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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.

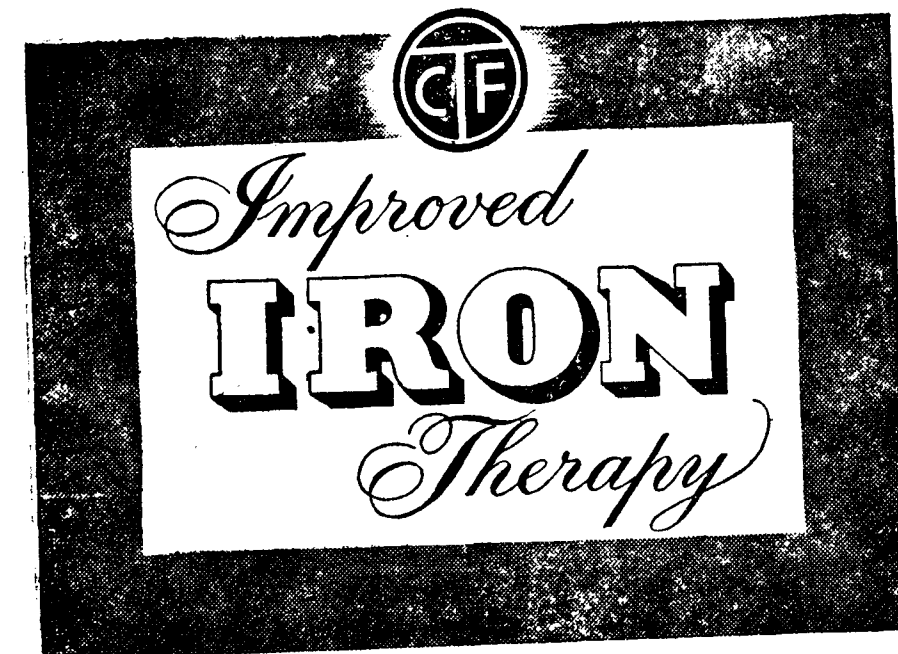
An attractive Souvenir will be published in commemoration of the Jubilee, and it will contain articles by eminent members of the profession and scientists of international repute on important medical and public health problems of the day.

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.

37th Conference of the All-India Medical Licentiates' Association VELLORE—1950

The above conference will be held in Vellore, North Arcot District on the 20th, 21st and 22nd April 1950. The 8th Provincial Conference also will be held at the same time. For further particulars please apply to:—

DR. T. M. KUMARASWAMY,
General Secretary,
37th Conference of the A. I. M. L. A., Vellore.



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THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
THE INDIAN MEDICAL ASSOCIATION

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ENIGMATIC TALES TOLD WITH CLUES

BY

Lt. Col. P. V. KARAMCHANDANI, M.B.B.S., F.R.C.P. (Edinb.)
District Medical Officer, North Arcot, Vellore.

What is the aetiology of diabetes mellitus, what are the easily distinguishable pathological types, what is the relationship of diabetes with carbohydrate metabolism and what is the rationale of therapy? On proper understanding of aetiology depends the therapy. This aetiology has been an enigma. Workers from time to time have put forth various explanations following various tracks. Some recent clues have come to hand. It is probable that these clues may provide a satisfactory answer. I intend discussing these in this article.

Before Banting discovered insulin in 1922, a Sindhi diabetic adult came under my care. I tried on him the then anti-diabetic therapy of starvation and carbo-hydrate reduction. The result was disastrous. He developed coma and died. A query shot through me "was this the right therapy?" This was clue No. 1. Two years later insulin came in the picture and it gave the answer to my query. It delivered the goods and I wrote a paper (Karamchandani 1928). But then a middle-aged heavy weight Mirasdar came under my care. I put him on mounting doses of insulin therapy. It did him no good. The dose was increased from 20 units to 200 units per day without bringing about much change in his urine sugar. In other words he was refractory to the influence of

insulin. I wondered if insulin was the final answer. This was clue No. 2. I reverted back to the old pre-insulin therapy of starvation. Sugar was more quickly controlled. I studied this subject extensively in Edinburgh and gave a comprehensive talk (Karamchandani 1941).

This is what I then taught:—

There are two separate types of diabetes mellitus distinguished by age and onset, namely:—

1. Juvenile or toxic type occurring at ages below 40 years. Development of symptoms in this are rapid and disease is severe. Coma sets in easily. Degeneration processes are absent. There is no history of obesity; sex incidence is equal. Under proper treatment prognosis is good, although patients if neglected, get coma readily and die.

2. Older or obese type occurring at ages over 40 years. Development of symptoms is insidious and disease is mild. Coma is rare while degenerative processes are present. Patient who has been putting on extra weight for years, suddenly loses weight, suffers from pruritus and sugar is found in his urine. The analysis of 150 cases which I then gave might be reproduced here with advantage.

TABLE I

Percentage of deaths due to coma at different age periods, (59 cases)

AGE	TOTAL DEATHS	COMA DEATHS	PERCENTAGE	AGE	TOTAL DEATHS	COMA DEATHS	PERCENTAGE
0-14 years	2	2	100	55-64	25	7	19.4
15-24 "	12	11	91.6	65-74	35	2	5.7
25-34 "	18	13	72.2	75 & over	5	0	0
35-44 "	16	12	75				
45-54 "	20	12	40*				

* decline after 50 years.

TABLE II

Causation of deaths in non-coma cases out of total 150 diabetic deaths (91 cases)

CAUSE OF DEATH	CASES	PERCENTAGE OF ALL DEATHS	AVERAGE AGE
Senility	8	8.8	73.4
Gangrene	8	8.8	69
Arteriosclerotic & heart failure	11	12.1	63.7
Cerebral Haemorrhage	15	16.5	61.8
Ch. nephritis	1	1.1	57
All cardiovascular	43	47.5	65.1
Respy	9	9.9	59.5
Acute abdomen	4	4.4	59.5
Septicæmia	2	2.2	70.0
Erysipelas	1	1.1	38.0
Cellulitis	1	1.1	29.0
All sepsis	17	18.8	57.5
T. B.	11	12.1	55.4
Malig. Disease	13	14.3	56.5
Anæmia Pernicious	2	2.2	48
Peptic ulcer Haemorrhage	2	2.2	30.5
Acromegaly	1	1.1	62
Hæmochromatosis	1	1.1	27
Accident	1	1.1	39
Total non-coma	91	60.7	59

It will thus be seen that during earlier years of life practically all cases developed coma before death, while during later life tendency diminishes and ultimately it disappears.

Subsequently in 1947 while I was District Medical Officer in Trichinopoly a middle aged thinnish woman nearing menopause sought my consultation. She complained of headaches, giddiness, defective eye sight and anæmia. Both the starvation and insulin therapies had only partially succeeded. She was put on oestroform (British drug) injections and her sugar was quickly controlled. This was clue No. 3. A very intelligent doctor who was in charge of the case and who had called me

in consultation, questioned the rationale. I explained as follows:—

"Anterior pituitary extract (A.P.E.) inhibits Hexokinase. Hexokinase converts glucose into glycogen. A.P.E. also inhibits insulin. Insulin burns glucose. Oestroform inhibits A.P.E. This releases hexokinase as well as insulin."

Then came yet a fourth patient who was given all the above three. These did all the good, but minimal amounts continued to trickle in his urine. Combination of Vitamin B by injection cleared the trickle. This was clue No. 4. The attending doctor queried the rationale and I explained as follows:—

"It has been experimentally shown that thiamine deficiency causes hyperglycaemia. There is interference with the chain of intracellular C. H. O. metabolism. It is possible that some break, lower down the chain has occurred, which was proved therapeutically." Thus there are three distinguishable types of diabetes mellitus.

	Type I (Insulin sensitive type)	Type II (Insulin resistant type)	Type III (Insulin blocked type)
1. Age	Young and thin	Older and obese	Older, may not be obese
2. Onset	Sudden	Insidious and mild	Insidious and grave
3. Causal factor	Deficient Insulin	Insensitive to Insulin	Inhibition of Insulin, also insensitive
4. Response to Insulin	Ready	Almost negligible. Despite mildness of symptoms astonishingly large amounts of Insulin are required to clear urine of sugar	Almost negligible
5. Insulin Glucose test	Action rapid; suppression of rise of blood sugar following ingestion of glucose is quick	Slow and weak (Little suppression of alimentary hyper-glycaemia)	Slow and weak
6. Arteries	Healthy with normal blood pressure	Arteriosclerosis with high blood pressure	Arteriosclerotic damage to pancreas is present also consequent dangers of same
7. Kætosis	Develops rapidly	Develops rarely which is light even on starvation	Develops now and again
8. Hypoglycaemia	Slight excess of insulin produces hypoglycaemia	Large excesses of insulin cause no hypoglycaemia symptoms	Large excesses of insulin cause no hypoglycaemia
9. CHO Metabolism.	Ability to oxidise CHO is impaired. Administration of insulin removes signs of diabetes	Ability to oxidise CHO is unimpaired. Only reduction of weight by dietary means removes signs of diabetes and restores sugar tolerance curve to normal.	Ability to oxidise CHO is unimpaired, but resists exogenous insulin until the enzyme hexokinase is liberated by administration of APE.

I shall now epitomise knowledge on this subject and focus thought on essentials.

A. Old Knowledge

(1) Islands of Langerhans:

In 1869 Langerhan first described these cells.

In 1889 he discovered their relation to sugar. When pancreas is de-Langerhanised to 1/9th extent, diabetes mellitus results. Pancreas consists of two glands (a) acinous, producing pancreatic juice (b) islands of Langerhan, producing insulin. These islands form only 1/100th

part of pancreas (alpha 1/3rd beta 2/3rd gamma few). The experiment on partially depancreatized dogs showed that excessive sugar over works surviving islands, hydrops of cells occurs, their granules disappear and vacuoles appear, finally the cells break up.

Conclusion: (i) beta cells control sugar (ii) when over worked, B cells become further handicapped.

(2) In 1922 Banting showed that when insulin is deficient, ability of tissues to use CHO is impaired. They send messages to liver for CHO and increased sugar production. Banting

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also showed that utilization of CHO by tissues is also governed by height of blood sugar, therefore body responds by raising head of blood sugar i.e. hyperglycaemia.

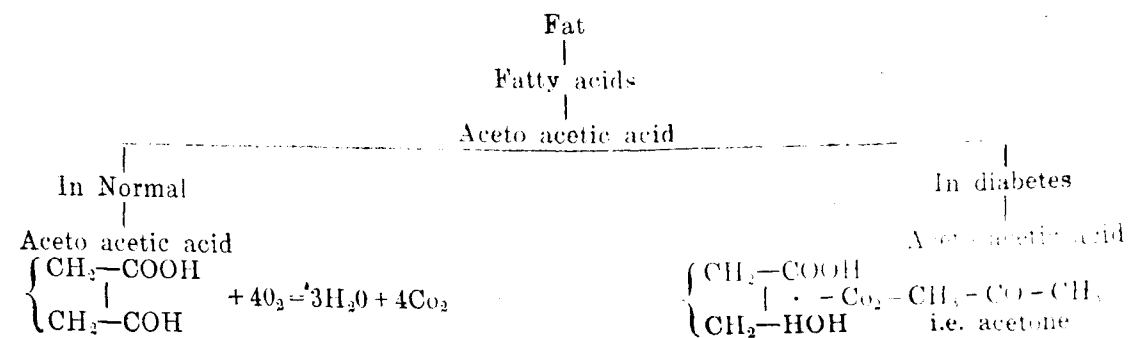
Conclusion:- (a) rate of sugar utilization is accelerated by hyperglycaemia; but the danger of this lies in overtaxing of B cells with further failure—a vicious circle vide I above (b) rate of sugar utilization is accelerated by insulin.

(3) Banting further showed that normal pancreas secretes insulin continuously called "basal secretion of insulin," and that when augmented by physiological needs e.g. meals, anger etc.,

there is stimulation (hyperglycaemic stimulation) with the result that blood sugar is kept at constant level of 80 to 120 mgm. Insulin is secreted in response to hyperglycaemia. The agent of these adjustments is liver.

4. The object of these fine adjustments is to ensure adequate supply of glucose to brain because brain utilizes only carbo-hydrate i.e. blood sugar is its life.

5. Fat metabolism: This is upset. In the normals, final product is CO_2 & H_2O , while in the diabetics it is acetone, as will be seen from the following table:-



B. Recent Knowledge

(1) What is the action of insulin and how does it act?

Action of insulin is to dispose of sugar through peripheral tissues.

Insulin acts by activating enzyme hexokinase. Glucose under influence of adenosine triphosphate (by enzyme hexokinase) is converted into glucose-6-phosphate. Once glucose-6-phosphate is formed CHO oxidation becomes possible even in diabetic animals.

APE inhibits hexokinase. (That is why hypo-physectomy ameliorates pancreatic diabetes.) This inhibition is enhanced by adrenocortical extracts (ACE) and counteracted by insulin, thereby facilitating activity of hexokinase.

Insulin also restores the ability of

liver to store sugar, or perhaps stops its excessive liberation, and is therefore important when animals are injected APE.

N.B.: Brain hexokinase (unlike muscle or liver hexokinase, is insusceptible to APE. Insulin is not necessary for brain metabolism. Brain oxidises CHO even in pancreatectomised animals.

Conclusion

When APE factors are in excess glycogen formation is retarded, glycogenolysis and new formation of sugar is accelerated and vice versa if APE factors are deficient glycogen formation is accelerated and new formation of sugar is retarded. Insulin and A.P.E. are regulators of those basic reactions which dispose of sugar i.e. APE retarding utilization in tissues while insulin facilitating same.

(2) Now if insulin is deficient, APE action will be unchecked i.e., there will be relative carbohydrate starvation in tissues i.e., starvation amidst plenty.

N. B.:—Insulin and APE are concerned only with regulating mechanisms and not with basic mechanisms; and that mass action effect of blood sugar level stands in a more fundamental relation to carbohydrate metabolism. In other words high blood sugar level can overcome this inhibition i.e. even if insulin is deficient provided head of blood sugar is high enough, tissues utilize it. Of course the dangers of hyper-glycaemia causing a vicious circle have to be remembered.

Conclusion

Hyperglycaemia is a physiological necessity i.e. a compensatory basic reaction. The protection ensures adequate carbohydrate utilization by brain even though utilization may be defective elsewhere in the tissues.

(3) What is the nature of linkage? How are the needs of tissues conveyed to APE-liver mechanism, which effects

(i) necessary adjustments of blood sugar

(ii) redistribution of metabolic priorities.

This is by means of osmotic changes, acting on certain centres in the hypothalamus which alter the rate of pituitary hormone secretion.

Conclusion

Therefore factors other than deficiency of insulin can cause syndrome of diabetes mellitus.

C. Further consideration

(1) Ordinary diabetes and insulin insensitivity. All cases of insulin insensitivity are not necessarily due to direct inhibition of insulin, because:-

(a) there may be failure of intracellular CHO metabolism at points further along the chain (b) incapacity on the

part of liver to store ingested CHO. proofs:

Hepatectomy in animals (Cancer or infection in man where 80% or more liver is obliterated) impairs sugar tolerance and produces relative insensitivity to insulin. This is so, because body is deprived of an organ which is adapted to store sudden influx of glucose.

(2) Obesity and diabetes.

Semi-starvation abates diabetes.

This is remarkable, because semi-starvation which in normal people impairs CHO tolerance and insulin sensitivity, cures obese diabetes. In other words there is no detectable abnormality of CHO metabolism, and so long obesity is prevented case is cured. We know that animals deposit fat when eating only CHO. Also we know emaciated diabetics replenish their fat depôt when given insulin because major part of CHO eaten is stored as fat. If such an animal is made diabetic by alloxan, formation of fatty acid from glucose stops and sugar which should have been converted into fat is excreted in urine. Same can happen in man vide analysis of his case by Lawrence (1946) i.e. diabetes was due to failure of insulin to change ingested sugar into stored fat. There was inability to store fat. When large doses of insulin were given greater part of CHO ingested went along the direct line of CHO metabolism and little sugar remained to be turned into fat; consequently lipaemia did not develop. When insulin given was a small dose, smaller part of CHO went along this line, there remained the large amount of sugar which in a normal person would have been synthesised into fat and stored as such. In this patient failure to store fat halted the synthesis of fat and as a result the remaining sugar accumulated in blood and spilled over in urine. In other words there was sustained hyperglycaemia in the pre-

sence of normal CHO metabolism which explains high B.M.R.

How is the obese cured by slimming?

Stores of fat are filled to capacity therefore proportion of ingested CHO which is normally turned into fat, can't be disposed of and is excreted as glucose in urine. In other words his ability to oxidise CHO as such is good, relative health without insulin is good, there is no ketosis, but there is insensitivity to exogenous insulin and beneficial effects are secured by depleting the body store of fat.

3. Infection and diabetes

Infection only precipitates manifest diabetes in a person so disposed but not in those who have no such potentiality. Infection may either act by poisoning liver and making it immediately discharge glycogen or put it out

of gear i.e. its regulatory mechanism is interfered with.

