, phenobarbitone will usually be found to offer the best line of attack. It may be given in doses of 1-1/2 grains (0.1 gm.) twice or thrice daily, gradually increased to 6 grains (0.4 gm.) or more daily. Should this produce little reduction in the number of fits, or cause drowsiness or other toxic symptoms one capsule (1-1/2 grains 0.1 gm.) of epanutin may be added twice daily and cautiously increased to three, four, five or even six capsules daily.

The dosage of epanutin will be regulated according to the reduction of fits or the production of toxic symptoms such as pyrexia, skin rashes, hyperplasia of the gums, nausea vomiting, tremulousness intention tremor, ataxic gait, nystagmus, ptosis, slurring speech, insomnia, or mental confusion. Such toxic effects will mostly disappear within a few days after discontinuance of the epanutin and therefore it may be tried again, gradually, until the optimum non-toxic dose appears to be reached. The other drugs, such as bromide or phenobarbitone which the patient is taking, may gradually be reduced or withdrawn. There is a very narrow margin between the therapeutic and toxic dose. Two capsules of epanutin daily may be useless. Three daily may prove to be the perfect therapeutic dose, and four daily may produce pronounced toxic symptoms and signs in the same patient. In practice, it will usually be found that few patients can take more than three capsules (4-1/2 grains 0.36 gm.) daily without toxic reaction sooner or later. The average dosage of phenobarbitone is also about 4-1/2 grains (0.36 gm.) daily in the type of case under discussion. As epanutin is much less hypnotic than phenobarbitone, the two drugs may usefully be given together, and

indeed this combination is one of the most satisfactory treatments of epilepsy to-day.

Mention must also be made of "mesantoin", not yet generally available in this country, but which appears to be a useful variant of epanutin, and "hydantal", which is a combination of mesantoin and phenobarbitone.

Rutonal or **prominal** may be given as an alternative to phenobarbitone, either alone or in combination with epanutin or other drugs. It is distinctly less soporific than phenobarbitone and can therefore make a welcome change for patients who complain of drowsiness. In almost all such cases, 3 grains (0.2 gm.) of rutonal will be found to be less hypnotic than 1-1/2 grains (0.1 gm.) of phenobarbitone and slightly more anticonvulsant. An alternative method of dealing with drowsiness due to phenobarbitone is to prescribe with it either benzedrine or methedrine.

In the very worst cases, when a patient may have hundreds of fits in a year and occasional status epilepticus, the following time-honoured mixture may prove to be most helpful:—

R Sodium bromide—10 grains (0.65 gm.)
 Chloral hydrate—5 grains (0.32 gm.)
 Tincture of belladonna—15 minims
 (0.9 c. cm.)
 Chloroform water—to 1/2 ounce (14.2 c. cm.)

This may safely be given twice or three times a day despite the high dosage of belladonna and, when required in severe cases, may be continued for months or years.

A change of drug, or combination of drugs, or increased dosage, may confer benefit for an indefinite length of time but, in a proportion of cases, adjustment of the

dosage is found to be necessary at least once a year. In some cases, complete remission of fits does not prove to be an unqualified blessing and should perhaps not be aimed at, for disorders of conduct and, occasionally, an alarming excursion into status epilepticus may follow a long fit-free interval.

Status epilepticus. As to the treatment of status epilepticus, no single measure will invariably prove effective and, usually, several concurrent procedures are advisable. As the patient's condition precludes ordinary oral administration of his usual drugs, and as convulsions may continue for days, the hypodermic injection of 2 c. cm. of somnifaine or other equivalent for phenobarbitone, is obviously important. Somnifaine, a combination of two barbituric acid compounds, may be repeated at intervals of four hours. Also, a large dose of bromides and chloral hydrate may be given by means of a stomach-tube. Paraldehyde (21 c. cm. in 43 c. cm. of olive oil) may be given per rectum and repeated if necessary, but it is not always retained. Inhalations of chloroform may at least temporarily abate or abolish the convulsions and, if the patient is not too restless, lumbar puncture, with the withdrawal of a test tube full of cerebrospinal fluid, may prove to be beneficial.