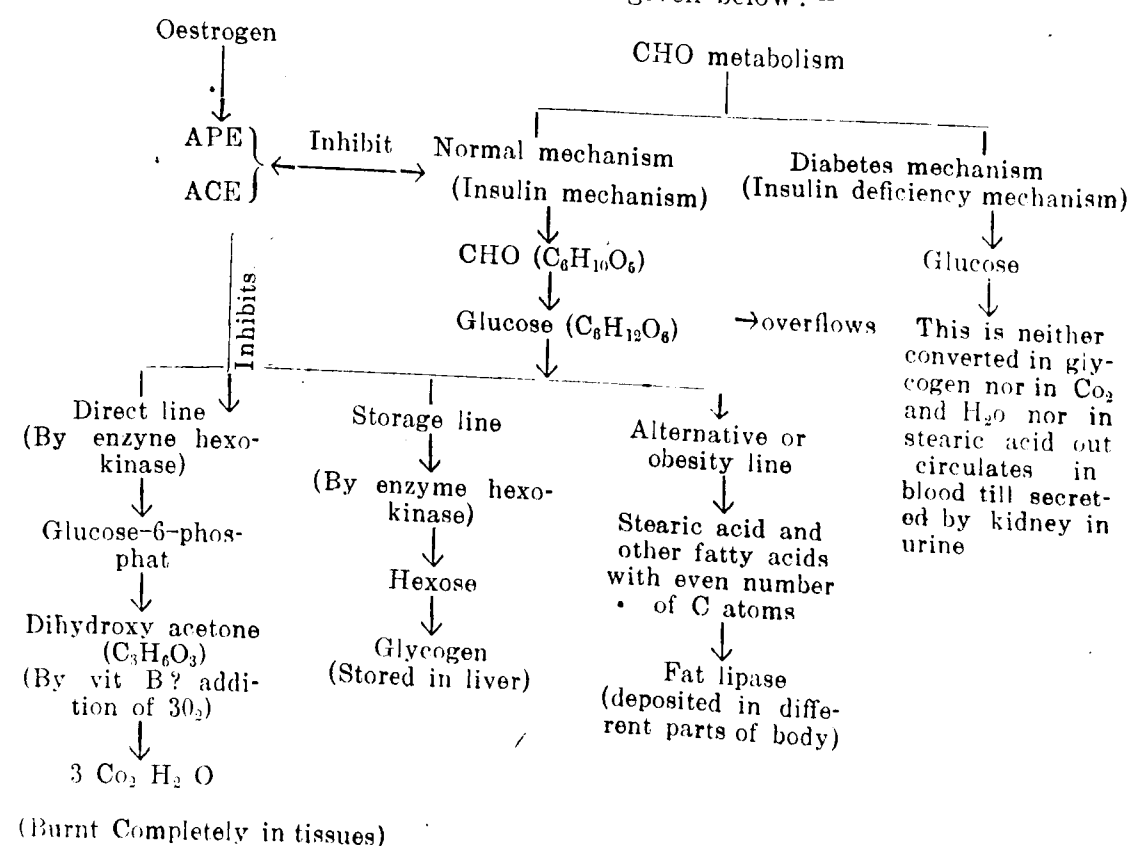
4. Growth and pregnancy

Growth hormone preparations cause nitrogen retention, through normally functioning islets of Langerhans. Growth hormone and diabetogenic factor of A. P. gland are closely related. High foetal mortality rate already exists in prediabetic period due to excessive secretion of A. P. growth (Diabetogenic) factor. If oestrogens and progesterone are given to pregnant diabetics, greatly improved results have been obtained.

Conclusion

Oestrogens inhibit A. P. activity and thereby remove the excessive strain on the islets of Langerhans caused by A. P. activity.

Graphic representation of the above is given below:—



Now I shall quote yet one more enigmatic case because it puzzled me for a long long time. In 1909 when I was a boy studying in the school, I noticed a case in my relation which remained very vivid in my memory. He was a case of elderly obese diabetic who had been put by the doctor on exercises and weight reduction therapy commonly in vogue then. He had developed coma and died. This case appeared to be fatal to my conceptions of diabetes varieties enumerated above. It remained an enigma for quite a long time, until I read work of Wilson & Byrom (1941) who cleared the haze. They said that the effect of hypertension per se, eg., arteriosclerosis of pancreas and thereby secondary insulin deficiency in these obese individuals must be disentangled from the manifestations of many conditions which might cause a high blood pressure. Now let us consider the effects of secondary insulin deficiency in this case whose hyperglycaemia had previously been due to some condition in which his CHO oxidation was unimpaired. Signs of CHO starvation e.g., ketosis would now appear, despite adequate CHO ingestion. Weight reduction would no longer cure his diabetes. Therefore, although he was originally not a case of primary insulin deficiency he ultimately died in typical diabetic coma. Perhaps similar islet lesions may be found at necropsy.

It thus appeared that we should remember that primary insulin deficiency is only one but not the commonest cause of diabetic syndrome. This does not mean that in other types insulin therapy is irrational.

Insulin is our only means of breaking down any excessive inhibition of the process by which glucose enters the metabolic stream. Within the cell there is a chain of reactions; and provided the level of any particular enzyme is not below the minimum, the increasing concentration of incoming substrate

should whip up rate of turn over. In rare cases insulin fails; perhaps the primary fault is too great for insulin to bear. What are these primary faults? In further study of these lies the solution of our enigma i.e. improvement of therapy and prevention of diabetic syndrome.

I shall wind up this tale by a quotation from Lawrence (1946).

Defects of carbohydrate and fat metabolism are most clearly seen in severe and wasting diabetes. The disturbance in carbohydrate metabolism is more obvious, and the failure to store and burn sugar is certainly the *primary* defect, producing the characteristic hyperglycaemia, glycosuria, and wasting from loss of sugar. This is essentially due to defective production of insulin.

From this primary carbohydrate defect arises the important *secondary* disturbance of fat metabolism, manifested by the appearance in the blood and urine of the ketone bodies oxybutyric and diacetic acid, and acetone. These are a striking and the dangerous feature of severe diabetes, leading to clinical signs of ketosis and ultimately to coma. It has long been known that these bodies appear during the processes of fat-catabolism in starvation as well as in diabetes.

It was, and is, accepted that fat is carried from the depots in the blood to the liver, which turns it into ketone bodies by β -oxidation or some such chemical step. Formerly it was thought that, for the further combustion of ketones to CO_2 and H_2O , the simultaneous combustion of glucose was necessary. We were all brought up on the phrase "Fat burns in the flame of carbohydrate," which implied an actual chemical reaction between the two whereby the combustion of one molecule of glucose burned three of fatty acids, a figure on which the carbohydrate-fat ratio, the ketogenic ratio, in many diabetic diets was built, in preinsulin

sutured together to prevent disfigurement or cicatricial ectropion or legophthalmos. When the raw surface is wide and irregular, skin grafting may have to be done.

If there are signs of involvement of deeper tissues, milk or Penicillin injections and Sulphonamides internally.

In children, think of bone involvement and tuberculosis—in which case, general treatment is more important. (See ocular tuberculosis).

ACCOMMODATION CRAMP

Atropine drops $\frac{1}{4}$ or $\frac{1}{2}$, once a day for a few days.

Bromides internally.

Correct refractive error, if any.

Dark glasses.

Rest, especially for near work.

Exclude Meningitis, poisoning as opium, etc.

ACCOMMODATION PARALYSIS

Any general tonic with iron, arsenic and phosphates in it.

Intramuscular injections of Vitamin B₁ 25 or 50 mg. about ten injections.

Nutritious diet, with articles rich in vitamin B.

Pilocarpin drops?

ADHESION OF LIDS

To prevent sticking of lids at bed time, especially in acute conjunctivitis, any bland ointment as Ung. Molle, castor oil or butter or Ung. Zinc Sulph., may be applied lightly to the lid margins at bed time.

AMBLYOPIA

1. **ARSENICAL AMBLYOPIA.** Stop all arsenical preparations.

Intravenous injection of Sodium Thiosulphate 10 c. c. of a 10% sol. for 3 to 5 days.

Intramuscular injections of Contramine (0.125) in sterile solution every 48 hours. Six such injections to be given.

Later, Vitamin B₁ injections, nerve tonics, and Potassium Iodide.

2. **ALCOHOL AMBLYOPIA.** *Ethyl Alcohol* Treatment same as in tobacco amblyopia. (See No. 10.)

Methyl (wood) alcohol In acute intoxication, stomach lavage with 5 Sod. Bicarb. Sol. three times a day for three days.

Hot vapour baths or subcutaneous injection of Pilocarpin Nitrates $\frac{1}{6}$ gr.

Mag. Sulphopurge.

Removal of some cerebrospinal fluid, if necessary.

Later, and also in chronic cases, treatment as in tobacco amblyopia. (See No. 10.)

Prognosis not very good.

3. **CARBON DISULPHIDE.** No further exposure to fumes.

Vitamin B₁ injections.

General tonics. Rest.

Prognosis usually good.

4. **HYSTERICAL.** Mostly psychic treatment.

Adrenalin nose plug on alternate days (See No. 14 for technique).

Vitamin B₁ injections.

Change of place and surroundings.

As a change, the following mixture may be given.

Sod. Valerian 10 grs.

Tr. Nuc. Vom. 10 m.

Tr. Capsic. 10 m.

Aqua Distil. 1 oz.

1 oz. of this may be given two or three times a day for 2 or 3 days.

Tab. Phenobarbiton gr. 1 at bed time.

Prognosis good.

5. **IODINE & IODOFORM.** Free administration of lime water.

Intramuscular injections of 5 Lecithin in sterilized olive oil.

6. **LEAD.** Contact with lead to cease. Calcium lactate and Pot. Iodide internally.

Other treatment as in tobacco amblyopia. (See No. 10).

7. **LOSS OF BLOOD.** Transfusion.

Liver injections.

8. **QUININE.** Stop the drug immediately. Stomach wash. Enema.

Hot baths followed by drinks of hot coffee.

Subcutaneous injection of Atrop. Sulph. $\frac{1}{200}$ gr.

Nicotinic acid by mouth or injections.

Hot fomentations 3 times a day.

Later Vit. B₁ injections and nerve tonics.

9. **SALICYLATES & ASPIRIN.** Treatment as in Quinine amblyopia.

Prognosis better.

10. **TOBACCO AMBLYOPIA.** Total abstinence from tobacco in any form—at least till recovery. Later, just a few cigarettes may be allowed watching effects.

Plug root of nose with gauze dipped in adrenaline. (For technique see No. 14)

Intramuscular injections of Vit. B₁ in high doses on alternate days, till full vision is restored.

Any nerve tonic internally.

Nicotinic acid 50 mg. tablet, three times a day after food.

Plenty of fluid, especially, milk.

Hot baths.

If addicted to alcohol, that also must be prohibited.

Better to have the blood examined for Kahn reaction test.

In very bad cases, intramuscular

injections of 1 c.c. ampoule (0.10 gm.) of Acetylcholine twice a day for three days, then once daily on alternate days for a fortnight, or

Sol. Carbamylcholine Chloride sol. (0.25 mg. in 1 c.c.) can be injected subcutaneously as above. Watch blood pressure.

Prognosis good.

To overcome the desire to smoke, advise as follows:

Keep away from the smell of tobacco or tobacco smoke.

Chew during day chewing gum or gentian root or comomila blossom, or suck Pot. Chloras 5 gr. tablets or Benzecdrine tablets.

Rinse the mouth after meals with a solution of 1% Silver Nitrate.

Eat plenty of fruits, especially oranges.

If the craving is intolerable, the following mixture may be tried for some days:—

Pot Bromide	2 gr.
Ammon. Bromide	2 "
Sod. Bromide	2 "
Pot. Iodide	2 "
Tr. Capsic	2 "
Syr. Aurant	ss dr.
Aqua Ad	1 oz.

To be given three times a day after food with water. This is to be given in addition to the nerve tonic.

If the patient cannot stand the abstinence, turkish baths to eliminate the poison as quickly as possible.

11. **TOXIC.** Removal of septic foci.

Intramuscular injection of 0.001 g. Thiohistamine on the 1st day. Next day, 0.002 g. Third day, 0.003 g. Four weeks should elapse before injections are given again.

12. **TRAUMATIC.** (Traumatic anaesthesia of retina) Hypodermic injection of Strychnine $\frac{1}{60}$ gr.

- Complete rest, especially for the eye.
- 13. **URAEMIC.** Treatment for uraemia.
Lumbar puncture.
- In case of pregnancy and if there is also eclampsia the advisability of evacuating the uterus may have to be thought of.

14. **CAUSE NOT KNOWN**

Plug nose with adrenalin gauze. Technique: Anaesthetise the mucous membrane of one side of the nose with a swab dipped in Anethaine 1% solution. Then, take a long, narrow piece of gauze, dip it in Adrenalin Sol., 1:1000 and push it up the nose, up to its root. Leave it there for five minutes and then remove it. A nasal speculum may be necessary for inserting the

gauze high up. Plug that side of the nose where amblyopia is present. Repeat every alternate day, about ten times. Where both eyes are affected each nostril may be taken up alternately on alternate days. Of course, this should not be done when there is an acute cold or when any pathological defect is suspected in the nose.

Injections of Vitamin B₁ or B complex intramuscularly on alternate days, up to ten injections

Retrobulbar injection of acetyl choline.

Nitroscleran also may be tried. Dose 1 c.c. given intramuscularly, one injection a day up to 10.

(To be continued)

January, 1950]

ASSOCIATION NOTES

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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 21st January 1950 in the Erskine Hospital, Mathurai. About 55 members attended. After tea the meeting commenced with Dr. P. Vadamalayan in the chair.

The minutes of the previous monthly meeting held on 17-12-1949 were read by the Hony. Secretary and adopted. The Hony. Secretary then made announcement regarding the programme of the Annual conference to be held on 25th February 1950 and also announced the date and time of the 3rd Madras Provincial Chemists and Druggists Conference and the monthly clinical meeting of the Erskine Hospital Clinical Society. He also read out the copy of the Surgeon General's circular regarding the particular to be filled in when prescribing brandy.

Dr. A. K. Rajagopalan then moved the following resolution which was seconded by Dr. T. S. Renga Iyengar:—

"This meeting of the Madura Medical Associations resolves that the G. O. No. 529 47D 49-1 dated 31-10-49, directing the member of the medical profession who are running dispensaries of their own, for dispensing medicine for their own patients, to take out a licence for possession of spiritous preparations, is causing much hardship and requests the Government to exempt the members of the medical profession from the operation of the said order."

Many members took part in the discussion on the resolution and all condemned the Government order as being very unfair to the medical practitioner.

The resolution was passed unanimously and Hony. Secretary was asked to forward the resolution to the authorities concerned.

The President, then introduced the lecturer of the evening, Major P. A. Menon, Anaesthetist of the Erskine Hospital. Major Menon began his lecture by saying that anaesthesia as practised in Madura in the present day is still far backward in comparison with Western countries. He dealt in detail about intravenous, Pentathal, anaesthesia and said that it was a very useful anaesthesia in short operations provided the patient was selected with care and the drug administered by an experienced person. If complete relaxation is required curare may be administered along with this anaesthesia but it would be absolutely necessary to have an instrument for forcing in oxygen and give artificial respiration. He also dealt in brief with spinal anaesthesia with heavy and light percaine and said that an isobaric solution prolonged the anaesthesia to nearly 5 hours. He then spoke about general anaesthesia and said that chloroform which was the main stay in the olden days had now almost been given up and was replaced with N₂O and O₂ and ether. He also mentioned about the intra tracheal anaesthesia for operations in the nose and face and intra bronchial anaesthesia for operations on the lung. He mentioned that open ether was safest for occasional anaesthesia and that a combination of the various types, in his opinion, reduced the amount of risk because of the administration of a small quantity of each. He then said that local anaesthesia was perhaps the safest

Amoebiasis

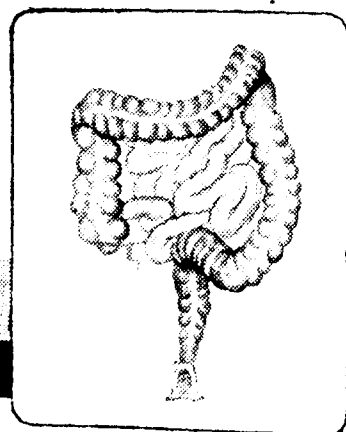
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method especially when the cardiac condition is not perfect.

In answer to Dr. K. S. Narayanan the lecturer was of the opinion that rectal ether was in no way better than inhalation and was likely to irritate the rectal mucous membrane. In shocked cases, he said, that the best anaesthesia would be local anaesthesia supplemented with Nitrous Oxide and minimal quantities of ether, combining at the same time antishock measures.

Many members took part in the discussion and the lecturer answered a number of questions. The President, in his concluding remarks, acknowledged the help of Dr. Menon, who as a safe anaesthetist had reduced considerably

the worry of the surgeon in major operations.

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

1. INTRAVENOUS ANAESTHESIA.
(Two parts)
2. STORY OF PENICILLIN.
3. EXTRACTION OF PENICILLIN.

Kindly lent by Messrs. Imperial Chemical Industries (India) Ltd. The film Intravenous Anesthesia coming as it did after the lecture was very much appreciated by the members.

The meeting ended at 8-30 p.m.

RAMNAD BRANCH

President: Lt. Col. M. A. Parthasarathy

Vice-President: Dr. T. S. Shetty

Secy. & Treasurer: Dr. S. Sundaresan

Jt. Secretary: Dr. K. Venkataraman

The nineteenth annual Conference was held at Latham's Bungalow Ramnad on 20th December 1949. More than fifty doctors including Dr. P. M. Ramasubramanian and Dr. S. V. Joseph of Madura, attended the function. The doctors assembled at the Ramnad Railway station platform at 12.15 p.m. and received the Honorable Dr. T. S. S. Rajan Minister for Public Health who arrived by the Indo-Ceylon Express. The Minister was garlanded by the President, and taken to the Latham's Bungalow. All the members were entertained to Lunch arranged by Messrs. Indo-Ceylon Commercial Syndicate, Ramnad 1.30 p.m. in a specially decorated pandal. The general body meeting commenced at 4 p.m. under the Presidentship of Lt. Col. M. A. Parthasarathy, F.R.C.S. District Medical Officer Ramnad. The minutes of the previous meeting was read and adopted.

The nineteenth Annual Report was

then read and the general body passed accounts and adopted the report. The following office bearers were elected unanimously for the year 1949-50.

President:

Lt. Col. M. A. Parthasarathy,
D.M.O., Ramnad.

Vice-President:

Dr. T. S. Shetty, Chettinad.

Hony. Sec. & Treasurer:

Dr. S. Sundaresan, Kamuti.

Joint Secretary:

Dr. Sara Tirunavukarasu, Sivaganga.

Representatives for the Central Council:

Dr. Meenakshisundaram, Ramnad.

„ Sreenivasulu, Pallathur.

„ Subanarayanan, Paganeri.

Representatives to the Provincial Council:

Dr. S. Sundaresan, (ex-officio).

„ S. N. Ganapathy, Virudunagar.

„ T. N. Sundararajulu, Srivilliputhur.

„ T. S. Shetty, Chettinad.

Committee Members

Dr. A. Jabbar, Karaikudi.

„ Rajaram Bharathy, Kondanoor.

„ Rajamirtham, Kondanoor.

„ Padmavathyammal, Kilakarai.

After group photo was taken with the Hon. Minister, the members were entertained to TEA at 5.30 p.m. by Messrs. South India Manufacturing Company, Mathurai.

The Annual Conference began with the Hon. Dr. T. S. S. Rajan, Minister for Public Health and Medicine, to the Govt. of Madras, presiding. Lt. Col. M. A. Parthasarathy, President of the association in a short speech welcomed the Hon. Minister, and thanked him for having consented to preside over the anniversary. The Secretary then read an abstract of the Annual Report. The Hon. Minister in his reply called upon the Medical Profession in the country to place service to suffering humanity above everything else. Saying that there was a dearth of medical men in the Province, the Minister deplored that knowledge was being denied to prospective entrants to the Medical College on communal grounds. He also said that in rendering medical service doctors should not be solely actuated by monetary considerations. 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 the average villager.

The Hon. Minister said that it was a matter for shame that the recent epidemic of cholera took a toll of 15000 lives during the period of 3 months in this Province and that the World Health Organisation had started a Cholera Investigating Research station in Trichi to combat this disease. He thought that a scientific and sensible investigation was necessary to wipe out this dangerous disease from this country.