Tridione in petit mal. The treatment of the *petit mal* epilepsies was always disappointing until the introduction of tridione in America (Everett, 1944; Lennox, 1945, 1947; Richards, 1944). There is no doubt that this drug has a pronounced inhibitory effect on *petit mal* and offers new hope to those who have found other treatments unavailing. It is supplied in 0.3 gm. capsules, the dose being from two to six capsules daily. Because of its toxicity, however, it should be reserved for patients who suffer from frequent *petit mal* and are seriously inconvenienced by their disability. A few days after starting to take the drug, four patients out of five will probably report a reduction in the number of their *petit mal* attacks. A week or ten days later, about three-fourths of them may mention that on walking out of a building they find the light too bright. The phenomenon may be described as "dazzle", or "glare", or "a white mist over everything". Others may say that objects appear to have changed colour. In most cases, this dis-

turbance of vision will not raise, serious objections to taking the drug but, in a few instances, the patient will be glad to wear dark glasses to mitigate the effect. Some may be aware of slight drowsiness and others report hiccup, epigastric discomfort or unsteadiness in walking. The majority, however, will prefer to continue taking tridione, as the relief obtained from the reduction in their attacks more than outweighs the "dazzlephenomenon" or the other symptoms. Should a skin rash appear, discontinuance of the drug is advisable, but it may be introduced again in small doses when the condition has subsided.

In addition, there is one more toxic effect of tridione of which the patient will not be aware, except indirectly, and which calls for the utmost caution. In a high proportion of cases, blood counts reveal a reduction in the number of white blood corpuscles. Three fatal cases of agranulocytosis following the continued use of the drug have been reported in America. Therefore the supervision of all patients taking tridione must include monthly blood counts. Should the neutropenia be progressive, discontinuance of the drug is essential. Fortunately, in most cases, *petit mal* attacks remain absent or fewer in number for several weeks after the patient ceases to take tridione, and if a month or two later a satisfactory increase in the white blood count is reported the drug may again be cautiously introduced.

Finally, tridione is contraindicated in patients with severe renal or hepatic disease, in cases in which optic-nerve disease is already present, and in patients with a history of blood dyscrasia or of pronounced idiosyncrasy to drugs. Despite all this, the drug is a valuable one and much appreciated by the severely handicapped sufferer from *petit mal*. Doubtless, now that a start has been made, others of its type, but less toxic, will follow in the near future.

Summary—Treatment in epilepsy is briefly considered under the headings of employment, diet, dehydration, electrical convulsion therapy, psychotherapy and surgery. Drugs, in particular phenobarbitone, epanutin and tridione, are discussed in some detail.

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PENICILLIN-VITAMIN "C" IN INFECTIVE ENDOCARDITIS—*The Practitioner, July 1949.*

A combined intravenous course of 360000 units daily of penicillin with Vitamin C (5000 I. U. every 12 hours in the same syringe as the penicillin) was given by L. Gibelli and L. Garelo (*Informatore Medico, 1948, 11, 255*) to a 24 years-old woman with infective endocarditis. Complete recovery resulted within twenty-one days. Two million units of penicillin by itself had previously been ineffective. Gibelli had already obtained 60 per cent. cures by this method (*Folia Cardiologica, 1947, 6, 405*). *In vitro* experiments to test these clinical results were inconclusive, but the authors believe that the addition of Vitamin C does not alter the action of penicillin.

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THE TREATMENT OF OBESITY—*The Practitioner July, 1949.*

As a result of their experience in the treatment of 299 cases of obesity, D. Adlersberg and M. E. Mayer (*Journal of Clinical Endocrinology, March 1949*) are of the opinion that in the majority of cases satisfactory results are obtained with a low calorie diet (1200 cal.) combined with thyroid or with amphetamine. In assessing the value of any form of treatment of obesity emphasis is laid upon the necessity for differentiating between the short term effect and the long term results. Irrespective of the form of treatment, best results were obtained in the first one or two months of treatment. During this period dietetic control alone was better than diet plus thyroid, but not quite as good as diet plus amphetamine. On the other hand, the initial effect of amphetamine gradually wore off, and to maintain a fall in weight larger doses had to be given. This induced unpleasant side-effects in some patients, such as dry mouth, halitosis and addolion. In two instances amphetamine poisoning occurred. The long-term results with diet alone compared favourably with those obtained with diet plus amphetamine. It is concluded that "amphetamine preparations should not be dispensed and refilled without a physician's prescription. These drugs should not be used routinely in the treatment of obesity.

Patients to whom they are administered should be closely observed".

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RADIATION INJURIES OF THE INTESTINES—*C. W. Hock, et al. Am. Jour. Med. 1948.*

This is a very important review of the course, symptomatology, pathology and prognosis in cases of intestinal damage after irradiation of cancer of the female genitalia. An analysis in detail of 19 severe reactions occurring in a series of 344 patients treated for cancer.

Some degree of reaction occurs in 50 to 65 per cent of the cases treated by combined radium and X-ray therapy, the necessary lethal dose for the cancer being sufficient to produce at least a mild reaction. It is doubtful if a dose adequate for cancer can be given without sometimes producing severe bowel effects. Symptoms of early reaction are a burning sensation in the pelvis, frequency of micturition and defaecation and diarrhoea, clearing up in about 2 weeks. In late cases, symptoms of incomplete intestinal obstruction, rectal haemorrhage, tenesmus, diarrhoea and severe pain with general deterioration. Fistula may form. The best treatment is prophylaxis by careful planning and carrying out of the irradiation treatment. Rest in bed, rectal lavage, instillation of bland oil, colostomy for obstruction and resection of damaged tissue may be called for, when the condition is established.

Previous workers, including Todd had recorded similar observations. The high incidence of rectal reaction after combined X-ray and Y-ray irradiation emphasizes the danger of independent administration of the two modes of irradiation without planning the entire treatment. *The differential diagnosis of the reaction due to irradiation is very important* for such rectal lesions can be and have been diagnosed to be rectal cancers and irradiation applied and perirectal fibrosis subjected to palliative X-ray therapy on the mistaken diagnosis of advancing neoplasm; needless to say the results were detrimental to the patient. T. N. S. R.

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EFFECT OF ORAL CARONAMIDE ON PLASMA PENICILLIN LEVELS—*Amr. JI. Med. Sciences.*

Sealer Collins, Findland of the Harvard medical school, studied the effect of caronamide (on persons over 60 and under 60 years of age) for enhancing the blood plasma penicillin levels. The first set of experimental studies related to the oral administration of caronamide (older people received 2 gm. every 4 hours ground and suspended in flavoured milk, and the younger ones 4 gm. every four hours). Caronamide was started 12 hours before the penicillin injections (intramuscularly administered in large doses) High penicillin plasma levels were maintained with relative ease. The effect of caronamide in prolonging penicillin plasma levels is greater than that resulting from a ten fold increase in the penicillin dosage. Sodi. benzoas in 4 patients was found to be much less effective than caronamide in enhancing penicillin levels. In the next set of experimental studies the effect of caronamide on the blood levels obtained during oral penicillin administration was determined. Both young and old men were included in the study. Tablets each containing 100,000 units of crystalline Pot penicillin G buffered with 0.5 gm. soda citras were used. One tablet was given every 4 hours (9 a.m. 1 p.m. and 5 p.m.) Food was given at 7 a.m. 11 a.m. and 4 p.m. Caronamide and penicillin were timed to the routine 4 hourly.

Oral penicillin when given alone in doses of 100,000 units every 4 hours could not be relied upon to maintain adequate concentrations of the antibiotic in the plasma of persons under 60 years of age. Penicillin levels of 0.08 units per c. c. were usually maintained in persons over 60 years old on the same dosage. Caronamide in oral doses of 4 gm. every 4 hours in persons under 60 and in doses of 3 gm. every 4 hours in those over 60 enhanced and prolonged the levels from oral penicillin.

T. N. S. R.

ANAEMIA ASSOCIATED WITH TRAUMA AND SEPSIS—J. Vaughan B.M.J. 1948.

In considering the aetiology of this type of anaemia it is apparent that the breakdown of tissues is a factor common to the stages of sepsis, trauma and sterile abscesses. The narrow is not aplastic and haemolysis is not usually a feature. The

well-known and recognized factors are not effective in treatment in these cases. There is usually a disturbance of protein metabolism. In treatment iron and liver are ineffective in general and the position of cobalt is uncertain. A high caloric, high protein diet should be given due care being taken not to upset the patients capacity for assimilation. Blood transfusion would be the sole effective remedy for restoring the erythrocytes.