The Secretary then proposed a vote of thanks to the Hon. Minister, to the Raja Sahib of Ramnad and to Indo-Ceylon Commercial Syndicate Ramnad for the Lunch, the South India Manufacturing Company, Mathurai for the Tea, and the Rajan Medical Hall, Ramnad for the Dinner, and to all the visitors and the organisers of the function.

At 8 p.m. there was a Film show on 1. Tuberculosis. 2. Journey into medicine. The films were sent by the United States Information Service. The Members were entertained to a nice Dinner arranged by Messrs. Rajan Medical Hall, Ramnad and the function terminated.

CHINGLEPUT BRANCH

President: Dr. C. S. Venkatasubramany Iyer

Vice-President: Dr. P. S. Sreenivasan

Secy. & Treasurer: Dr. R. Varadarajan

Proceeding of the meeting of the General Body, held on Saturday, the 19th November, 1949 at 2.30 p.m. at the Municipal Council Hall, Chingleput, Dr. C. S. Venkatasubramanyam, M.B.B.S., President of the association presiding.

1. The minutes of the Previous Meeting was read and approved.

2. The statement of account for the year 1948-49, presented by the Secretary was approved and passed.

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

President:

Dr. C. S. Venkatasubramany

Iyer, M.B.B.S.,

Dt. Medical Officer, Chingleput.

Vice-President:

Dr. P. S. Sreenivasan, L.M.P., M.L.C.,
Medical Practitioner, Kancheepuram.

Secy. & Treasurer :

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

Members of the Executive Committee :

Dr. A. Sundararaja Rao, L.M.P.,
Chingleput.

„ V. L. Raja, M.B.B.S., Chingleput.

„ P. K. Varugheese, L.M. & S.,
Tambaram.

„ T. K. Thayumanava
Mudaliar, L.M.P.,
Kancheepuram.

Election of a Representative to the
Central Council as per Rule 15 1 B (a)
of the Indian Medical Association.

Capt. A. Chandramowli, I.M.S., (Late)
E.C., L.M.S., B.S.Sc., L.O., Medical Practi-
tioner and Eye Surgeon, Kancheepuram.

Election of Two representatives to the
Provincial Council, South Indian Pro-
vincial Branch of the Indian Medical
Association.

Dr. P. S. Ananthanarayanan, L.M.P.,
Medical Practitioner, Kancheepuram.

Dr. C. S. V. Rajappa, L.M.P.,
Medical Practitioner, Kancheepuram.

4. Read Circular No. 50 49 51 dated
27-10-49 of the Hony. General Secre-
tary, I. M. A. Delhi.

“ Recorded ”

5. Read invitation letter of the
Chairman, Reception Committee of the
26th, All India Medical Conference,
Allahabad, to be held on 27, 28 and
29th December, 1949.

“ Recorded ”

After Tea, Dr. T. M. Sreenivasan,
B.Sc., M.B.B.S., E. N. T. Specialist spoke
on “ EAR DISCHARGE ”. The lecture
was very instructive and a good num-
ber of members took part in the discus-
sion following the lecture.

With a Vote of thanks proposed by
the President of the association to the
learned Lecturer, the meeting came to
a close.

Announcement

Sir Balachandrakrishna Gold Medal for Dr. H. I. Jhalla

We congratulate Dr. H. I. Jhalla, M.D. (Bom.) Professor of Pathology,
B. J. Medical College, Ahmedabad, on his getting the Sir Balachandra Krishna
Kt. Memorial Gold Medal Prize for his thesis on “ Hippuric Acid Synthesis —
as a Liver function Test.”

This article was written by him, in the year 1947, when he was
attached to the Grant Medical College, Bombay. The article of Dr. Jhalla,
being the best, it was selected by the Board of Examiners of the above-
mentioned Memorial Trust and Dr. Jhalla was invited to read it before the
members of the Medical Union of Bombay in October last. On this occasion
he was decorated with the Gold Medal by the President, of the Medical
Union, Bombay in the presence of the large gathering of the members of the
profession.

Dr. Jhalla's persevering and studious habits are worth admiring.
After passing L.C.P.S. and M.C.P.S. examinations, he passed the M.B.B.S., exami-
nation, and lastly he has obtained the M.D. degree of the Bombay University.

We wish Dr. Jhalla will continue his activities and win more laurels
in future.

MANAGING EDITOR.

January, 1950]

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

TERSE THOUGHTS ABOUT HEAD-ACHES—E.E.N.T.—July 1948.

Considerable progress has been made in
recent years by medical men in understand-
ing one of the most distressing of human
disorders—headaches. Although headaches
will always trouble mankind, most head-
aches can be relieved, and when understood,
cured. In this connection, the first step
to knowledge is to know too little.

1. Eyestrain covers a multitude of
ocular symptoms. The most unpleasant
symptom associated with eyestrain is
headache. No patient suffering from obs-
cure headache should be content with
general medical treatment alone unless the
possibility of eyestrain as a provocative
factor has been eliminated. The presence
of small refractive errors often give rise
to ocular disturbances. Strictly speaking,
it is not so much the error that causes
the trouble as the continuous effort to
correct it.

2. Headaches caused by neuralgias of
the cranial nerves are characteristically
limited to one side of the head, are severe
and sharp, and occur in paroxysms. An
infrequently recognised affection is sphen-
opalatine ganglion neuralgia which causes
a “lower half headache”—a boring and
burning pain over one side of the cheek
that can sometimes travel to the neck and
shoulder. The diagnosis is conclusive if
the symptoms are relieved within a few
moments by anesthetizing the ganglion
lying in the posterior recesses of the nasal
cavity.

3. Emotional tension and adverse life
situations of frustrated, aggressive, anxious
people may lead to sustained contraction of
the head and neck muscles. Headaches
due to sustained muscle contraction in
combination with emotional duress are only
temporarily influenced by sedatives. The
physician's main therapeutic effort in these
instances is directed at improving the
relation of the individual to his environ-
ment and by explaining to him the nature
of his dilemma and the basis of his head-
aches.

4. Proper treatment of a complaint in
or about the head depends on correct diag-

nosis of the cause. Although man prides
himself on “using his head”, it is ironic
that he maintains all sorts of notions
about the diagnosis and treatment of sinus
disease without even knowing what the
functions of the paranasal sinuses are.
Contrary to widespread belief, sinus disease
is not as common a cause of headache as
some conversationalists opine.

5. Migraine is sometimes thought to be
an allergic reaction. Whether allergy, the
endocrines or some other factor sets off
the explosion, the migraine attack is
formidable. Many a physician has been
able to collect a series of cases favouring
his pet theory. However, in the light of
current knowledge it appears that—like
the blind men and the elephant—each
doctor espousing a special theory can see
the migraine problem only from his own
limited point of view.

6. No other disorder so strains the
ingenuity, skill and patience of the physi-
cian as does migraine. Small wonder,
then, that among chronic ailments migraine
ranks high as a cause of loss of time and
of broken business and social engagements.
On the other hand, if one isn't unreason-
ably gloomy, there is a brighter side to the
migraine problem. Migraine doesn't figure
in statistical complications of the corner's
office as a cause of death.

7. High blood pressure has created so
much anxiety—and so many headaches—
that some physicians believe it would have
been a blessing had the machine that
measures it was never invented. Indeed,
it is probably correct to say that in the
present era of enlightenment more people
are concerned with the measurement of
their blood pressures than with the poten-
tial dangers of the atomic bomb. The
facts of the matter are that headaches
due to hypertension are not always directly
related to variations in the height of the
blood pressure.

8. Although headache, biliousness, “in-
digestion” and a sense of fatigue may at
times accompany a siege of constipation,
this does not mean that these symptoms
are caused by constipation and “auto-
intoxication.” It has never been satisfactorily
established that poisons are produced

by a constipated bowel. Yet it has been repeatedly demonstrated that there is no law of nature requiring a bowel movement every day. Careful study of the habits of thousands of healthy individuals has established that many normal people have a bowel movement every two, three or more days without the slightest ill effects.

9. Fortunately for mankind, the headaches that call for prompt and often heroic measures—those due to brain tumors, brain abscess, meningitis and certain intracranial hemorrhages—constitute a small proportion of the total number of pains involving the head. Failure to separate the ominous from the trivial, may subsequently cost life. No chronic headache should be dismissed lightly without investigating the possibility of brain tumor.

10. Headaches in children are as varied and as widely dissimilar as in adults. Headaches may be anything from headaches of convenience, to eyestrain and brain tumors. By imitating his parents, a young child may quickly grasp the excuse-value of headache as a means of escaping from an undesirable or unpleasant task. Just as the mother may plead a headache to avoid an afternoon bridge-session, so may the offspring utilize the headache to circumvent a disagreeable situation.

11. Although there is no diagnostic test that can be efficiently applied in the early stages of poliomyelitis, symptoms and observations are now believed to be sufficiently characteristic to enable the diagnosis to be established in most patients within 24 hours of the onset. While it is known that the disease varies in the intensity of its attack, the early medical symptoms are common to all types of cases including those which do not at any stage show evidence of muscle weakness. Headache is the most distinctive initial complaint. Usually this is a severe, generalized, unrelenting type of headache which is rare in the illnesses of childhood.

12. It has been said that if you want to break a person of the coffee habit, the best way is to make bad coffee. However, for some people even bad coffee is a specific treatment for the avoidance of headaches. The dose of caffeine in an ordinary cup of coffee is from 1. 1/2 to 3

grains, and this is an average medical dose of the drug. Like all other drugs, tolerance is established and confirmed coffee drinkers require larger doses to get the effect. For most people there is no evidence that routine coffee consumption is a harmful practice. The feeling of well-being and increased performance which it produces is one which few individuals would care to give up. This is especially true of those whose functional withdrawal headaches are relieved by

13. Acute illness commencing with high fever may cause headaches. Headaches can be early symptoms of scarlet fever, and occasionally of measles, chickenpox and even German measles. Headache can be quite severe in the first day or two of mumps. Headache in these diseases usually occurs in the first few hours and lasts no longer than a day or two.

14. The hangover victim of an alcoholic bag more often than not gets a headache. At present, medical men are uncertain about the specific mechanism of the hangover headache, but apparently it is produced by the effect of alcohol on that portion of the brain controlling the constriction and dilatation of blood vessels and cells. Since alcohol affects all the tissues of the body and notably the central nervous system, headache, in large measure, may also be a nervous reaction to the effects of alcohol on other parts of the body. The hangover victim can only be advised to try an ice-pack on his head, some aspirin tablets, to get some rest and to keep quiet. Where the hangover is characterized by considerable fatigue, a warm bath and prolonged sleep are recommended.

OVER-MEDICATION AND UNDER-TREATMENT—E.E.N.T.—June 1949.

Over-medication of the nasal cavity and under-treatment of diseases of the throat are twin problems coming to the fore in current therapy. Sufficient time has now elapsed to whittle down the clinically available antihistaminic agents from a "wonder-drug" status to its true size. Nevertheless, for the relief of allergic rhinitis, the antihistaminic drugs easily equal, and in numerous instances surpass, the older therapeutic trial horses.

Allergies maintain strongly that the specific methods of managing allergy (i.e. elimination and desensitization) should not be abandoned because at the present time these are the sole hopes for achieving lasting benefits. Be that as it may, it is most interesting to observe that in their published communications various allergists have made more extravagant claims as to the amount of relief obtained by antihistaminic drugs than by methods involving desensitization and elimination.

While it is unsound to administer any drug to allergic patients on a routine basis rather than when the particular need arises, particularly when the drug is capable of producing a number of undesirable side-reactions, it is reasonable to suppose that the antihistaminic era is in for a period of mounting abuse. No one can prognosticate with certainty what will happen to certain economic phases of the practice of allergy when improved antihistaminic drugs with a spreading horizon of effectiveness are introduced into clinical practice and used widely by the general public. Certain it is, however, that there will be an era of over-medication. In general, astute allergists, like astute rhinologists, realize that they are living in a changing world.

Nasal vasoconstrictors are among the most important drugs available to rhinologists. The weight of evidence indicates that these agents afford symptomatic relief only and are not curative. Nasal vasoconstrictors can relieve nasal congestion for varying periods of time and when intelligently used assist in promoting adequate drainage from the paranasal sinuses. Even temporary relief from the discomfort of nasal obstruction is a boon to the person so afflicted, and a number of sympathomimetic amines have come to assume a legitimate position in the therapeutic armamentarium.

Experiences of the past decade have demonstrated that it is possible to curtail greatly, if not completely, two man-induced sequelae to promiscuous nasal medication—lipoid pneumonia and argyrosis. Recognition of the shortcomings of mineral oil as a vehicle for nasal medicaments, and its subsequent omission in numerous preparations, in all probability have diminished the incidents of lipoid pneumonia from

this source. On the other hand, if one were to propose an aphorism to describe the over-medicated cavity, it would run something like this; over-treatment can sometimes prove just as damaging as the absence of treatment. It is known, for instance, that argyrosis of the nasal mucous membranes can be due to prolonged administration of silver salts in direct contact with the nasal mucous membranes.

In individuals in whom sensitivity to nasal vasoconstrictors has been established, the predominant complaint is nasal stuffiness. The patient who over medicates his nasal cavity usually does so to relieve a sensation of congestion. Ordinarily the underlying condition is an acute cold or a recurrent attack of chronic sinusitis. The use of nose-drops may have been initiated on the patient's own responsibility or in some instances on the advice of physicians. As the practice of frequent intranasal medication continues over prolonged periods of time, the relief becomes less pronounced; finally, little or no relief is obtained. Clinically, the mucous membranes of the over-medicated nasal cavity are often indistinguishable from tissues seen during acute allergic episodes. In general, many synthetic products provide a greater degree of vasoconstriction and a more prolonged effect than ephedrine.

Excessive use of sympathomimetic amines for a prolonged period of time can cause a clinical syndrome appropriately termed vasomotor rhinitis medicamentosa. Fortunately, nasal sensitivity to vasoconstrictors can be checked rapidly by discontinuing the offending medicament. Vasomotor rhinitis medicamentosa, like lipoid pneumonia and argyrosis, is man-induced; its saving grace is the promptness with which cures can be established. No rational employment of nasal medication will countenance deliberate and promiscuous over indulgence.

Various authors have called attention to the secondary congestion arising from use or misuse of privity hydrochloride. In general, the collective experiences appear to have been closely parallel. Attention has also been called to the fact that children may exhibit a different response to ephedrine and privity hydrochloride than that of adults, with sedation following

a period of 1/2 to 1 1/2 hours of mild stimulation. The systemic effects that may follow administration of the latter drug to children include prolonged hypertension with peripheral vasoconstriction; mild cortical stimulation, followed by depression; depression of the basal centers; and an ability to resemble and potentiate the action of the barbitals in depression of respiration. It has also been pointed out that absorption from the mucous membranes of the nasal cavity and paranasal sinuses is much more rapid when these membranes are inflamed. This may offer one explanation for an occasional case of systemic reactions. There is, in addition, also the possibility of sensitivity or idiosyncrasy to nasal medicaments.

That ephedrine and other types of nasal vasoconstrictors can cause secondary congestion has long been known. Secondary reactions (returgescence, atony and bog-giness) have been observed following frequent daily instillations into the nasal cavity of ephedrine and amphetamine in oil. Moreover, a recent report alludes to the distressing disturbances to the olfactory sense which apparently came on after the intranasal instillation of 2 different preparations of tyrothricin, both containing tyrothricin in concentrations of approximately 1:5000. The solutions were applied by spray and as nose-drops. Anosmia or parosmia developed after a solution of tyrothricin was used in the nasal cavity. These symptoms persisted from four to eight months. The symptoms have outlasted by months the condition for which the solutions were originally prescribed. At the time of the report none of the patients had regained a normal sense of smell. Most of the patients thought there had been some improvement, at least as far as intensity of parosmia was concerned.

As in the case of nasal medication, inadequate dosage and indiscriminate usage of antibiotics and sulfonamide compounds in the treatment of infectious diseases of the throat can breed resistant bacterial strains. As customarily used, the term "resistant" is applied to a micro-organism when it requires more medication to prevent its multiplication than most other strains of the same bacterial species. Penicillin resistance proceeds slowly in man and can ordinarily be over-come by

sufficient increase in dosage. In the case of streptomycin, bacteria acquire resistance at a much more rapid rate.

Today it is axiomatic that inadequate dosage and indiscriminate usage of penicillin are leading factors in breeding resistant strains of bacteria. There have been a number of reports of delayed serum types of reaction to penicillin. A substantial number of sulfonamide and penicillin reactions appear to be on an allergic basis. As in the case of the sulfonamides, promiscuous use of penicillin in unwarranted in trivial infections. A sane attitude suggests that when antibiotics are employed they be used in reliable therapeutic dosages.

ASTHMA IN CHILDHOOD—C. Astley Clarke, M.D., M.R.C.P.

The Practitioner August 1949—It was Buckle who said of history that if one could know all the circumstances leading up to an event one would be able to explain exactly why that event happened.

Asthma is a way of reacting to many different, often summing stimuli. It has no one "cause" but, using Buckle's argument, if we were able to know the circumstances leading up to an attack we should theoretically be able to say why that attack occurred. It is as well to be humble and to realize that this is a counsel of perfection. Anyone who has run an asthma clinic for any length of time knows that in a considerable number of cases one simply ends up by saying "I do not know." But patience is sometimes rewarded and in children, so it seems to me, an assessment of that important thing, "the total situation," is more easily arrived at than in grown-ups who, as all children know, are complicated and unpredictable beings, set in their ways and ruled by the basest motives. Hence the Play Clinic.

The Play Clinic: Here asthmatic children between the ages of three and fourteen come together once a week, with or without their mothers, to report progress and to play. The Clinic has dealt with all the asthmatic children who were referred to the asthma clinic proper by their general practitioners during the course of twelve months; the group is therefore entirely unselected and the children were

not referred for psychiatric reasons. At the main clinic a full history had been taken and physical examination carried out; skin tests were also done as a routine, together with X-rays of chest and sinuses and a specialist opinion on ear, nose and throat. A line of physical treatment had then been decided upon.

The *raison d'être* of the play clinic is to evaluate the results of the physical treatment, to assess the background of the child and to arrive at some sort of conclusion as to the circumstances in which the attacks are produced.

Two helpers, experienced in the problem of asthma and in looking after children, preside over what really amounts to an informal group discussion with the mothers, and extract from them all possible information relating to the attack. The children in the meantime play (often accompanied by normal brothers and sisters) as they like and with whom they like. The older ones naturally tend to mix together and play billiards and ping-pong; the younger ones play with building sets, wooden bricks, cars, plasticine, chalks, mosaics. Tea is made, the babies crawl about the floor and the atmosphere is most informal—and incidentally full of dust.