T. N. S. R.

THE EFFECT OF SOME GASTRIC DRUGS ON THE MOTILITY OF THE STOMACH—in English Acta. Med. Scand.

Brummer and Bundul have recorded their observations on the radiological appearances in 137 patients before and after the administration of various drugs by mouth. Atropine sulphate 0.5 gm. diminished peristalsis in 27 out of 40 patients but had no effect on tone. Papaverine hydrochloride in 0.1 gm. doses diminished peristalsis and tone in duodenum. Sodium bicarbonate (10 out of 10 cases) and sodium barbitone (22 out of 40 cases) increased peristalsis, calcium carbonate had no effect in the presence of achlorhydria. Hcl, Mag. carb. and Mag. oxide exert a greater effect on the motility in the duodenum.

The relief of gastric distress which these drugs afford is due to their action on motility and not to a chemical neutralization, as commonly believed.

T. N. S. R.

A NEW TREATMENT FOR VERTIGO—Louis A. Witzeman, M.D.—E.E.N.T.—June 1949.

Every otologist is confronted frequently with patients complaining of vertigo. The problem of giving these patients relief of this symptom is often a perplexing one.

Of first importance from an aetiological point of view are foci of infection such as the teeth, tonsils, nasal sinuses and intestinal tract. The systemic toxemias produced by alcohol, quinine, tobacco and ptomaine poisoning are other likely causes. Next in importance are the end organ abnormalities, such as refractive errors, disturbances of the neck reflexes and the altered cutaneous impulses. Another cause is negative pressure in the

middle ear due to eustachian tube and sinus diseases. Still other aetiological factors are increased intracranial and perilymph pressure, and vascular diseases such as hypotension and hypertension. Next we must consider diseases causing nerve tract interference, such as disseminated sclerosis, tabes and Friedreich's ataxia and the mixed group of diseases which include epilepsy, syphilis, meningitis, encephalitis lethargica, laryngeal vertigo, chronic nephritis and arteriosclerosis. Finally one must consider the potential influence of intracranial lesions such as cerebellar tumors and abscesses. It is my opinion that dental infections, eustachian tube diseases and refractive errors make up the majority of the commoner causes of vestibular vertigo. Until the diagnosis is finally made, it is often essential to prescribe some remedy to give the patient effective relief. No such remedy has been available until very recently when Dramamine a new drug, came into use for so-called motion sickness. Its chemical name is B—dimethylaminoethyl benzohydryl ether 8—chlorotheophyllinate.

It will be observed that Dramamine is another of the drugs classed as antihistaminics. It is a rather weak one, originally suggested for use in the treatment of urticaria and other skin lesions of allergic origin.

Dr. Leslie N. Gay of Johns Hopkins, made the observation that Dramamine relieved motion sickness in a patient whom he was treating for a skin allergy. The patient commented to him that never before had he been able to ride the bus to his office without experiencing car sickness. Later by means of a carefully controlled experiment on soldiers and war brides aboard ship, Gay learned that this drug was more than 97% efficient in preventing and curing motion sickness, that is, sea, air, elevator and car sickness.

As I have so employed it with maximum success, I was led to give it a trial also for the symptomatic complaint of vertigo when the vestibular apparatus was the probable seat of the disturbance. If motion sickness was prevented or stopped in over 97% of all cases with the use of Dramamine, why should not vertigo which most probably is a symptom of a physiologic upset of that same area, mainly the vestibular apparatus, be likewise relieved?

I employed this drug in forty-seven patients in whom vertigo was the principal complaint. Complete relief was experienced by all but four, and two of this number received marked improvement when the usual dosage was increased. Two of undetermined etiology claimed to have received absolutely no benefit.

At first I prescribed the drug in dosage of 100 mg. to be taken three to four times daily by mouth. A few of the patients complained of drowsiness, some extremely so. Thereafter I employed doses of 50 mg. often reducing them to 25 mg. three or four times daily. In patients in whom the vertigo produces extreme nausea and vomiting, it can be administered quite successfully per rectum by introducing it in a capsule perforated at each end. It proved 100% effective in one patient with suppurative labyrinthitis secondary to cholesteatoma, and in another patient with early meningitis secondary to chronic purulent otitis media with a fistula of the horizontal canal.