By observing the children in their natural environment—that of play—and by discussion with the mothers and older children an attempt is made to answer Halliday's queries concerning psychosomatic disease in general; "What sort of child is this? Why did he get the disease he did? Why did he get the disease then?"

The idea of this Play Clinic is not original, but was taken directly from Rogerson of Guy's, whose recent death we all so much deplore. He found in his clinic that nearly all the children showed an initial anxiety and lack of self-confidence, far greater than that usually seen. Some would scarcely play at all, and others only very cautiously with a few toys in a corner of the room. Soldiers and cannon were treated carefully and often with alarm. When the children became more confident their behaviour showed an aggressiveness and over-activity in marked contrast to their earlier play. During this phase of vigorous activity there was in most cases a striking clinical improvement, but relapses

occurred if the children's freedom of self-expression was curtailed or thwarted in any way. He regarded this behaviour as typical of asthma and as expressing underlying emotional tension. Such things as over-anxiousness about school work and overfussiness of mothers—are obvious examples of situations productive of tension in a child (Rogerson, C.H. (1937): Quart. J. Med. 24,367).

We have failed to corroborate Rogerson's findings as regards the behaviour of our thirty children *at play*. They seemed on the whole to be normal. The older ones thoroughly enjoyed playing ping pong and billiards. The quiet or shy little ones played happily with mosaics and jig-saws; the more boisterous ran about after balls and chased each other. Often, like all children, they ceased to play properly and simply "mucked about", threatening one another amicably with billiard cues and hitting the ping-pong balls wildly all over the room. It would have been quite impossible for an independent observer to pick out our asthmatics from among their normal brothers and sisters. Naturally the children vary—some are shyer than others—but do they differ as a group from normal children? We thought not, superficially, but to determine the point we asked the headmistress of a small school for a report on her fourteen healthy children. She said "one is antisocial and uncooperative; one completely home-ridden and with no desire to try anything at all difficult—mother overwhelmingly fussy and anxious; one very little go and no push, and one weeps too easily". She found them all excitable, and 100 per cent. were self-conscious, some more than others. All except the one, were cooperative in general games, obviously enjoying companionship and keen to do well at work. Our children appear to come out of the comparison with hers quite creditably; we now have no child that is antisocial and uncooperative, and only three abnormally shy retiring ones out of thirty.

The conclusion therefore is that we have not been able to learn anything positive about asthma from watching our children *at play*.

There are several possible reasons why the findings differ from Rogerson's. He was a psychiatrist and as such there would

be a marked tendency for psychiatric cases to be referred to him. In support of this, ten of his patients were only children, whereas in our series the figure was only five out of a similar number. Again, being a psychiatrist it is quite certain that he would be both able and likely to read more into children's play than we would. Moreover, his controls were not normals but non-asthmatic problem children.

Factors Precipitating Attacks:—

I now want to say something about what we learnt by getting to know the mothers and discussing with them the setting in which their children's attacks occurred. Several features immediately strike one. First the roll of excitement. In no fewer than fourteen out of thirty cases was excitement given by the mother as the main "cause" of the asthma. Here are some typical examples from the mothers' letters and statements:—

Diana's attacks appear occasionally without any known cause but we have noticed that when she is looking forward to anything, such as examinations or going away for outings with the girl studies, she gets worked up and excited and the asthma appears before the event comes off".

"He gets all worked up before he gets an attack and bites his elder brother, a thing he never does at other times".

"James often gets asthma when he is excited about going away for a holiday or going to a party. I can't tell him he's going anywhere because he gets all worked up, has asthma and can't go".

Secondly, one cannot help being struck by the art played by infection: "It came on after whooping-cough"; Every time he gets a cold off starts the asthma"; "He's been wonderful since he had his tonsils out"—all these remarks are common, and in fact we found them mentioned as major factors in fourteen of our cases. If in our series we take the emotional and infective triggers together we find that they are regarded as the "causes" by the mothers in twenty-four out of thirty cases. Sometime it is one and sometimes it is the other in the same patient—the mothers anyhow recognise what is meant by psychosomatic disease!

Thirdly, one is struck by the very few occasions in which the history suggested hypersensitivity to the common allergens (three of our cases only.)

Fourthly, there is an equally small group in which the asthma appears to be precipitated by climatic conditions—fog, change of temperature, East winds and the like.

What do these observations mean? It is difficult to be sure. It seems reasonable to deduce that in asthma the bronchioles are a locus minoris resistentiae, to be sent into spasm by stimuli which vary even in the same individual. When, however, excitement is the trigger it must be something different from the normal exuberance shown at the play clinic, otherwise we should be constantly witnessing attacks, whereas they are in fact very rare. The excitement which starts of the asthma appears to contain in it an element of tension, but we have been impressed by the fact that the tension is acute and not chronic. The homes, mothers and general background of these children appear reasonably normal but the child over-reacts, either to an ordinary tensional experience or to a quite trivial infection. He is in fact allergic in the widest possible sense.

Great stress has been laid by others on chronic tensional situations in the home but we have not been able to substantiate this. We must remember that life is not a bed of roses and that it is possible to discover sources of irritation and friction in all human lives and relationship. Perfection is not natural and only questionably desirable. The point I want to make thereof is that it is the child and not the environment that is mainly wrong. Trivial normal things start off asthma.

Results:—

The results, as might be expected, are excellent. Unless there is gross deformity of the chest or much emphysema I am sure the majority of children do quite, literally grow out of their disability as they become more stable in mind and body. Getting better, however, may be a tedious business with many fluctuations. Multiple causes call for multiple treatments and we find that in practice we treat most of our children at all levels—reassurance and explanation, sedation avoidance of allergens, desensitization, breathing exercises and convalescent homes; most unscientific, but we rationalise it by saying that as many elements go to the recreation of a healthy child as go to the

winning of a long war, and I fully believe that it is only by a combined operation that victory can be achieved.

But the right is often long, and the use of the play clinic is to provide a focal point where patients can be sure of receiving sympathy, time, encouragement and advice. We feel it is useful because they keep on coming, they write to us, responded in a body to the follow-up, and constantly express their gratitude for the interest which continues to be taken in them.

LOCAL ALCOHOL INJECTIONS IN HAY FEVER:—*The Practitioner—August, 1949.*

The results obtained by injection of alcohol into the nasal mucosa in over 100 patients with hay fever, of ages ranging from seven to fifty years, are recorded by Bedford Russel (*Lancet*, June 25, 1949, i, 1098). The method employed is as follows: Using a solution of cocaine hydrochloride, 20 per cent, with equal parts of adrenaline hydrochloride 1:1000, the nasal passage is lightly sprayed and the sensitive patches packed with ribbon gauze soaked with the same solution, for fifteen minutes. Starting at the postero-inferior border of the trigger area, a tiny drop of seventy per cent alcohol is injected with a fine 3" needle the next drop is introduced ¼ of an inch forward and upward, and so on until the mapped-out spot has been covered. Within an hour or two of injection the nasal passage is usually occluded by swelling of the mucosa and the formation of a plastic exudate from the injected area. It is therefore inadvisable to inject both sides of the nose at the same time: four days later it is usually possible to free the injected nasal passage for breathing by removal of the exudate; the opposite side then may be treated. The patient is seen preferably a week or more before the expected sneezing is due to begin; if seen after the pollen season has begun it is less easy to anaesthetize the affected area, and bleeding may occur. Of the cases treated, two patients treated in 1928 have been free from hay fever ever since. Both these patients were over forty years of age, and are stated to be exceptional. The usual result is to "reduce symptoms

below the threshold of distress, and often to obliterate them for at least one season." Contraindications to the treatment are the presence of the inflammation of the teeth or sinuses, and the rare "characteristic sensitivity" over most of the mucosa.

VAGINAL INSTILLATION OF SULPHATHIAZOLE AFTER DELIVERY—*The Practitioner—August, 1949.*

The instillation of sulphathiazole powder into the vagina immediately after delivery has been carried out in a large series of cases at both the Glenville Hospital, and Memorial Hospital, Cleveland Ohio. The method adopted and results obtained are described by C. W. Rotter and R. H. Long (*American Journal of Obstetrics and Gynecology*, May 1949, 57, 925) The method was as follows:—After the baby and placenta had been delivered and all necessary repair completed and bleeding controlled, the labia were separated with two fingers and 5 g. of Sulphathiazole powder instilled deep into the vaginal tract and spread down into the posterior fornix and about the cervix with the index and middle fingers. In cases so treated it was noted that the amount of lochia was suppressed and also the offensive odour. Among the patients so treated redness and oedema of episiotomy wounds occurred in 19.3 per cent. compared with 40.5 per cent. in those not treated by instillation of sulphathiazole powder. Other points noted were: (1) Nonoccurrence of wound disruption among the sulphathiazole treated cases; four instances among those not treated. (2) A tendency to lower temperature elevation among these treated cases. (3) Pain, especially in episiotomy cases, required medication in 32.2 per cent. of the treated cases compared with 55.2 per cent. in the untreated. No untoward reactions were noted.

TREATMENT OF HYPERTENSION:—

A note on the results obtained by Grimwald (Sovietskaia Medizina, 1948, 5) by the use of the Steinberg-Barschak method of treatment of hypertension appears in *Medicine at Hygiene* March 15, 1949, 17, 84. The method consists in the alternative administration daily of 10 ml.

of 20 per cent solution of sodium hyposulphite and 10 ml. of a 40 per cent glucose solution, to which is added 2 ml. of a 25 per cent solution of magnesium sulphite by intravenous injection. The treatment is not begun until the seventh to fourteenth day of hospitalisation, when it is determined that there is no important fluctuation of the blood pressure. A course of light to twenty injections is given. No success was obtained in cases of malignant hypertension but in the other forms the blood pressure became normal in 10

cases, was improved in 28, and remained stationary in 7 of the 50 cases treated. It was noted that the systolic pressure could be reduced more easily than the diastolic. The cerebral symptoms were markedly relieved: five to seven days after the beginning of treatment there was disappearance of headache and vertigo. Also, in 17 cases there was diminution of the cardiac symptoms. A follow up in 31 cases showed that the good results were maintained eight months after cessation of treatment.



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AN APPEAL

Dr. Yellapragada Subbarao, was one of the brightest sons of India. He has not been spared to us unfortunately to continue his very useful and valuable researches in medicine which revolutionised the understanding and treatment of some of the most refractory conditions and contributed greatly to the well being of man.

Yet very little is known to the public about Dr. Subbarao or his work and activities though the results of his investigations are well known to the medical profession.

He was an Andhra, graduated in medicine from the Madras Medical College and took his M.Sc. from the Madras University. He did his D.T.M. at the University of London and while at London he met late Dr. Richard Strong, of the Harvard School of Tropical medicine at whose instigation he went to the U. S. A. In U. S. A. he worked under the direction of Prof. Fisher, Professor of Bio-Chemistry at Harvard. His contributions in the field of Research were varied and many, well known to the profession. His investigations helped the understanding of the mechanism of muscular contraction. His researches in the fractions of liver extracts led to a new approach to the study of cancer. His recent work led to the development of Aureo-mycin another antibiotic.

The desire is but natural that such an illustrious name should never be forgotten by his countrymen. The Andhra Provincial Branch, Indian Medical Association therefore decided to commemorate his life by instituting a worthy memorial. It appeals to all the medical men and women of India through the Indian Medical Association to contribute their mite and help establishing the memorial. This branch makes a special appeal to the numerous friends and admirers of Dr. Subbarao to take an active interest and collect contributions not only from the Medical profession but from the General public as well.

The contribution may be sent to the Honorary General Secretary, Andhra Provincial Branch, Indian Medical Association, Visakhapatnam or to the Andhra Bank, Visakhapatnam to the credit of Dr. Y. Subbarao Memorial Fund, Andhra Provincial Branch, Indian Medical Association, Visakhapatnam.

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PASTEUR INSTITUTE OF SOUTHERN INDIA, COONOR

The Clinical Laboratory of the Pasteur Institute, Coonoor, is undertaking clinical, pathological, biochemical and other diagnostic work for the benefit of medical institutions and private medical practitioners. A list of the tests carried out with the charges for the same is appended below. As a rule, Wassermann and Kahn Tests are done on Fridays. It is advisable that an appointment is made for examinations like glucose tolerance test, fractional test meal etc. before the patient is sent to the Institute. It is proposed to extend the diagnostic work, for virus diseases in addition, as early as possible. Details will be announced later.

Animal inoculation tests	Rs. 16
Autogenous vaccine: cost of preparation	16
Cost of each dose supplied	1
Blood: Agglutination with Enteric, Typhus or Brucella group of organisms	10
Complete blood examination (Total R.B.C. & W.B.C. counts, Haemoglobin estimation, packed cell volume, colour index, average diameter of R.B.Cs., differential leucocyte count and general blood picture)	15
Total leucocyte count	3
Differential count	5
Reticulocyte count	5
Film for Malaria	5
Film for Filaria	5
Sedimentation rate	5
Bleeding time	5
Coagulation time	5
Blood Culture	10
Estimation of Calcium	10
" Chlorides	10
" Cholesterol	10
" Iron	10
" N. P. N.	10
" Proteins	10
" Sugar (Single)	10
" " (Glucose tolerance test)	10
" Sulphanilamide	25
" Urea	10
" Uric acid	10
Van den Bergh (Quantitative)	10
Wassermann Reaction	6
Kahn Test	3
Wassermann Reaction & Kahn Test combined	7.8
Grouping	5
Cerebro-spinal fluid: Chemical examination qualitative	5
Blood Sugar	5
Chlorides	5
Cell count and microscopic examination	5
Culture Blood	10
Fractional test meal	25
Faeces: Microscopic examination	5
Cultural examination	10
Friedman's test for pregnancy	30
Miscellaneous microscopic examination (including sputum & nasal swabs)	5
Miscellaneous cultural examination (including sputum & nasal swabs)	10
Pathological examination for morbid tissues	15
Throat swabs for Diphtheriae and Vincent's organisms only	5
Throat swabs for other organisms: Culture	10
Urine: General examination	5
Culture	10

January, 1950]

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Urine: Estimation of albumin	Rs. 5
" Chlorides	5
" Diastase	5
" N. P. N.	5
" Sugar	5
" Urea	5
" Uric acid	10
Urea clearance test	10
Urea concentration test	10

(Pasteur Institute,
Coonoor, 8-1-1950.

N. VEERARAGHAVAN,
Director.

GOVERNMENT OF MADRAS

PUBLIC WORKS (INFORMATION AND PUBLICITY) DEPARTMENT

PRESS NOTE No. 6

Dated Fort St. George, the 5th January 1950

It has been represented to the Government that in certain cases, the wearing of plastic watch straps affects the portion of the skin which comes into contact with the strap and causes skin diseases like dermatitis or leucoderma. The expert opinion of the Plastic Committee, Council of Scientific and Industrial Research, New Delhi, has therefore been obtained on the subject. It has been reported that the plastic material of the watch strap is a vinyl plastic and that Vinyl Plastic products such as rain coats, handbags, shoes, belts, surgical gloves, watch straps, baby pants, etc., have been successfully marketed for many years without any complaint in applications where they came into daily contact with the human skin. The ingredients of P.V.C. compound used in watch straps are—

(i) Poly vinyl chloride base resin.

(ii) Stabilizers and pigments.

(iii) Plasticisers of many kinds of which the most important are dibutyl phthalate, dioctyl phthalate and tricresyl phosphate.

It is reported that it has been definitely established that poly vinyl chloride base resin, stabilizers and pigments are innocuous and will not have any effect on the skin. As regards plasticisers, it is stated that dibutyl phthalate and dioctyl phthalate have no injurious effect on the skin and that tricresyl phosphate is the only ingredient which can be toxic and cause skin irritation. But it has however been pointed out that at present tricresyl phosphate is no longer used as a plasticiser for P.V.C. in production of film or sheeting for which dioctyl phthalate is the preferred material. It would appear that if a film or sheeting of P.V.C. contains extractable plasticisers which are likely to have irritant action on the skin, such film or sheeting should not be used where prolonged contact with the skin is made. Presumably certain manufacturers have imported strips of plastic without any knowledge of the end use of the material and made these up into watch straps and this has led to the complaints. It is reported that ribbons of vinyl plastics are now being manufactured in India for use as watch straps and the compounds are entirely suitable and completely free from any risk of skin irritation and that there is, therefore, no cause for any alarm in regard to the use of plastic watch straps.

(Issued by the Director of Information and Publicity.)

GOVERNMENT OF MADRAS
PUBLIC WORKS (INFORMATION AND PUBLICITY) DEPARTMENT

PRESS NOTE NO. 193

Dated Fort St. George, the 26th October 1949

Prior to 1939, any person proposing to sail by a vessel, whether as a passenger or as a member of the crew, from any port in the Madras Province subject to the Indian Ports Act, 1908 to any port outside India, could, before sailing, be required by the Port Health Officer to satisfy him that he had been vaccinated or re-vaccinated not less than 12 days and not more than three years before the date of sailing. This rule in its practical working gave rise to grave abuses, corrupt practices and untold hardship to passengers. Unscrupulous touts taking advantage of this situation began to fleece the unwary public, while securing for them the required vaccination certificates. With a view to arrest this evil, and in view of the decision of the Government of India that passengers embarking at the Indian ports need not be required to produce such certificates before embarkation and that it was for the passengers to equip themselves with evidence to satisfy the public health requirements, if any, at the ports of debarkation, this Government considered that the requirement that passengers to Malaya should produce vaccination certificates before embarkation at Nagapattinam should be abolished and with the approval of the Government of India they dispensed with this requirement by amending the rules. The above position was given wide publicity in order to prevent victimization of the poor passengers and the traffic in certificates through touts.

2. The Government now regret to note that of late there have been complaints of corrupt practices in the grant of certificates and their countersignature at Nagapattinam. They would, therefore, caution the public to guard themselves against deception or victimization by unscrupulous touts and others who promise to help them. They want to make it clear once again that under the rules passengers are not required to produce certificates of vaccination or inoculation before embarkation. At the same time, they would inform the public that, it is understood, deck passenger at the ports of debarkation, especially in Malaya, are placed in quarantine for a short period whether they possess the certificates or not, while cabin passengers are allowed to land on production of the certificates. It is, therefore, for the deck passenger to decide whether he should arm himself with a certificate as, on occasions, its possession may save him from the inconvenience of quarantine.

3. The Government of India have suggested in this connection that with a view to obviate any possible objections in the acceptance of these certificates in the countries of debarkation, passengers should, as far as practicable, obtain such certificates from Medical Officers in Government or Municipal employ. At the same time they point out that there is no legal authority to compel intending passengers to obtain their certificates only from Government or Municipal Medical Officers. This Government have accordingly permitted all Government and Municipal Medical and Health Officers to issue these certificates on payment of the prescribed fee which will be Rs. 2 for a certificate in the International Form and rupee one only in other cases. Cabin passengers may get such certificates as may be advised by the shipping companies in pursuance of the health regulations at the destinations and these certificates will be given by the Government or Municipal doctors as desired by the Government of India. Deck passengers may also, if they desire, get these certificates from Government or Municipal Medical and Health Officers or even from private medical men if they so choose. What the Government would like to reiterate is that the deck passengers should guard themselves against victimization by touts and other unscrupulous men who, while promising to get these certificates for them, may not hesitate to fleece them of their money for the assistance offered. This Government also desire to make it clear to all concerned that no countersignature by the Port Health Officer, Municipal Health Officer or any other officer is necessary for certificates issued by private practitioners.

[Issued by the Director of Information and Publicity (on behalf)]

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ODDS & ENDS

One foot on the brake, is worth two in the grave.

∴ ∴ ∴

It is said that in Brazil members of different trades and professions wear rings to show their vocation. The doctor wears an emerald, the lawyer a ruby, and engineers wear sapphires. Professors are known by their green tourmaline rings and dentists wear a topaz.

∴ ∴ ∴

"Are you an experienced doctor?"

"Yes, I have been practising for the last 20 years."

"You are still practising! Let me go to some one who is perfect."

∴ ∴ ∴

"You have charged Rs. ten for consultation, doctor. Is not your fee five rupees?"

"Don't you see it is double pneumonia?"

∴ ∴ ∴

"What are you going to give me doctor?"

"An emetic."

"An emetic! No use doctor. Another doctor gave it to me twice and on neither occasion did it stay in my stomach for more than 2 minutes."

∴ ∴ ∴

Doctor, examining the wife: "Let me see your tongue. You seem to need a stimulant."

Husband of the patient: "Good heavens, doctor, are you going to give a stimulant to that?"

∴ ∴ ∴

"What exactly is the name of my disease, doctor?"

"Psychoprenia"

"Is it constitutional?"

"Go and ask the constitution making people at Delhi."

Edited and Published by Dr. P. A. S. Raghavan, Z. M. R. E. (Vienna), Teppakulam, Tiruchirapalli,
and Printed by Rev. Fr. K. A. Lourdes, Superintendent, St. Joseph's Industrial School Press, Tiruchirapalli.

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सर्वजनाः सुखिनो भवन्तु

THE MISCELLANY

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

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FEBRUARY 1950

No. 8

THE RECEPTION COMMITTEE
37th Conference of the All-India Medical Licentiates' Association
VELLORE—1950

Office:
 No. 44, THENNAMARAM STREET,
 VELLORE, (N. ARCOT DT.)
 23rd December, 1949

DEAR DOCTOR,

The 37th Conference of the All-India Medical Licentiates' Association will be held in vellore, N.A. Dist., on the 20th, 21st and 22nd April 1950. The 8th Provincial Conference will be held at the same time. On this momentous occasion the future of the Licentiates and the problems confronting them will be discussed. It is 17 years since the parent body was invited to our Province and the town of Vellore was chosen as the venue for forging the future of the Licentiates of India in order that a lead may be given for the emancipation of this section of the medical profession existing in our country catering to the needs of the population with their unwonted skill and credit and whose lease of life and sphere of activities would continue to exist for a life-time despite the abolition of the medical schools in India. The Reception Committee earnestly request your whole-hearted co-operation and kind help to ensure an unqualified success for the Conference.

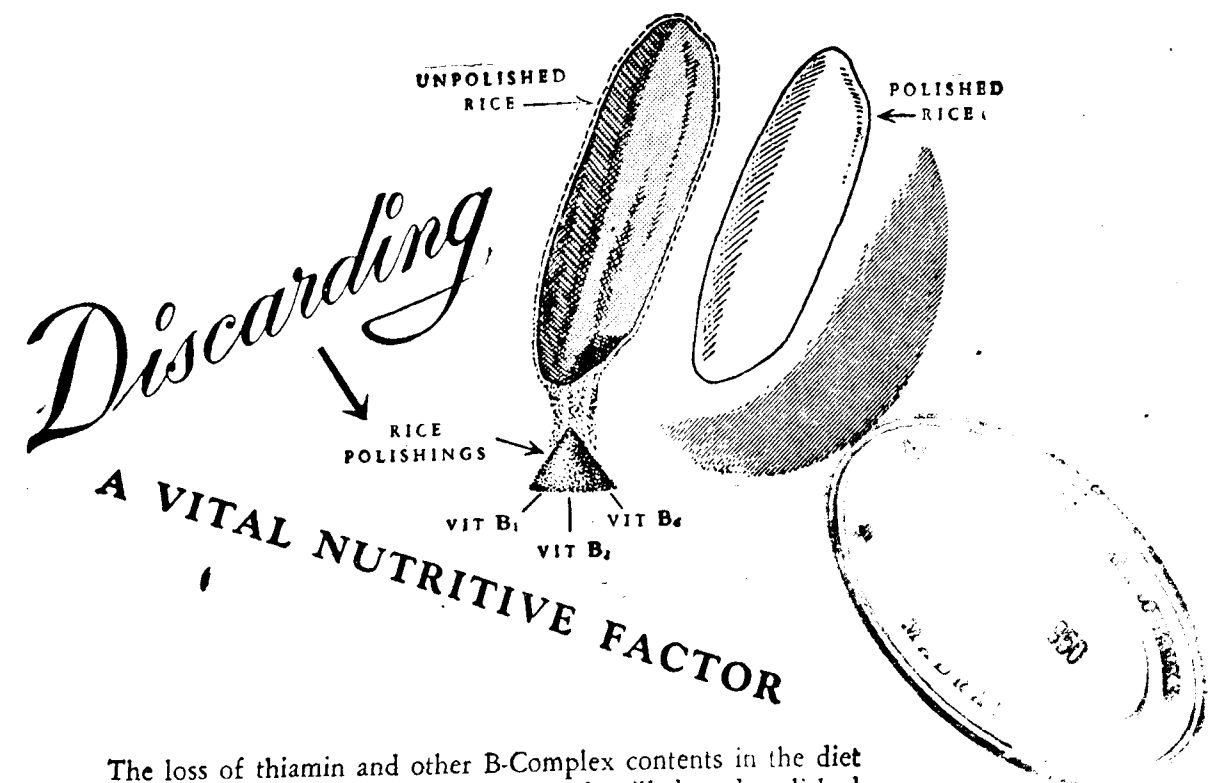
An Exhibition of Pharmaceutical products will be staged and an attractive Souvenir will be published containing valuable information on medical and public health topics useful to the profession and the public. The Scientific Section will be of great interest and benefit as eminent members of the profession will take part in the deliberations. Delegates and members of the profession including visitors from all parts of India will be present. The Reception Committee are making elaborate arrangements for the conduct of all the functions connected with the Conference. As all these items entail a huge expenditure may we request you to enrol yourself as a member of the Reception Committee by a liberal contribution to make the Conference a complete success. The minimum subscription for membership has been fixed as Rs. 10 -

Remittances may be sent to Dr. T. M. Kumaraswami, General Secretary and Hony. Treasurer, 37th Conference of the All-India Medical Licentiates' Association, Vellore, N. Arcot Dt.

Thanking you,

Yours cordially,
T. M. KUMARASWAMI,
General Secretary.
 37th Conference of the A. I. M. L. A., Vellore

The MISCELLANY—February, 1950



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produced. It is sufficient to say that after a fair trial in the various parts of the world, Sanoerysin has been abandoned. Though its use has long been given up by those countries which originated it, unfortunately its use is still prevalent in our country. I remember when I asked a teacher in this country not very long ago, to give a list of indications for gold, he straight-away said, "When A. P. fails, give gold". That shows there are still many who advocate the use of gold in this country, in spite of its disapproval abroad. Therapeutic firms in this country are still advertising the efficacy of gold in tuberculosis. Extensive studies in foreign countries have proved beyond doubt the ineffectiveness of gold salts in the treatment of tuberculosis. Equally extensive studies have been made with those drugs in sulfanilamide and sulfone series. Promin and some sulfa and sulfone compounds have apparently cured tuberculosis in some guinea pigs. But clinical studies have not shown great promise in human beings. So it is not sufficient that a preparation is tried on animals; but it has to be tried on man and found effective. The efficacy of a drug is to be determined not on the percentage based on a few cases, but should be calculated on its effects on a wider scale and carefully compared with controls.

The latest advertised as a wonder drug is the Streptomycin. During the course of my short stay in Great Britain and the continent, I had opportunities of treating cases with Streptomycin and also I could observe cases being treated in well-known institutions. I am constrained to make the observation that we in India have not been bestowing as much care and attention in the selection of cases for the administration of Streptomycin, as in the foreign countries. The discovery of this drug was almost as phenomenal as that of Penicillin. Waksman found that no other micro-organisms were

present in soil where certain *streptomyces* existed. By growing some of these *streptomyces* in media, he extracted a substance that suppressed the growth of many bacteria. This product he called Streptomycin. Other people followed in his wake and found out the anti-bacterial effect of an extract of the *streptomyces griseus* on bacterial cultures. It was tried on guinea pigs and results were found to be encouraging and the preparation of this drug was immediately taken up by Messrs. Merk & Co. As soon as the product was made available, it was tried on humans by Hinshaw and Feldman and others at the Mayo Clinic. Their work showed that pulmonary tuberculosis could be considerably suppressed by the use of this drug. It was also found that acute diseases responded more readily than chronic diseases, and that fresh pneumonic tuberculosis responds very well to streptomycin therapy. But individuals who have developed fibrotic changes with or without cavitation do not respond well. In the individual with fresh pneumonic tuberculosis, without fibrotic changes, free drainage follows streptomycin therapy due to the intact bronchial tree. When fibrotic changes take place in the lung, the drainage mechanism is altered and streptomycin therapy becomes unsuccessful. Cases of genito-urinary tuberculosis, tuberculous sinuses, tuberculous laryngitis, tracheo-bronchial tuberculosis, certain forms of miliary tuberculosis and the frightful and cent-per-cent fatal tuberculous-meningitis were all found effective by treated with streptomycin therapy.

It was however soon found that some cases after a favourable course reversed and grew definitely worse. This matter was looked into by experts and this was found to be largely due to the development of resistance to the drug by the tubercle bacilli. This resistance proved to be a stumbling block in the progress of this wonder drug.

Experiments are being conducted and from reports available, we find that resistance of the organisms to streptomycin does not develop when clearing of the lesion is taking place. It follows that the drug is to be withheld if this resolution does not take place. It is also observed that streptomycin resistant strains are less common in meningitis and miliary tuberculosis than in pulmonary tuberculosis. It is a toxic drug and certain signs of toxicity cannot be disregarded, especially the damage caused to the eighth nerve. As a result of the difficulties encountered, a wider study is being made. It has been noticed that comparatively smaller doses acted more effectively than larger doses and the reaction with smaller doses were negligible if not nil. Since then 0.5 gm. up to 0.75 gm. per day is considered to be sufficient and the period of treatment restricted to 42 to 60 days.

Going through the records of workers, we find that they have been instituting streptomycin therapy, some alone, some in connection with other collapse measures, some before collapse and some after collapse measures and some others in combination with P. A. S. Some report the early cavities having been closed with streptomycin treatment, I am afraid, the term early cavitation is vague. The early stage of tuberculosis is symptomless. The progressive phases as well, such as intra-bronchial spread, extension of existing foci and hematogenous seedlings take place without symptoms or without any change in the blood picture. Cavitation sometimes proceeds with symptomatic improvement, such as relief of toxæmia and even gain in weight. I mention these just to show how unreliable the relief of symptoms are in cases of pulmonary tuberculosis. We cannot be carried away by the relief of symptoms which I should say, the administration of streptomycin even for a few days unfortunately shows. From reports and our knowledge of the pathology

of tuberculosis, we are inclined to think that streptomycin is not a sufficient weapon against closure of cavities of some duration. Where there has been some destruction of lung tissue, and where there has been formed protective wall surrounding the cavities, it will be too much to expect closure of such cavities by depending on the action of streptomycin. Young small cavities frequently heal with absolute bed rest alone. Old standing cavities usually have fibrous coats. They need collapse therapy for closing. Considering the pathology of cavity formation and the mechanisms involved in its closure, it does not seem likely that they close with the help of any of the chemotherapeutical measures.

There are sufficient number of cases of early cavities disappearing by strict bed regimen alone. So we have to treat a group of cavity cases with bed rest alone, and another similar group with streptomycin alone. Unless we are able to prove that the streptomycin group has shown better improvement, we cannot give credit to streptomycin therapy. We have at our disposal different effective collapse measures which close cavities.

Streptomycin in the treatment of tuberculous-meningitis has proved to be a little effective. This disease used to be cent per cent fatal previously. Streptomycin has been able to save about 10% cases. Though there have been cases of relapse after a short respite, as we have nothing else to fight this fatal disease, a 10% success-giving drug is certainly a precious weapon to fight with.

Tubercle bacilli do become streptomycin resistant after a time. Nobody has yet known at what particular time they develop this resistance and whether they at a later date become sensitive again. Anyhow, we in India do not as a rule investigate if the bacilli is streptomycin resistant or not, before we administer the drug. How-

ever there is sufficient proof that streptomycin is useful in post operative complications. So it seems sensible that we should use this weapon in such cases only where needed.

Every case has to be treated in its own merits. If a particular case would ultimately go in for surgery, it is imperative that streptomycin is withheld. So I feel the use of streptomycin for minimal lesions or for cavities which would close only by surgery may be withheld. I can understand the principle of giving streptomycin to check fresh spreads in a chronic cavity case, without waiting for the organisms to develop resistance and the contemplated surgery performed, as soon as the fresh spread is checked. In our country it should be made known to the public and to the medical men that streptomycin does not replace collapse measures in pulmonary tuberculosis.

As long as there is no provision for isolation of open cases either in institutions or homes, and as long as our masses are not tuberculosis-conscious, as long as our children are not protected with B. C. G. vaccination, and as long as there are some cases of tubercle bacilli becoming streptomycin resistant after a course of streptomycin injections, there is always a chance of our children, when infected with such strains of bacilli developing tuberculous-meningitis, the only probable remedy becomes useless in this case and we become helpless against the 100% mortality.

We in India have been using streptomycin for some time now, but have we collected any data? Have we any reports as to the beneficent effects of streptomycin or its adverse after effects? It is up to us medical men to follow up cases where we have administered streptomycin and make known to the medical world its effects on patients in our country and thus contribute to the stock of world knowledge about this wonder drug. Any indiscriminate

use of this drug may prove harmful (who knows?). In any case, it is a huge drain on the country's finances especially when we have to spare dollars for better and more effective uses.

Another point I have to emphasize in connection with the administration of this drug is about the control principle. The British investigation on miliary tuberculosis and meningeal tuberculosis raised the question as to the necessity of intrathecal treatment of streptomycin. The problem was attacked by withholding intrathecal streptomycin from a random group who were in other respects similar to the rest of the patients in their study. When it became apparent that those patients were faring much worse than their intrathecally treated fellows, the question was answered. This is an example of the effective use of the control principle.

It should be remembered that tuberculosis is both an acute and a chronic disease. The progressive phases and cavitation are all acute processes and it does not take a long time to find out if streptomycin is doing good in arresting the progression of the disease. In chronic cases the healing processes are very slow and to give credit to any therapy, one has to follow cases not for weeks or months, but for years. But many years have not elapsed since the discovery of streptomycin and in my opinion, it is better to be conservative in adopting new drugs. We should wait for more reports from other countries, we should also watch cases in our country and carefully study the results before the universal introduction of this drug in our country.

Mention may be made in this connection of another drug, para-aminosalicylic acid. Bernheim in 1919 observed that the oxygen consumption of tubercle bacilli was increased by salicylic and benzoic acid. Lehman studied different derivatives of benzoic acid with the purpose of discovering a

substance possessing bacterio-static properties against the tubercle bacilli and found that P. A. S. was very effective. Trial of this drug by Lehman and his collaborators in 1946 in chronic pulmonary tuberculosis indicated that a favourable clinical effect was produced on symptoms of this disease. No serious toxic effects after the administration of P. A. S. have been reported. Although in vitro studies suggest that this drug is not so powerful a bacterio-static agent as streptomycin, experiments on animals including guinea pigs and rats have confirmed the reports of some workers that this drug has a definite retarding effect on the development of experimental tuberculosis on those animals. The dosage generally used is 10 to 11 grms, administered in 3 to 5 doses daily for 3 consecutive weeks, with a free interval of one week. One or more courses may be given but this depends on the toleration of this drug by the patient. P. A. S. appears to be a useful drug in patients with pulmonary tuberculosis especially those in whom an acute exacerbation of chronic disease has occurred and in cases where streptomycin is withheld because of development of resistance. Though Lehman stated that resistance does not take place as a result of P. A. S. therapy, there are cases to the contrary also. At the present stage of our knowledge of P. A. S., it is not possible to state anything definitely as to the absolute beneficial effect of this drug.

India is a poor country. We do not have the National Health Scheme as

in England. Very few people can afford treatment with such costly drugs as streptomycin and P. A. S. It is most often the wage earner who is the patient. The slender resources of the family therefore have to be conserved and made to last as long as possible. We should rather be conservative in the use of new drugs. We cannot think of a universal introduction of these drugs in our country. We should also remember in this connection that what all benefits have been now claimed for streptomycin are being claimed by the protagonists of P. A. S. and were previously claimed by the advocates of gold in the olden days gold has been completely given up now in all Western countries. Science is progressing and the day may not be far off, when a definite cure is found out for this terrible malady. Till then we have to be making use of all available resources for the benefit of the patient and not swear by any particular drug, which has been advertised as a wonder drug by its manufacturers. Streptomycin and P. A. S. are weapons the like of which we never had before and their use, considering the aspects mentioned above, has to be restricted to selected cases.

I have been maintaining records of a few interesting cases and am observing the effects of streptomycin and P. A. S. administered to some of my patients, and as these have not yet been finalised, I shall reserve my observations for a future occasion.



ABRIDGED OPHTHALMIC TREATMENT—II

G. J. G.

(NOTE: These series contain no original matter but are only a compilation of well known useful therapeutic measures in a condensed form. They are published in the hope they will be useful as a ready reference for practitioners particularly in the mofussil)

ANGIOMA OF LIDS

A small one may be destroyed with volatile sulphuric acid, or red hot thermocautery, or it may be excised.

Galvano-cautery may be used for larger tumours, but it should be done at several sittings, taking a limited area each time.

For still larger tumours, electrolysis and later, excision if necessary. Spare as much of the normal skin as possible.

Carbonic acid snow also may be used instead of electrolysis.