I have not yet had the opportunity to treat patients with Meniere's syndrome, but I would anticipate a marked improvement in this condition. Neither has the opportunity presented itself to use the drug in patients with brain tumor.

Conclusion. It is appreciated that this group of patients is entirely too small from which to draw accurate scientific conclusions. Neither have many of them been adequately studied and diagnosed. Suffice it is to say, however, that all of them had the common complaint of vertigo. As a result of this preliminary study I am led to believe that those patients who exhibit lowered thresholds of vestibular response to the Barany turning tests are the ones most benefited by the use of this newer drug.

Since the vast majority of the cases of vertigo are vestibular in origin, it seems reasonably certain that finally we have available a much needed palliative agent. It will at least serve to afford the patient relief while we are determining the various etiological factors. In the unfortunate patients in whom the cause cannot be found, Dramamine will give welcome relief. It is suggested that 50 mg. be given by mouth, three or four times a day. If this dosage is not effectual, up to

800 mg. in 24 hours may be administered. Drowsiness seems to be the only side effect. Relief from vertigo persists for about four to eight hours after the last dose has been given.

* * * * *

CONSTRUCTION OF PENIS—J.A.M.A. July 2, 1949.

Question: Is the construction of an artificial penis possible after complete or partial amputation?

Answer: The construction of a new penis has been successfully performed by Drs. R. T. Bergman, H. Howard and R. W. Barnes, of Los Angeles. However, Dr. Bergman and his associates were unable to do more than construct a penis which served as a water carrier. It had no active erectile function. The wimpus made by the late Reinhold Wappler was satisfactory in some cases in permitting of penetration.

The only way to enlarge the organ and make it efficient is by the operation of Lowsley, which consists of shortening the ischiocavernosus (erector penis) muscles and the bulbocavernosus muscle with chromic ribbon gut, which permits the slightest constriction with the maximum of erection.

* * * * *

TREATMENT OF FOOTBALL INJURIES—J.A.M.A. June, 9, 1949.

Question: I see a great many football injuries. Recently the trainer has been told that ice applied to injuries immediately was dangerous. What is your opinion?

Answer: Authorities on the treatment of athletic injuries differ with regard to the wisdom of applying ice following certain types of injuries. Stevens and Phelps in their textbook on "The control of Football Injuries" (New York, A. S. Barnes and Company, 1933) have said: "Compression with the application of an ice bag to constrict blood vessels is the first principle in the treatment of muscle bruises." But Thorndike in his textbook on "Athletic Injuries" (Philadelphia, Lea & Febiger, 1938) has said: "The most annoying skin inflammation that one encounters in caring for athletes is superficial phlebitis, which is the result of

immediate packing of sprains and strains in ice. It represents a mild degree of frost-bite and comes from careless application of ice to acute injuries. Owing to this complication we have forbidden the use of ice pack treatment altogether. In five years, 10 such cases have been encountered, mostly in thigh contusions. A better treatment is to place the injured part in an ice water whirlpool bath where the same effect is produced without the danger of air pockets and frost-bite."

It is obvious that application of cold is valuable in the early stages of treatment of recent contusions, and the procedure is a sound one provided the ice is not applied carelessly. Perhaps the variation in technic advised by Thorndike might be worthy of consideration. Certainly, with proper technic, such applications cannot be considered extremely dangerous, and at worst, they can do nothing more than produce, as Thorndike says, "annoying skin-inflammation."

* * * * *

CLEANSING OF WOUNDS—J.A.M.A. July 2, 1949.

Question: Is the use of soap, water and peroxide combined recognized as an especially effective wound cleanser?

Answer: An excellent treatise on the cleansing and treatment of wounds by W. L. Estes (Am. J. Surg. 47: 369, 1940) summarizes: "Efforts to treat an open wound to promote rapid healing without infection must be directed first to the control of hæmorrhage and then to the removal of all debris and devitalized tissue by irrigation with saline, but so gently, carefully, and thoroughly, as to wash out and rid the wound of every free necrotic bit, but not to damage the healthy tissue remaining. This is by far the most important element in the treatment. The most essential adjunct is debridement or excision of all the devitalized and contaminated tissue that is not free and cannot be washed out.

"Antiseptics are of value in skin disinfection, but in the treatment of the wound itself are seldom necessary, and their indiscriminate use may harm normal processes of repair. An antiseptic, however, would be an added safeguard in anaerobically or soil contaminated wounds.

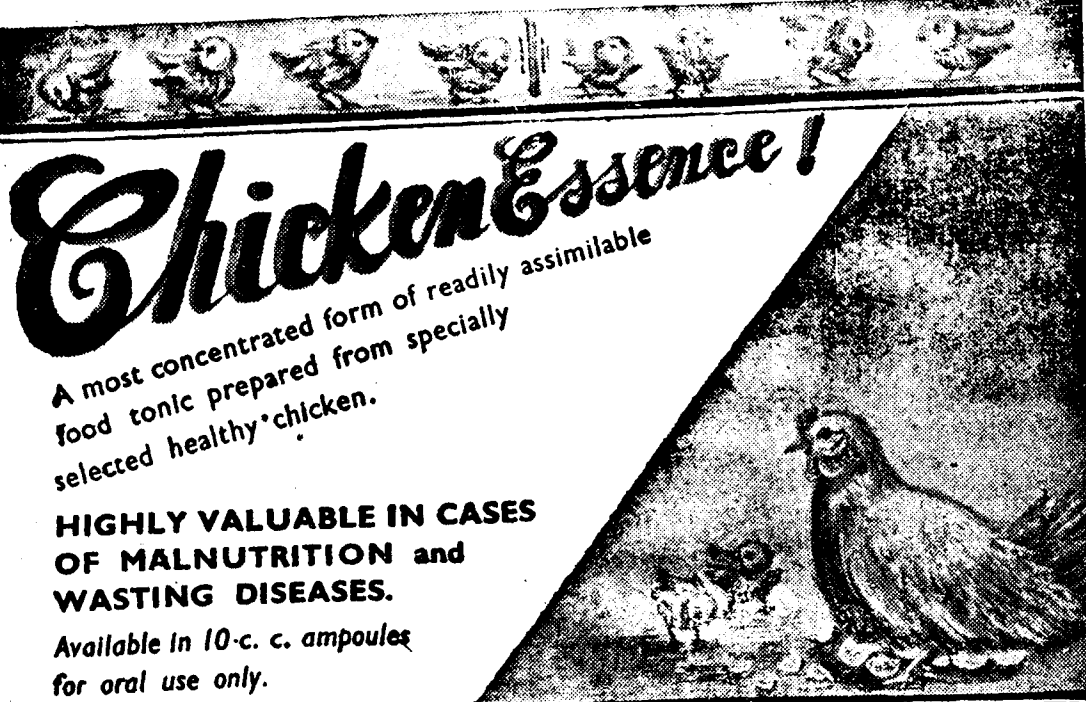
In this category, it is suggested that Dakin's solution may be used. An ideal antiseptic for use in open wounds should possess effective bactericidal action and be nontoxic to tissues and not interfere with or delay healing".

Since hydrogen peroxide solutions, in noncaustic concentrations, possess feeble and comparatively short germicidal activity, their greatest value probably lies in the ability of that oxidizing agent to remove dead organic matter from areas where mechanical removal would be difficult.

* * * * *

THE VIRUS OF THE COMMON COLD—Survival in frozen state—Amer. J. Hyg. Jan. 1948.

Pollard *et al* have shown that the virus of the common cold could remain active and infective for nearly four months after collection in the frozen state at -20°C . The fluid used for washing the nasal passages was 2% rabbit serum in normal saline. After collection the material was frozen. At intervals human volunteers were inoculated and it was found that the infective potency was evident 115 days after collection and volunteers inoculated at the end of this period developed the common cold. T. N. S. R.



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PUBLIC WORKS (INFORMATION AND PUBLICITY) DEPARTMENT

PRESS COMMUNIQUE

Dated Fort St. George, the 13th December 1949.

Several instances have been brought to the notice of Government where unqualified persons practising medicine have added to their names titles, descriptions, letters or abbreviations which imply that they hold degrees, diplomas, licences or certificates as their qualifications to practise medicine. In the Press Communique No. 30, dated 3rd May 1947, the Government have already explained the relevant provisions in the Indian Medical Degrees Act, 1916, as amended by the Madras Amendment Act of 1940 and conveyed a warning of the penalties for violating the provisions of the Act. The medical profession has also been warned that in case they engage unqualified persons as their Assistants, they will be offending the code of medical ethics and will have to face the risk of removal of their names from the Madras Medical Register.