ANGULAR CONJUNCTIVITIS

On the first one or two days, if there is much watering and some discharge, or if there are superficial ulcers on the cornea, brush the conjunctiva of the everted lids with 2% Silver Nitrate solution, in the mornings. In the evening, zinc sulph. ointment.

On the following days, apply Rivanol cum Zinc sulph. ointment, twice daily. Or, irrigate the conjunctiva with Rivanol solution 1:5000 and apply zinc sulph. oint. Zinc drops may be alternated with the zinc sulph. oint.

If there be angular stomatitis as well, apply white precipitate oint. for the corners of the mouth at bed time.

Another useful drug for angular conjunctivitis is Propamide ophthalmic solution drops twice daily, for a fortnight.

Cod liver oil internally. Vitamin B Complex injections. Diet rich in vitamin A & B.

ANIRIDIA

Tattoo the periphery of the cornea with Gold and Platinum chloride solu-

tions, leaving in the centre, a clear area about the size of a moderately dilated pupil. Dark glasses.

Keep a watch on the intraocular tension.

ANKYLOBLEPHERON

Slit the adhesion between the lids and cover the raw surface with conjunctiva, and suture. Dress daily. Bandage till the wound heals.

See the conjunctiva covers the denuded surface well, so that there is no adhesion again.

ARGYROSIS OF CONJUNCTIVA

Inject subconjunctivally in the discoloured area $\frac{1}{2}$ to 1 c.c. of the following:—

Sol. Sod. Thiosulph. 12 0.35 c.c.

Sol. Pot. Ferricyanide 2 0.65 c.c.

Mix immediately before use.

The conjunctiva to be anaesthetised previously with Anethaine 1% sol. with adrenalin sol. and washed with saline.

Use a platinum needle. The injection should be as superficial as possible, so that the solution comes in direct contact with the discoloured tissues. Massage the area over the lids, so that the fluid spreads out as wide as possible.

One area to be taken up at each sitting, but only after the reaction after each injection has subsided.

ASTHENOPIA

May be associated with:

Muscle imbalance

Refractive error

Light intolerance

Vitamin A deficiency

Anæmia

Hysteria

Overwork and debility.

In all these cases, correct the cause, and give in addition, Vitamin B₁ parenterally and nerve tonic by mouth.

Rest essential for the last mentioned condition.

ATROPINE IRRITATION

Stop the drug.

Paint the skin with Tr. Benzoin Co.

Instil into the eye Adrenalin sol., thrice daily.

If mydriasis is still necessary, you may use Hyoscin Hydrobrom., Scopalamine or Duboisine sol. 1%, or Lachesine sol. or subconjunctival injection of Mydriacaine.

When there is a previous history of atropine irritation, use Atropin Methylnit., $\frac{1}{2}$ to 1% instead of Atropine Sulphate. This is less toxic and less likely to cause irritation.

It is said Atropine often loses its unpleasant irritative effect if combined with quinine.

If Atropine irritation does not subside even after stopping the drug, auto-hæmotherapy.

Antihistamine drugs also may be used for treating Atropine irritation. They have to be administered by mouth and through local applications.

ATROPINE POISONING

Warmth. Stimulant (as brandy or hot coffee)

Wash out stomach with Sol. Acid Tannic 20 grs. to a pint, or Pot. Permang. 1:5000.

Inject Pilocarpin Nitr. $\frac{1}{3}$ gr. or Physostig. 1.50 gr. hypodermically, once in 2 hours, until the skin becomes moist.

If there is delirium, Morphia $\frac{1}{4}$ gr. hypodermically.

Prevention: When applying the Atropin drops, keep the canaliculi pressed for a minute or two to prevent the passage of the solution to the nose, particularly in children.

AUTO-HAEMOTHERAPY

General: Draw 5 to 10 c.c. of blood from the vein of the patient and inject it immediately intramuscularly, in the gluteal region. Or, the blood may be allowed to clot and the serum alone injected.

Local: Draw 1 c.c. of blood from the patient's vein and inject it beneath the bulbar conjunctiva. It takes about 10 to 15 days for absorption.

It may be repeated several times.

There is relief of pain. It is found useful in tub. keratitis, trachomatous pannus, rheumatic iritis, scrofulous keratoconjunctivitis and reactions of sensitivity to Atropin. No use in hypopyon ulcer, syphilitic interstitial keratitis and tubercular, traumatic or post-operative iritis.

BAND-KERATITIS

In early cases, apply cod liver oil cum sulphonamide oint.

General health to be improved.

In well marked cases, the keratosed tissues may be scraped out. Or better still, that layer may be excised (Keratectomy). After scraping or Keratectomy, apply the cod liver oil cum sulphonamide oint., for a few days and keep the eye bandaged till the epithelium covers over.

An iridectomy, in extremely bad cases, may be done, especially if the tension shows signs of a rise.

BLEPHERITIS

BLEPHERITIS PEDICULOSA. Remove as many pediculi as possible with the aid of a loupe.

Bathe the eye lashes with Infus. Quassiae twice a day.

Apply over the lids borders morning and evening at bed time 3% Ammoniated Mercury ointment, or

Resorcin 1 gr.

Chloral Hydr. 1 gr.

Paraff. Moll. Alb. 100 grs.

BLEPHERITIS SQUAMOSA. Remove all scales from the lid borders. To soften them, use lukewarm water, or lukewarm boric lotion, or the following.

Sod. Bicarb. 10. grs.

Aqua Camph. 10 m.

Aqua ad. 1 oz.

Dilute the above with an equal part of hot water and use the tepid lotion to clean the lid margins with the aid of a clean cotton wool or gauze piece.

Warm milk also may be used for softening the scales.

Clean the borders as above twice daily and apply 3% Ammoniated Mercury ointment. This should be well rubbed into the lid margins.

The white oint. may be alternated with Noviform oint. 2%.

If the surface is raw after the removal of the scales, apply Silver Nitrate Sol. 2% over the area in the mornings for two or three days, followed on other days by the above mentioned ointments.

If improvement is not marked, epilate the eye lashes, a few at a time every day, and rub the white precipitate ointment well in.

Treatment to be continued for 6 months, even if there is any apparent cure.

Correct refractive error if any.

Cod liver oil internally and attention to improvement of general health.

BLEPHERITIS ULCEROSA. Remove all crusts, in the morning, using castor oil, cod liver oil, milk or tepid water to soften them.

Apply to the inflamed area, Silver Nitrate Sol. 2%, for a day or two, followed by Ammoniated Mercury oint. 3% or Noviform oint. 2%.

When the inflammation is not so acute, it is better the eye lashes are gradually pulled out, a few every day, before the application of the ointment.

Treatment should be gentle first when the surface is inflamed and vigorous later. It should be continued at least for a month after apparent cure.

If it is a staphylococcal infection (as is very often the case), Penicillin, or Sulphathiazole or Sulphadiazine oint. 3 times a day, instead of the white ointment.

In persistent cases, auto-vaccine or staphylococcus toxoid.

For infection from H. duplex, apply Sulphathiazole oint.

Attend also to any accompanying dermatitis on the scalp, brows or behind the ear lobes.

Attend also to general health. Cod liver oil and Vitamin B Complex are particularly indicated. Also airy surroundings.

In very persistent cases, x-ray therapy (one-third erythema dose) with sufficient protection for the eye ball.

Ultra Violet Ray therapy also may be tried.

Other alternative drugs are:

Equal parts of

Yellow oxide of Mercury oint. 1%

Salicylic acid. 1%

Mix well.

Brilliant green 2% sol. in 70% alcohol.

Where the sulphathiazole oint. is not of much benefit, Thyothricin in a suspension of 3 mg. per 10 c.c. may be applied locally.

BLEPHEROCONJUNCTIVITIS

Swab the conjunctiva of the everted lids and the lid margins with 2% sol. of Silver Nitrate for 2 or 3 days in the mornings.

Evening, Zinc Sulph. oint.

On following days, Zinc Sulph. oint., or Rivanol cum Zinc. Sulph. oint., or wash the eye with Rivanol 1:5000 solution and apply the Zinc Sulph. oint.

Cod liver oil internally. Vitamin B Complex injections. Diet rich in Vitamin A and B₂.

If angular stomatitis is present, apply white precipitate oint., to the corners of the mouth at bed time.

BLEPHEROSPASM

Just for the first time, a drop of Pantocaine 1% or Anethaine 2% may be instilled into the eye—to enable the eye to be opened, for finding out the cause for the blepherospasm. But, repeating this drop every day to give relief is not advisable.

In children, especially in keratoconjunctivitis, even this drop may not enable the child to open its eyes. In such cases, splash cold water on the face of the child. This might help some times.

Other drastic methods are: dip the child in a tub of cold water. When the head comes up, the eyes may open. Still more drastic is this: take hold of the legs and whirl the child round and round. The giddy feeling may make it open its eyes!

The moment the eyes are opened, examination must be made for any cause for the blepherospasm.

In adults, a drop of Pantocaine or Anethaine sol. is sufficient to enable an examination of the eye. If there is no visible cause for the blepherospasm, just a drop of Atropine sol. 1½% and a few words of encouragement to keep the eyes open will do.

If the spasm be due to glare asthenopia, dark glasses. If necessary, keep the patient in a perfectly dark room for 2 or 3 days and also improve the general health.

If due to foreign body, ingrowing hair, injury or disease, treat the condition.

Small superficial ulcers of the cornea cause severe photophobia and blepherospasm. Swab the conjunctiva of the everted lids with 2% Silver Nitrate sol., for a day or two in the mornings. If indicated, Atropin ½% drops, in addition.

In chronic cases, as in keratoconjunctivitis, a drop of Dionin 1% now and then might be of help.

In very bad cases, injection of Novocaine sol. 2% with adrenalin, into the orbicularis oculis. Or, injection of alcohol 80% at the outer canthus, over the area of the insertion of the orbicularis fibres on the ligament. A drastic measure is canthotomy. But, in these cases, later inability to close the lids and consequent complications should be borne in mind.

General treatment for calcium deficiency, endocrine disturbance, neurosis, etc.

BLINKING-FREQUENT

Purely nervous—no special treatment.

Test for any refractive error.

Treat anaemia or debility if present.

Psychic treatment.

Bellargol?

BLOODY TEARS

May be from an ulcerating angioma, especially behind the caruncle.

With a suture put underneath, the tumour may be snipped off, followed by Argyrol 20% drops or Irgefen or Cibazol eye oint., and bandage for 2 or 3 days till the wound heals.

(to be continued)

REPORT ON CHOLERA IN TIRUCHIRAPALLI DISTRICT

BY

DR. L. S. RAMACHANDRAN, B.S.Sc., M.B.E.S., D.T.M.,
Retd. District Health Officer, Tiruchy.

A. Cholera

The Presidency and the District are having Cholera epidemics frequently.

1. Causes for the spread of the disease:

The Presidency is in Deccan plateau which slopes from West to East. It is intersected by many rivers rising from the West and flowing to the East. The rivers have a number of channels which form the main source of drinking water supply. The occupation of the people is agriculture. Channels irrigate the lands and as wells are not many, the channel water is used freely for drinking purposes. Channels form the main source for spread of infection in Lalgudi, Tiruchy, Musiri and Kulitalai Taluks.

2. Festivals:

Festivals are common and people congregate. Drinking water supply is inadequate. Pilgrims resort to all sources of water supply. They carry infection from place to place. This is the case in Samayapuram, Konaseelam and Kallankurichi festivals.

3. Economic conditions:

Economic condition is very bad. Food is scarce and rationed. During harvest, people eat all sorts of raw and indigestible food. This predisposes them to Cholera.

4. Endemic places:

There are some endemic places in Lalgudi, Kulitalai and Trichy Taluks which get frequent attacks. They act as foci for infection. That is the case of periodicity of infection every 4 or 5 years.

5. Kinds of Epidemics:

There are two kinds of epidemics:—

(a) Winter epidemic during winter i.e., November, December and January.

(b) Summer epidemic: Immediately after South West Monsoon in June and July.

B. Geographical Distribution

1. Villages on the banks of channels and rivers are more affected than inland areas. E.g., Lalgudi, Tiruchy and Kulitalai Taluks.

2. Deltaic areas are more affected than inland villages Tanjore and Tiruchirapalli Districts.

3. During summers, inland villages have poor drinking water supplies and people resort to all sources of water supply. It is then, that Cholera flares up in inland villages. This is the case in Perambalur, Manapparai and Udayarpalayam Taluks.

4. Dry areas are relatively more free than wet areas. This is the case in Perambalur and Udayarpalayam Taluks.

5. Tiruchirapalli and Tanjore Districts are mostly channel areas and they are more prone to Cholera than other districts in the Presidency.

6. Towns like Tiruchirapalli and Karur town which have protected water supply are free from Cholera, although they get infected and being densely populated are prone to quicker and extensive spread of the disease.

C. Diagnosis

In every village early cases are bacteriologically diagnosed and subsequent cases, clinically diagnosed. Smears from stools are invariably taken and sent to King Institute, Guindy. In cases where stools are not available, rectal smears are taken and

sent for bacteriological examination. "Ogava" type is responsible for infection in Southern Districts and "Inava type" in Northern districts of the Presidency. Enough culture tubes are kept with each Cholera Officer for taking smears. All varieties of cholera are found. Mortality is very heavy in the beginning of an epidemic.

D. Prevention

1. Bili Vaccine was tried as a preventive measure in Tiruchirapalli District in 1931 and 1932. But it was not useful.

2. Bacteriophage was also tried and found in-effective. This was in the years 1932 and 1933.

3. Anti-Cholera inoculation is the method now adopted for prevention. It is our sheet anchor. It is popular.

4. On account of poor financial condition, there is only one Isolation Hospital in the whole of Tiruchy District, i.e., for a population of 1,900,000 inhabitants. It is impossible to remove Cholera patients to the hospital from a distance of 60 to 80 miles. Home Isolation is also impossible in the poverty stricken huts.

E. Treatment

1. On the whole the treatment for each individual case is very poor.

2. There is only one Cholera Inspector for 5 to 10 villages. If many cases occur in a village he can attend on the patient only once in a week.

3. Saline infusion is done only in hospitals, and occasionally by Private Practitioners. Very few cases receive intravenous saline. Doctors are few.

4. Only Mistura Prodiarrhoëa is given to the patients.

5. The village head man is the only man available (so called doctor) in the village, both day and night. He is an unqualified man but is given instructions for the treatment of the Cholera patients in his village.

6. Many places cannot be reached by Doctors. They are far inland and communication is difficult. There are no roads to many villages. This is the case in Perambalur and Udayarpalayam Taluks.

F. Propaganda

This is done by lectures and magic lantern shows. In fact, in some places villagers possess as much knowledge as Doctors. But the real difficulty is economic condition. The houses they live in are huts. Food is scanty, poor and rationed. There is not enough money with them. There is no protected water supply. What they learn by lectures, is easily and quickly forgotten in action.

G. Conclusion

1. Severe Cholera for 6 years.
2. Moderately severe Cholera for 3 years.
3. Mild Cholera for 6 years.
4. No Cholera for 3 years.

Every year there is dread of Cholera. Drinking water supply is poor. Food shortage is acute. Economic condition of the people is at a very low level. Many villagers cannot pay even for fuel for providing themselves with boiled water. Cholera patients have to lie on floor and they infect the whole flooring. They have no cots. Infected clothings cannot be changed often as extra linen in the house is practically nil. There is not enough medical attendance. In fact, villagers live in poverty and misery. No wonder that Cholera is severe every year. The Madras Government in Public Health Administration Report 1938 says as follows. "In spite of all public health activities, unless the economic standard of the people is raised, carrying with it the implications in improvement of Nutrition and water supply, the rural population will not be able to withstand the ravages of Cholera Epidemic".

ASSOCIATION NOTES

MADHURAI BRANCH

President: Dr. P. Vadamalayan
Vice President: Dr. T. S. Renga Iyengar
Secretary: Dr. K. G. Ramabadrnan
Treasurer: Dr. A. S. Annamalai

The 22nd Annual Conference of the Association was held on Saturday the 25th February 1950, in the Victoria Edward Hall, Madurai. About 120 doctors from the city and mofussil and a few members from the Coimbatore, Salem and Ramnad District Medical Associations attended.

The meeting commenced at 11 a.m. with Dr. P. Vadamalayan in the chair. After prayer by Kumari Vijayalakshmi, the Hony. Secretary, Dr. K. G. Ramabadrnan, welcomed the distinguished speakers of the day, the members of the various sister associations, the representatives of medical firm, chemists and druggists etc. Copies of the Souvenir had been distributed to the members and the Hony. Secretary announced that a journal of this type would be an annual feature of the Association and requested suggestions from members for getting up a better Journal in the coming year.

The Annual Report was then read by the Hony. Secretary. The annual statement of accounts and the auditor's report were taken as read. Dr. A. K. Rajagopalan moved and Dr. G. A. Naidu seconded that the annual report and the annual statement of accounts be approved and adopted; passed unanimously.

The Budget for the year 1950 was presented by the Hony. Secretary and was passed nem con being proposed by Dr. S. Kanthimathinathan and seconded by Dr. G. A. Naidu. The Hony. Secretary then announced the names of the new office bearers elected for the year 1950.

1. Dr. P. Vadamalayan *President*
2. " T. S. Renga Iyengar *Vice President*
3. " K. G. Ramabadrnan *Hony. Secretary*
4. " A. S. Annamalai *Hony. Treasurer*
5. " S. V. Joseph *Member of the Governing Body*
6. " G. A. Naidu "
7. " H. Venkatachalam Chetty *Member of the Governing Body*
8. " S. Kanthimathinathan "
9. " A. Narayanan Menon "
10. The sixth member of the Governing Body to be elected by the Governing Body.

Proposed by Dr. A. S. Annamalai and seconded by Dr. K. S. Narayanan, Dr. K. G. Ramabadrnan, Dr. T. S. Renga Iyengar and Dr. K. S. Krishnan were unanimously elected as members of the Central Council of the I. M. A.

Proposed by Dr. M. Venkatachalam Chetty and Seconded by Dr. T. S. Renga Iyengar the following members were unanimously elected to the Provincial Council.

1. Dr. A. S. Annamalai
2. " S. Kanthimathinathan
3. " H. Shama Rao
4. " A. K. Rajagopalan
5. " G. A. Naidu
6. " K. G. Ramabadrnan, Hony. Secretary Ex. officio.

Proposed from the chair, Dr. K. Ramachandran was unanimously re-elected as collaborator of the Journal of the I. M. A.

The president, in his address, referred to the efforts being made to procure a site for the building of the Association and hoped that the efforts might prove fruitful during the coming year. He then referred to the proposed building of a T. B. Sanatorium in Madhurai District and appealed to the rich and philanthropic minded citizens to contribute liberally for that purpose. He requested the Government to take up the proposed Madhurai Medical College as a top priority. He said that the wealth of clinical material in Madhurai should be fully utilised in the training of doctors.