Some practitioners of Indigenous Systems of Medicine are now reported to be committing the offence of using bogus titles. Such practitioners are now classified into two groups. Those, who have obtained the L.I.M. qualification are permitted to get themselves registered in class 'A' of the Register of Practitioners of Indigenous Medicine, while certain other practitioners have been registered in Class 'B' of the Register. The Government have decided that 'A' class practitioners of Indigenous Systems of Medicine may style themselves as doctors and prefix the title "Dr." provided they affix their qualification to their names and indicate that they are registered practitioners of Indigenous Medicine. "B" class practitioners should not under any circumstances prefix the title "Dr." to their names but they may prefix the words "Hakim" or "Vaidya" to their names according to the system they practice and indicate clearly that they are practitioners of Indigenous Medicine. Those who contravene these instructions are liable to prosecution.

R. PARTHASARATHI,
Director of Information and Publicity.

PRESS NOTE NO. 106

Dated Fort St. George, the 2nd June 1949.

[Medical Colleges—Admission of Refugee students—
Reservation of seats—Educational concessions.]

The Government have reserved two seats for the M.B. B.S. course in each of Government Medical Colleges in the Province for the admission of refugee students from Pakistan. Applications for admission to these seats will be considered on their merits without reference to the question of domicile and no capitation fee will be levied from the refugee students admitted to the course.

Under the scheme for the grant of financial assistance sponsored by the Government of India, non-Muslim refugee students from Western Pakistan who have arrived in this Province and who for want of funds cannot continue their studies will be granted loans for the prosecution of studies in the course at the following rates:—

Maintenance	Books and apparatus	Outfit and contingencies	Fees
Rs. 420	Rs. 250	Rs. 160	Rs. 250

The actual amount to be sanctioned will, however, depend on local circumstances. All applications for grant of loans under this scheme should be submitted by the student or his guardian through the Head of the Institution concerned, who is expected to verify the facts as far as possible and forward them to the sanctioning authority with his recommendations. Pending the sanction of such loans, the Head of the Institution is competent to sanction an interim relief up to a maximum of Rs. 200 in any case to avoid distress and this amount will be adjusted against the loan when sanctioned.

CERTIFICATES OF VACCINATION

(For careful attention of doctors who issue certificates of vaccination)

R. No. 84068-1-Epi/1949. Office of the Director of Public Health, Dated 13th Dec. 1949.

SUBJECT:— Defective Certificates of vaccination against Smallpox and Inoculation against Cholera.

(REFERENCE:— Letter No. 25-7-49/P.H. II dated 8th December 1949 (Health Services))

Copy communicated for information and guidance.

(Sd.) T. R. RENGASWAMI,
For Director of Public Health.

(True Copy)

Copy of the letter No. 25-7-49/P.H. II (Health Services) dated 8th December 1949.

It has repeatedly been brought to the notice of this Directorate by our Port Health Officers that certificates of vaccination against Smallpox and of Inoculation against Cholera which are issued by some of the doctors in Government or Municipal Employ are often found to be defective in some respects as the entries therein do not strictly conform to the International requirements as laid down by the International Sanitary Convention 1947.

2. A few samples of the remarks offered by the Port Health Officers who have to scrutinise the certificates are given in the attached statement:—

3. It is pointed out that:—

(a) in the case of the Smallpox Certificates the following details should always be given:—

(i) the place and date of vaccination along with the signature, official position and office stamp of the vaccinator.

(ii) The signature in full and the home address of the person vaccinated (along with his age and sex).

(iii) The date of place of inspection and result of inspection together with the signature, official position and office stamp of the doctor. (This inspection should be carried out by a doctor).

N. B.:—A Certificate will be considered as null and void if the result is indicated as 'No-reaction.' The result should be stated in one of the following terms viz.,

1. Reaction of Immunity.
2. Accelerated reaction (vaccinoid).
3. Typical Primary Vaccinia.

The result of vaccination should be interpreted on the basis of the following explanations:—

1. Reaction of immunity—a papule appears on the first day, does not develop into a vesicle and rapidly fades away.

2. Accelerated reaction (vaccinoid)—a papule appears on the second day, a vesicle on the third, pustule (if present) on the fourth day, scabbing starts on the fifth day and the scab, is off by the eighth day.