He deplored the waste of enormous amount of money in the revival of indigenous systems of medicine in these days of rapid scientific progress and requested the Government and Legislators to ponder over and rectify this retrograde step for the benefit of the suffering humanity.

Dr. Miss A. Thomas, then read case reports of a few cases of Ruptured Uterus met within the Erskine Hospital and discussed their symptoms and treatment.

Dr. P. Vadamalayan presented two cases of Spinal Tumour recently operated by him. The patients and X-ray pictures were demonstrated. Many members took part in the discussion that followed Dr. D. S. Iyer of Madras gave a clear account of the principles involved in the management of a paralysed bladder.

Dr. T. V. Venkatesan presented a case of Aortic Stenosis and Dr. P. Arunachalam of Madras discussed in detail the aetiology and pathology of the condition.

The last case presented was one of Tumour Abdomen by Dr. K. S. Krishnan. This was a problem case and after

examination of the patient, and the barium meal, barium enema and urography skiagrams, many members took part in the discussion and presented their respective reasons for their provisional diagnosis which could only be confirmed by a laparotomy.

The meeting adjourned at 1.15 p.m. for lunch which was served in the spacious hall downstairs.

The afternoon session commenced at 2 p.m. Dr. D. S. Iyer of Madras gave a very learned address on Occlusive Vascular diseases. At the outset he explained the physiology of the blood supply to the limbs. He dealt in detail with some of the conditions such as arterio sclerosis, thrombo-angitis obliterans, thrombo-phlebitis etc. and mentioned the principles involved in the treatment of these conditions. He also explained the limited value of sympathectomy in these diseases.

The lecture was followed by an interesting discussion in which many members took part. This lecture will be published in the next year's journal.

Dr. P. Arunachalam of Madras then gave a lecture on recent trends in Therapy which was of great interest to the general practitioner. From his vast experience he evaluated the effects of chloromycetin in typhoid fever and the use of streptomycin in Tuberculous conditions.

He then dealt in detail with conditions of congestive cardiac failure and discussed their pathology and treatment. He emphasised the value of Digoxin in the treatment of these conditions and the value of accessory treatment with mercurial diuretics and ammonium chloride.

He mentioned the effect of Vitamin B₁₂ in the treatment of neurological complications of Pernicious Anaemia. He then dealt with the treatment of cirrhosis of the liver and the value of the recently introduced analgesics.

Finally he warned the doctors to be careful in what they say to the patient and not to produce cardiac neurosis which he called a doctor-made disease.

The lecturer then answered a large number of questions. The gathering adjourned again at 5 p.m. for tea.

The evening session commenced at 6 p.m. Dr. V. S. Subramaniam of Madras gave a masterly survey of the "common ear conditions and their management." He dealt with conditions causing pain in the ear and those producing discharge from the ear. He also mentioned the causes of deafness and explained the conditions of otosclerosis.

SOUTH ARCOT BRANCH

President: Dr. S. Sankararam Iyer

Vice-President: Dr. S. Nataraja Jatavallabhar.

Hon'y. Secretaries: Dr. N. Ramachandran

Dr. V. Visvanathan,

Hon'y. Treasurer: Dr. P. Mahendranath Singh

The monthly meeting of the Association was held in the premises of the Government Head-quarters Hospital, Cuddalore on 21st January 1950 at 5 p.m. with Dr. S. Sankararam Iyer in the chair. Thirty members were present and the members were introduced to Dr. Iswarayya, Professor of Pharmacology, Medical College, Madras, and the chief guest and lecturer of the evening. After tea provided by courtesy of Dr. S. Chandrasekara Iyer, the minutes of the last meeting were read and adopted.

Then the President requested Dr. Iswarayya to address the members on "ANTIBIOTICS".

Dr. Iswarayya traced the progress in the field of therapeutics by the advent

The lecturer answered a number of questions at the end of the lecture.

After the concluding remarks of the President, the Hon'y. Secretary proposed a vote of thanks to the distinguished lecturers and to the members of the various sister associations, the authorities of the Victoria Edward Hall and Regal Talkies.

The conference ended with the singing of 'Jana Gana Mana' by Kamari Vijayalakshmi.

Later a silent film depicting the operation performed by Dr. Leupert for otosclerosis by making a new opening in the bony canal was shown. This film was kindly lent by Dr. V. S. Subramaniam who also gave a running commentary.

of the Antibiotics such as Penicillin, Streptomycin, Chloromycetin and Aurcomycine. The avenue of antibiotics opened with the discovery of Penicillin by Florey the Nobel Laureate.

The learned lecturer dealt in detail the marvellous results achieved by Penicillin against infections by sensitive pathogens by administering systematically topically and by Aerosol medication. He described a point of importance necessitating bacteriological assessment of infections, as the susceptible pathogens maintain a control over organisms unaffected by Penicillin and when the specific effect of Penicillin removes the check the unaffected organisms grow in population and virulence.

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Penicillin resembles an amino acid and it produces certain allergic symptoms. Simultaneous administration of Coronamide orally helps to maintain plasma Penicillin level for longer hours.

Streptomycin, another member of the antibiotic against organisms not affected family has its spectrum of therapeutic activity against organisms not affected by Penicillin and by its value not only does it supplement sulphonamides and Penicilins but also fills in the gap between them.

Its value in tubercular affections is a boon to suffering humanity. It has got a selective toxic effect on the eighth nerve. Chloromycetin is an oral antibiotic useful in intestinal affections. In Enteric its therapeutic efficacy to combat toxæmia and temperature after a correct schedule of dosage is of undoubted value.

Lastly Auroimycin comes as a versatile genius of the family, having a high bacteriostatic activity against both gram-positive and gram-negative groups of organisms in all forms of typical Pneumonia. No bacteriological assessment of infection is necessary. Further it is claimed to hold the master-key for all venereal diseases. It is very effective in Rickettsial infections and Brucellosis.

The lecturer concluded his talk with the advice to weigh the hazards of drugs against hazards of diseases and in some cases a gamble to save life may be pardonable.

Then Dr. N. Ramachandran demonstrated a case of Acute Rheumatism admitted into the Hospital, which got inter-current diseases of emphysema and Pneumo coccic Meningitis threatening life and the case was saved by Penicillin.

The following two resolutions were passed unanimously:—

Resolution No. VI:

"This Association views with deep concern the recent order of the Revenue Board directing Medical Practitioners to take out a licence by payment of fees for stocking Tinctures used for compounding mixtures and requests the authorities to exempt doctors immediately from this order to take out licence."

Resolution No. VII:

"This Association resolves to reiterate its former resolution No. II, dated 19 11 49 requesting the President of the South Indian Provincial Organisation of the Indian Medical Association to move the Government to fix the salary of Local Fund Sub-Assistant Surgeons in conformity with the salary of Civil Assistant Surgeons Class II in Government service".

The meeting came to a close with the vote of thanks to the Chair, to the chief guest and lecturer of the evening, to Dr. B. G. Shenoy for his kind interest and efforts to secure the learned lecturer to our Association and to Dr. S. Chandrasekara Iyer for his kindness to provide the delicious tea for the function.

The following candidates have passed the D.M.R. (Diploma in medical Radiology) examination Part I, held in December 1949:

Mr. Masthan Vali	Dr. G. Srinivasan	Dr. Manmohan Singh
Dr. Ramadasse	Dr. Raghubir Singh	Dr. N. M. Sangai
Dr. S. L. Mathur		

The following Army candidates have passed the C.R.A. (Certified Radiological Assistants) examination Part II and III (final) held in December 1949.

54462 I.O. Rad Jem. S. N. Misra, I.A.M.C.
50058 I.O. Rad Jem. Hari Singh, I.A.M.C.

ASSOCIATION NOTES					[The Miscellany]	
Date	President	Lecturer	Subject	Host	Place	
23-24-41	R. K. Ramalingam	Dr. N. R. Subramanyam	Management of Tuberculosis	Dr. A. S. Ramalingam	R. H. H. School	
24-25-41	do	K. Rama Murthy	Various topics in Tuberculosis	Dr. A. S. Ramalingam	do	
25-26-41	do	P. K. Kalyanaswami	The Pharynx	Dr. N. R. Subramanyam	do	
26-27-41	Dr. P. S. N. Raman, Minister for Public Health	K. V. Venkatasubramanian	Cholera investigations in the district	Dr. N. R. Subramanyam	I. B. Sanatorium	
		R. Subramanyam		V. Balasubramanian		
		Col. S. L. Bhatia, S.G.				

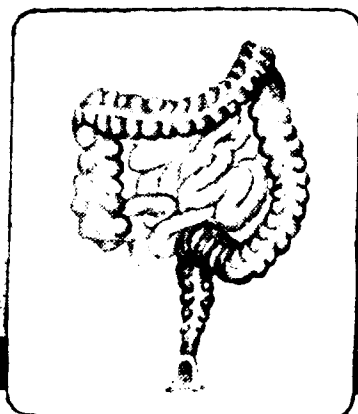
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February, 1950]

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

THE TREATMENT OF BOILS—

R. S. Handley O.B.E., M.B., F.R.C.S.—*The Practitioner*—August, 1949.

A boil, or a furuncle, begins as a staphylococcal infection of a hair follicle or sweat gland. The organisms having affected an entrance, spread to a varying extent into the surrounding subcutaneous tissues before they are localized by a barrier of leucocytes, mobilized by the local inflammatory reaction. Suppuration occurs within the encircling defensive zone and the boil subsequently bursts to the surface of the skin to discharge pus and its "core", the latter consisting of the part of the tissue battleground which has suffered to the point of necrosis. The vast majority of boils remain localized inflammations, but serious complications do occasionally arise.

Treatment involves consideration both of the local lesion and of the patient as a whole. To consider the latter first: most sufferers from boils seems to be predisposed to staphylococcal infections without there being any apparent reason; but any generalised cause of ill health e.g., a deficient diet, prolonged overwork or debilitating diseases, will predispose a normally resistant person to invasion by the staphylococcus. It is mortifying to overlook, amid the minutiae of local treatment, diabetes or chronic nephritis, sufferers from both of which conditions are particularly liable to boils. It is clearly of greater importance to remedy underlying causes than to attend to the local manifestations of any disease, and the patient with boils is no exception to the rule that a sick man should be regarded as an entire person and not as a symptom.

There are local predisposing causes for boils. The neck, the forearms and the axillae, favourite sites for recurrent boils may be chafed by sweat-soaked and infected clothing. Clean clothes, avoidance of chafe, and a dry skin are desirable as discouraging to bacterial multiplication and spread.

General treatment:—A man with a single small boil is unlikely to need or to submit to any alteration of his daily routine. But recurrent boils require that his diet be overhauled to see that it

contains as much protein and vitamin-containing foods as is possible in these difficult days and that it is not overweighed with carbohydrates. A congenial holiday is a recommendation often regarded as a Utopian and impracticable but its value is great. General Ultra violet light and injections of staphylococcus toxoid seem both to be useful in raising the body's general resistance to staphylococci but it is doubtful whether there are any other useful methods of doing this, despite the claims of numberless preparations and treatments.

Local treatment:—The aim of local treatment is to raise the efficiency of the local defence mechanisms, or to weaken the invading bacteria, or to combine both.

Rest is essential to local resistance. It is most commonly and most abruptly interrupted by the patient or a nurse giving the inflamed area "a good squeeze". The squeezing of boils is always a mistake and has, on occasions, proved to be a fatal error. Rest can be obtained in various ways, e.g., by providing a sling for those with boils on the arm; and a boil of any size is an indication for a patient to cease work so that the inflamed part can be rested.

The intensity of local inflammatory reaction is increased by heat, which is therefore useful. An infra red lamp is the ideal method of applying it but a hot water bottle on top of a kaolin poultice is usually more practicable. Hot boracic fomentations are an abomination—they remain hot for a very short time, are infrequently changed and are really always too wet. They macerate the skin without offering compensations for this assistance to the growth of bacteria. Heat may be applied in the form of hot soaks in the basin or hand-bath, or by the old expedient of bandaging some cotton wool to the bowl of a wooden spoon, dipping it into a basin of hot water repeatedly charged from a kettle, and applying to the boil. Such methods bring heat to the inflamed part without keeping it constantly moist. Hypertonic crystalloid solutions draw water out of exposed tissues by osmosis and may be thus promote a flow of fresh tissue fluid into an inflamed area. Intact

—secretion of gas into the bowel is less easy to demonstrate. It is, however, now an accepted fact that it can and does take place. It is indeed difficult in any other way to account for the sudden large quantities of intestinal gas that appear under certain conditions, the most striking examples being in cases of ureteric calculus and during the operation of retrograde pyelography. This gas is often symptomless; it appears within a matter of minutes and may disappear almost equally quickly. It seems likely that its appearance is related to sudden loss of intestinal muscular tone of reflex origin. It is noteworthy that the disappearance of the gas after injection of pituitrin is not usually manifested by expulsion of large quantities per rectum. Most of it is probably reabsorbed, the process being speeded by the increased pressure with in the lumen of the bowels due to the action of the pituitrin.

Defective elimination is a less important cause of intestinal flatulence. It may be voluntary. Plugging of the lumen of the colon in severe constipation by a mass of hard faeces is certainly a most uncommon cause of flatulence. There is no doubt, however, as to its frequent association with a redundant colonic loop, and here kinking of the bowel probably plays a part, although not the whole part, since deficient absorption from venous congestion is also likely to be present in such cases.

The Carminatives:—These drugs belong to the group of volatile oils given for the purpose of aiding the expulsion of gas from stomach and intestines. Pharmacologically they act, when taken internally, mainly by increasing peristalsis and relaxing sphincter tone. They are in fact gastro-intestinal irritants and act violently as such if taken in large doses. They are mildly antiseptic, but it is not to be anticipated that this property will have great effect in reducing intestinal fermentation. These actions are not particularly striking, and if these were all it is doubtful if the carminatives would have retained their popular reputation throughout the centuries. They do, however, directly stimulate the mucosa of the mouth, pharynx and oesophagus, and produce in so doing a pleasing sensation of warmth from lips to cardia. This may be described as a counter-irritant action, and taken post-

prandially when discomfort due to gastric flatulence is present they are undoubtedly effective in relieving to some extent the sensation of fullness. Relaxation of the cardia may also assist in the physiological expulsion of excess swallowed air from the stomach. Their efficiency in flatulence distal to the pylorus is far more uncertain, but by promoting peristalsis they probably do assist to some extent in the expulsion of gas from the colon.

Somewhat overshadowed by the powerful and specific drugs of the twentieth century the carminatives should nevertheless retain their place in every day therapeutics, although reflection on the numerous mechanisms involved in the production of intestinal gases will show that their efficiency in its control is limited.

ORAL PENICILLIN IN THE TREATMENT OF PNEUMONIA—*The Practitioner*—Oct. 1949.

A comparison of the effects in pneumococcal pneumonia of intramuscular and oral penicillin is reported by W. W. G. MacLachlan and his colleagues (*Canadian Medical Association Journal*, August 1949). Orally, penicillin was given as the calcium salt in tablet form, each tablet containing 100,000 units. One tablet was given every four or six hours and then every two hours for eighteen doses; i.e. a total dosage of 2,400,000 units. Intramuscularly, the total dosage of penicillin was 500,000 units. The type of pneumonia treated in this series was said to be a particularly severe one: with a high incidence of bacteraemia, many chronic alcoholics, a poor physical type of patient, and about 20 per cent. of the patients over the age of sixty. There were no children under the age of fifteen years. Of the 75 patients treated with intramuscular penicillin, 90.7 per cent. recovered, compared with 91.7 per cent. of the 74 patients receiving oral penicillin. Even more striking is the fact that the recovery rate among the 19 patients with bacteraemia treated with intramuscular penicillin was 84.2 per cent., compared with a recovery rate of 89.7 per cent. among the 29 bacteraemia cases treated with oral penicillin. Among the 29 patients in whom penicillin blood levels were estimated, the average blood level one hour after 100,000 units by mouth was 1.09

units per ml. of serum, whilst two hours after administration it was 1.09 units per ml.

THE USE AND ABUSE OF CALCIUM—J. W. Chambers—*The Practitioner*—July 1949.

Calcium salts have a wide range of therapeutic applications. Some of these are rational and successful, others have no definite scientific sanction and are of doubtful efficacy.

Dietary requirements:—The recommended daily allowance of calcium for children is 1 g., rising to 1.4 g. for adolescents; that for adults is a little less than 1 g., but 1.5 to 2 g. is necessary in pregnancy and lactation. The best dietary source is milk, of which one-and-a-half pints provide 1 g. For optimum growth and for the formation of good teeth in children, and for the protection of the maternal bones and teeth against the demands of the foetus and of milk production, ample intake of calcium and vitamin D must be assured.

Preparations and Administration:—The chief calcium salts and preparations in the B. P. are: calcium chloride, 10 to 30 grains (0.65 to 2.0 g.); calcium carbonate, calcium lactate, calcium gluconate, each 15 to 60 grains (1 to 4 g.); calcium mandelate, 30 to 60 grains (2 to 4 g.); injection of calcium gluconate (10 per cent.), 10 to 20 ml., intravenously or intramuscularly. There are also 5-grain (0.32 g.) tablets of calcium lactate (in this dosage a convenient placebo).

For oral administration, to increase calcium intake, calcium lactate (13.6 per cent. Ca) and calcium gluconate (9 per cent. Ca) are well tolerated and readily absorbed. Calcium chloride is liable to cause nausea and vomiting; it is much too irritant to be given intramuscularly and extravasation during intravenous administration may cause necrosis and ulceration.

For parental use injection of calcium gluconate is much to be preferred; intramuscular injection is usually well tolerated (although necrosis of muscle has been reported after massive doses given to infants). When given intravenously the rate must be slow at least 5 minutes for 10 ml. and the injection should be stopped at once if the patient complains of flushing,

or a sensation of heat in the tongue or discomfort in the chest. If used at all in the digitalized patient, parenteral calcium preparations demand great care in administration, or synergism may cause serious toxic effects (sometimes fatal).

Oral administration of calcium (dietary or medicinal) should be accompanied by adequate vitamin D. Two teaspoonful of cod-liver oil, one teaspoonful of the cod-liver oil compound of the Ministry of Food, or suitable proprietary capsule can provide the daily intake of 800 units which suffices for prophylactic dosage for all normal children and all adults.

Defective calcification.—In the prophylaxis and treatment of rickets and osteomalacia vitamin D in adequate dosage should be combined with ample calcium in the diet (milk and milk products). If in osteomalacia sufficient milk is not available or tolerated, medicinal calcium is indicated in doses up to 120 grains (8 g.) of calcium lactate or gluconate three times daily. In treating rickets, supplementing the diet with calcium gluconate has been advised to prevent the occurrence of tetany which may follow the rapid utilization of body calcium for calcification.