3. Typical primary vaccinia—a papule appears on the fourth day becomes a vesicle on the fifth day and pustule on the eighth day. Scabbing starts on the eleventh day and the scab is off between the sixteenth and twentyfirst day.



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detailed literature from the makers:

SARABHAI CHEMICALS
(Pharmaceutical Division)

Baroda.
SC (Med) 10



CERTIFICATES OF VACCINATION

(b) in the case of the Cholera Certificate the following details should always be given :-

- i. Age and sex of the person inoculated.
- ii. Dates of inoculation of the two doses.
- iii. Origin, batch No. and type of vaccine used.
- iv. Signature, date, official title and office stamp of the doctor.
- v. Signature and home address of the person inoculated.

4. Laxity on the part of the Medical Officers completing the Health Certificates vitiates the value of such certificates and may result in considerable inconvenience to Indian Passengers at their destinations. It is, therefore requested that instructions may kindly be issued to all the doctors in Government and Municipal employ that they should strictly conform to the international requirements as stated above while issuing these certificates (specimen forms enclosed).

5. It is requested that these instructions may be given the widest publicity through circular letters to all Medical Officers and through the medium of the Medical Press. Notifications through Medical Press may be repeated at frequent intervals.

A few samples of the remarks offered by the port Health Officers as a result of their scrutiny of the Health Certificates of International Passengers.

REMARKS:— On Smallpox vaccination certificates.

Remarks on Cholera Inoculation Certificates.

- | | |
|---|--|
| 1. Results noted as 'No reaction.' | 1. Given by Sanitary Inspector, Dispenser, Vaccinator, Food Inspector, and Sub Assistant*Health Officer etc. In some cases countersigned by a Medical Officer and in other cases not even countersigned. |
| 2. Results noted as 'unsuccessful' | 2. Official title of Inoculating Officer not properly noted. |
| 3. Results noted as 'unsuccessful' and no 'reaction.' | 3. Given by private Medical Practitioner. |
| 4. Reaction noted by a Head Vaccinator but not by a doctor. | 4. Certificate not in International Form. |
| 5. Result noted as 'no result.' | 5. Certificate on Old Form with the foot note about countersignature which is misleading. |
| 6. Vaccination results not entered. | |
| 7. Certificates not on international form. | |
| 8. Reaction wrongly noted and quite different from what was actually the case. | |
| 9. Vaccination reaction not noted. | |
| 10. Old Form of certificate with foot-note regarding countersignature used. | |
| 11. No entry in the result column. | |
| 12. Results of vaccination entered by Public Vaccinator under his signature although countersigned below by Asst. Health Officer. | |
| 13. No. dates given. | |
| 14. Date of vaccination inspection not entered. | |
| 15. Result noted as 'No reaction' successful etc.' | |
| 16. Result of vaccination noted as 'Good.' | |
| 17. Certificate given by Public Vaccinator but countersigned by the Health Officers. | |



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A model "anti-atomic hospital" has been built in California, U.S.A., beneath a commentional superstructure, the protection to underground facilities is adequate to make the plant invulnerable to atomic blasts.

Those attending the International Ophthalmic Congress in London from 17th to 21st July, are invited to attend the Annual Congress of the French Ophthalmological Society in Paris from 23rd to 27th July.

A woman called upon a surgeon and said, "I'd like to have you do an operation on me, doctor."

"An operation for what, madam" inquired the surgeon.

"Oh, anything you're good at" replied the patient. "You see, I go to so many woman's parties and clubs and as I've never had an operation I simply can't enter into the conversation."

Joy: "The doctors now say that low neck dresses help women ward off colds and pneumonia."

Mary: "Well, I was at a ball last night where all the girls seem ed to be trying to ward off lumbago as well."

The aged villager complained of pain in the left leg.

After a lengthy examination the doctor suggested the trouble might be due to old age.

"Old age be hanged," shouted the old chap. "The other leg is the same age and there isn't anything wrong with it."

Nurse, showing the newly born crying baby: "Whom does he look like?"

Happy father: His eyes are mine, the nose is my wife's and his voice, I believe, he has taken it from the horn of our motor car."

Doctor Yell fell down a well

And broke his spinal bone

Doctors should care the sick

And leave the well done.