Diseases which may secondarily give rise to rarefaction of bone, such as steatorrhoea, hyper-parathyroidism, hyperthyroidism, require, in addition to the specific treatment of the disease, adequate calcium and vitamin D intake. In hyperthyroidism the daily calcium requirement may be twice the normal or more, and this should be supplied to patients on medical treatment or in the pre and post-operative phases of surgical treatment.

Rheumatoid arthritis and osteitis deformans (Paget's disease) also are associated with a negative calcium balance and undue loss of bone calcium. Adequate calcium and vitamin D intake should be ensured but there is no clinical evidence that very large doses of either or both are of special benefit. *Senile osteoporosis* shows no radiological improvement after increased calcium and vitamin D sufficient to produce a positive calcium balance; prophylaxis throughout earlier life is probably the only satisfactory treatment. In bone diseases with grossly disturbed ossification of unknown etiology,

"A French gentleman," wrote Montaigne many years ago, "used always to blow his nose into his fingers, a thing very inimical to our custom. In justifying himself for so doing, he asked me what privilege that unclean excrement enjoyed that we should go and provide a dainty piece of linen to receive it, and, what is more, that we should wrap it up and keep it carefully about us. He maintained that it should sicken and horrify us more than to see it thrown away, wherever it may be, like all other evacuations."

About three-quarters of a century ago a distinguished American preacher wrote to an equally distinguished physician for advice. He had been suffering from hay fever for many years and his "annual torment" was about to begin again. "Is there any cure?" asked the Reverend Henry Ward Beecher of Dr. Oliver Wendell Holmes. "Yes," replied the poet-doctor, "gravel is an effectual feet deep."

Despite the current ballyhoo in behalf of anti-histaminic agents as effective common cold cures—anti-histaminic drugs, incidentally, are neither anti-viricidal, anti-bactericidal, nor anti-bacteriostatic—Dean William R. Inge's comment before the students of the London Hospital in 1933 is especially apropos. Said this Anglican prelate, "I should feel myself ungrateful if I did not testify to my enormous respect and gratitude to the medical profession, and really, on the whole, the doctors I have known have been, I think, among the finest men of my acquaintance. I may have been very fortunate, but that has been my experience. And I am thinking not only of their great skill—though I think I should think even more of them if they had discovered how to prevent and how to cure a common cold."

For O. Henry, the short story-writer, life was made up of sobs, sniffles and smiles, with sniffles predominating. While for William Lyon Phelps, the American educator and literary critic, the common cold was both positive and negative: sometimes the Eyes had it and sometimes the Nose. On the other hand, Dr. S. W. Wynne, former health commissioner of New York City, maintained that a person's age was not dependent upon the number of years that have passed over his head, but upon the number of colds that have passed through it. It is impossible,

however, to lack compassion when Charles Dickens writes in this vein: "I am at the moment deaf in the ears, hoarse in the throat, red in the nose, green in the gills, damp in the eyes, twitchy in the joints and fractious in temper from a most intolerable and oppressive cold."

As for snoring, it has been claimed that snoring is merely sleeping out loud. "Laugh and the world laughs with you," asserts an unidentified wag, "Snore and you sleep alone." But it was Jonathan Swift, the eminent seventeenth century satirist who pictured the process in these words: "He snored so loud that we thought he was driving his hogs to market."

Finally, there are defenders of your nose and mine. Declared Napoleon Bonaparte early in the nineteenth century, "Give me a man with a good allowance of nose.....when I want any good head-work done I choose a man—provided his education has been suitable—with a long nose." But perhaps the kindest words of all were uttered by Pascal, the eminent French philosopher, theologian and scientist nearly three hundred years ago. "If the nose of Cleopatra had been a little shorter, it would have changed the history of the world."

PREVENTION OF GONORRHOEA WITH PENICILLIN TABLETS—*The Practitioner*—Oct. 1949.

A study to test the efficacy of penicillin tablets, taken by mouth, for the prevention of gonorrhoea has been carried out by H. Eagle *et al.* *Journal of the American Medical Association*, July 1949. Military personnel were used for the test, being divided into two groups, one receiving penicillin tablets and the other placebo tablets containing no penicillin. Penicillin G was used for the study, initially a single 100,000 unit tablet being issued to the men on return from shore leave, whether or not there had been exposure to infection. Later the dosage was increased to 250,000 unit tablets. With the initial dosage of 100,000 unit tablets there were 5 cases gonorrhoea in 3,215 liberties, in 3 of which it was doubtful if the penicillin tablet had been taken; this group consisted of 151 to 213 men. When the dosage of the tablet was increased to 250,000 units, there was only one case in

37 to 141 men with 569 liberties, and the man denied having received a tablet. In a control group of 176 to 195 men receiving placebo tablets there were 43 cases of gonorrhoea in 3,616 liberties in a twenty-four week period. An estimate of the over-all incidence after withdrawal of penicillin showed 46 cases of gonorrhoea in 4,920 liberties during sixteen weeks (total number of men 265-303). Penicillin was then made available to the entire station on a voluntary basis, to that it was taken only by those who had actually been exposed. The incidence figure was: "I questionable case in 1,454 liberties followed by penicillin prophylaxis."

RAPID LOSS OF HAIR IN ELDERLY PATIENT—*Geoffrey Hodgson, M.B.E., D.M.—The Practitioner*—Oct. 1949.

The hair of a patient of seventy-four started to fall out a month ago and in brushing her hair each morning it comes off in handfuls. Naturally she is distressed at the prospect of baldness. I cannot account for it, whether it may be due to lack of vitamins or be the sequel to a severe attack of influenza some six months ago. On the whole she enjoys good health for her age, except for twinges of arthritis in the spine and lower limbs, with occasional nocturnal cramp, sometimes severe.

There are three main possibilities of a sudden hair fall in a patient aged seventy-four:—

(a) **Symptomatic of debility**, intercurrent illness, of general disease such as anaemia, or as a result of fatigue as may occur with long-continued nervous strain. Six months is perhaps a little out side

the usual time limit for a convalescent alopecia after influenza. The whole root of the hair may be seen attached to the hair in such alopecia.

(b) **Senile Seborrhoea**, due possibly to some endocrine alteration in balance or in the oestrogen-androgen ration, may produce rapid alopecia. Seborrhoeic "dandruff" should be present with general scaling of the ears or scattered areas of scaling which may resemble psoriasis behind the ears or on the scalp. Such seborrhoeic states may be influenced by inadequate diet or unbalanced diet with excessive carbohydrate, lack of protein and Vitamin B complex. Injections of crude liver, 4 ml. of "plexan" or "campolon", may be given twice a week. Anxiety which may be *post* or *propter hoc* will aggravate, and phenobarbitone, $\frac{1}{4}$ of a grain (16 mg.) t.d.s., usually helps the older patient. Thyroid may also be tried.

Locally, use ointment of salicylic acid and sulphur N.F. or with tar added ("pragmatar": Menly & James). The latter is tested on a small area to exclude sensitivity. (Estrogens locally, such as dienoestrol ointment (B.D.H.), can be tried.

(c) **Alopecia areata**. Small round patches may be seen among the areas losing hair, and the hairs may be depigmented and exhibit the exclamation mark appearance where they break off short. Rapid alopecia may occur.

General management requires massage of the scalp at night, brushing of the hair and the use of a soapless shampoo fortnightly. If ultraviolet light is contemplated, exposures must be very gently graduated, as the senile skin does not tolerate it well.

LOCAL BOARD MEDICAL EMPLOYEES AND UNIFICATION OF CIVIL ASSISTANT SURGEONS CADRES

To the memorandum dated 27-2-50 submitted to the Government of Madras in the Department of Public Health, the Government have replied in their letter No. 9476 L 50-2, dated 17-3-50, that it is not feasible to raise the scales of pay of Medical Officers of Local Fund Dispensaries to that of Govt. Medical Officers nor in the alternative to exempt them from doing medico-legal work.

The matter of unification of cadres of the Civil Asst. Surgeons Class I & II will be expedited.

P. A. S. RAGHAVAN,

President.

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Copies can be had from the Author

DR. A. VISWANATHAN,

Vengudi Village,
Thimmarajampet Post, Chingleput Dt.
(Via—Madras and Conjeevaram)

ODDS & ENDS

Transfusion of blood from a husband to his wife who is in the child bearing age is not advised, even though both may belong to the same blood group, as the child may be still born.

Cortisone, found useful in rheumatoid arthritis, costs £ 50 per injection.

Recent session of the World Medical Association in London has drawn up an International Code of Medical Ethics.

A new Medical College has been started in Sweden "because of the great need for more physicians." There are 4200 physicians for a population of 6,70,000, nearly 1 for 160. In India there are barely 45,000 doctors for a population of over 32,00,000 nearly 1 for 7000.

"Why do you close your eyes before taking your drinks?"

"The doctor has asked me not to look at anything stronger than water."

The Resident Medical Officer, taking a class of students round the wards pointed with some pride to a girl who had been successfully treated for pneumococcal meningitis.

"But why does she squint?" asked a critical student.

"Examine her and find the cause" replied the R.M.O.

A few moments later the students, having examined the girl, reported: "There is paralysis of the external recti muscles and the pupil is fixed."

"What is the cause?" asked the R.M.O.

"Damage to oculo-motor nerve resulting from meningitis," was the answer.

The R.M.O. turned to the patient. "Show the doctor your eye, Nelly," he said.

The girl made a swift face-wiping movement and before the astonished students had time to think, they saw in her outstretched palm-a glass eye.

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Occurrence: Found everywhere and nowhere

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Caution: Highly explosive in inexperienced hands.

Edited and Published by Dr. P. A. S. Raghavan, Z. M. R. E. (Vienna), Teppakulam, Tiruchirappalli, and Printed by Rev. Fr. K. A. Lourdes, Superintendent, St. Joseph's Industrial School Press, Tiruchirappalli.

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THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

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XVI

MARCH 1950

No. 9

Announcement

Copy of letter received from the Provincial Drug Controller, Madras
addressed to the Medical Officer, Neills Clinic, Kotagiri

In P. No. 7, d/50

Office of the Provincial
Drug Controller,
79-81, Mount Road, Cathedral P. O.
Madras-6, dated 6th March 1950

SIR,

Subject:—Prohibition—Tinctures possession of

Reference:—Your letter N. C. Des. No. 2817/50, dated 22-2-50

The Government have already been addressed to amend the Rules suitably to allow the Registered Medical Practitioners to possess at least one pound in each variety of the tinctures at a time without a permit. Their orders are awaited.

Yours faithfully,

(Sd.).....

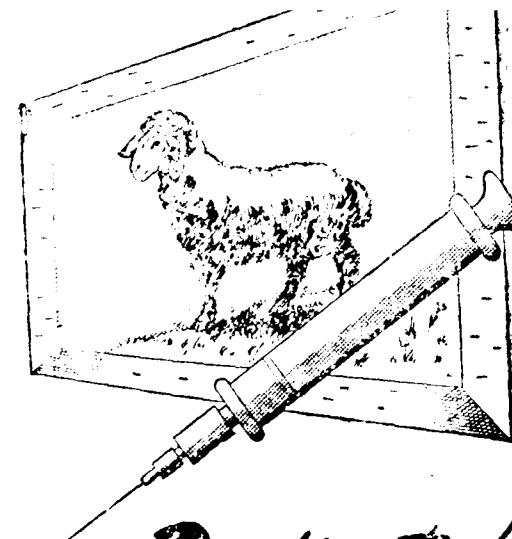
For Provincial Drug Controller

Medical Institution—Primary Centres.

With reference to the enquiry whether subsidised medical practitioners particularly the Licentiates will be appointed as basic doctors when such rural dispensaries were converted into Primary Centres, the Govt. of Madras has passed the following order:

G. O. No. 353-P.H. dated the 28th January, 1950.

If the rural dispensary has been functioning well under a popular Rural Medical Practitioner, it need not ordinarily be disturbed and the primary centre need not be opened. If, however, it is considered 'definitely desirable and necessary to open a primary centre in that place, then there is no objection to the conversion of the rural dispensary into a primary centre, provided the Rural Medical Practitioner who has been responsible for the successful working of the dispensary can also be taken in Government service. Where, in such case, the Rural Medical Practitioner is unwilling to be absorbed in Government Service, the rural dispensary should be transferred to some other suitable place if the local body concerned and the Surgeon-General are agreeable to such transfer, and if the Rural Medical Practitioner is prepared to move along with the dispensary.



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to my clinic at the suggestion of somebody. On examining the child thoroughly, I found it to be a case of advanced diphtheria.

It was too late to do anything for this case. Tracheotomy was suggested after giving bad prognosis; the parents refused this and the child died in less than twenty four hours after I saw her in spite of the best attention. There are records of yet a few more cases of diphtheria, the diagnosis of which was missed in proper time by the practitioners, only because the local examinations were not done. I have heard some doctors saying that diphtheria is never seen in our country specially in the south. This is not a correct. If a routine examination of all acute throat lesions is made, if bacteriological and cultural methods are availed of you will find it is not so rare a condition as a few of you might believe. Some years back, a learned Barrister, the brother of a well-known Civil servant, whose another brother was a reputed Lawyer and later a Judge, came to my Clinic from his headquarters 60 miles away. He had low fever, swollen painful, cervical glands, slight hoarse throat and slight cough for over 10 days. He was attended to by capable doctors. He was attending Court, and arguing cases with temperature up to 102 F. during this period. Throat examination did not reveal anything special when I saw him. Tonsillar area was absolutely clear. He was aged over 35. He consulted me and went away in spite of my advising him to stay for observation and treatment.

I never suspected it to be what it turned out to be in the end. As he became worse day by day, he was brought to my place a week later, to be admitted as an in-patient. The cervical glands were highly enlarged and tender. I was groping in the dark as to the diagnosis till one day he coughed out some hard lump about an inch long and the bacteriological exami-

nation revealed it to be loaded with diphtheria bacilli. We had to struggle hard to save his life and it took three months of hospital life for him. As there was not even a trace of membrane anywhere in the throat it did not give any suspicion of diphtheria. The cervical glands which were highly enlarged and tender, should have directed my attention to think of this disease. But it is likely that in the early stages when I had no opportunity to see him till about 12 days, the typical membrane might have been present but the patient informed me that no examination of the throat was done by his doctors then. He was an adult of 35 years and if any doctor did not suspect the disease which is less common in adults, there is surely some excuse. It is also important to know that it is not always that a typical membrane is visible near the tonsillar area.

If the disease is in the nose, and nasopharynx, you will find fetid blood-stained discharge and the typical false membrane may not be visible. When it is in the fauces, you will have to differentiate it from lacunar form of tonsillitis. In diphtheria one sees the typical, false membrane leaving a readily bleeding surface when attempted to remove not limited to the tonsil alone, but extending to the soft palate, to the uvula and to the posterior pharyngeal wall. The colour of the membrane may be white, yellow or brown though usually it is greyish.

Recently, a child aged 8 years was brought to my Clinic for a swelling on the left side of the neck at its upper part. It was diagnosed as mumps by some one. The history of the case was that he had a severe fall on the head 15 days prior to the swelling when at Madras and the fever and pain on the left side of neck with swelling started a few days later. This was attributed by the family doctor to the fall. The father of the child said

that the child could not swallow but no history of throat lesion was forthcoming. The duration was five days and trouble unilateral. On a thorough examination, it was found to be a typical case of diphtheria which settled down remarkably well with 65,000 Units of detoxicated vaccine. Here is a case which from the history directs the medical attendant's attention to causes other than the real ones. The fall on the head 15 days previous was a factor that would easily divert one's attention from the real trouble.

In this short paper it is impossible to go into the details of treatment. One point, however, I would like to impress is, that when there is a strong suspicion of diphtheria, take the suspicious membrane for bacteriological examination, but without waiting for the results, it is better to give a proper dose of serum on strong suspicion. It does no harm if the report is negative. Irrespective of the age, the dose should be large enough to have therapeutic value. I need not mention that the usual precautions for serum treatment should be observed.

Acute lacunar or follicular tonsillitis is a frequent condition that any general practitioner might come across. This should not be mistaken for diphtheria, which it may resemble closely sometimes. Here the crypts of the tonsil are involved and in an inflamed, congested and swollen tonsil, one sees whitish spots, a sort of fibrinous matter of various sizes many of which, may coalesce and resemble diphtheritic membrane. It is important to know that these can be easily removed leaving no bleeding surfaces underneath as in diphtheria. Moreover, they are limited to the tonsillar surfaces and do not extend to the palate or to the uvula or the pharyngeal wall, though inflammatory symptoms may extend to the area surrounding the tonsil. There is a tendency to press the sides of the tonsils to see if pus is present. This procedure is harmful and should not

be done because there is a chance of driving the infection deeper and making the case worse by this procedure.

Quinsy

One of the commonest and most painful of the ailments of the throat, is acute peritonsillar abscess which is usually called 'Quinsy' generally a disease of the adult and seldom of children. It is characterised by pretty high fever, difficulty to swallow, dribbling of saliva with a thick muffled voice on account of the swelling and retained secretions in the throat. Due to inability to open the jaws well, examination is not easy. When well developed, the whole of the tonsillar region is swollen, highly congested and the uvula and the palate on the side are oedematous. The uvula is often pushed to the opposite side.

As the name suggests, the lesion is extra tonsillar and the tonsil may not be visible due to the enormous swelling. The cervical glands on that side are slightly enlarged and painful. The condition is almost always due to infection spreading from a septic tonsil. It is mostly unilateral and the adult male seems to be more frequently the victim. Though penicillin and sulfonamide therapy have their place in the early stage of the condition, they cannot replace surgery, when pus is present about the fourth day of the disease. An incision is to be made to relieve the agonising pain. It is however important to know some details of this procedure as any one of you might be called upon to deal with this condition in the mofussil practice, where specialists are not many and the condition is one of the common and most painful throat complaints. Any ordinary bistury is good enough but its blade should be well protected with adhesive plaster with the exception of half an inch of the tip. A superficial incision may be made with a sharp gum lancet as well and the pus is best evacuated by opening of the wound

The plug can be left over for about forty-eight hours. In some cases haemostatic serum might be needed. Cauterising the area with a bead of chromic acid on a small probe and neutralising with sodium bicarb solution is a good treatment in the quiescent stage.

Another cause of bleeding from the nose is fibro-angiomata or as is termed "bleeding polyp" of the nose. The treatment is easy. Removal by nasal snare is easily done. It has tendency to recur however, but cauterising the base after complete removal is effective.

Of the ear conditions, the most abused is foreign body in the ear. I had within the past few years, five serious cases of foreign bodies in the ears of children where carelessness on the part of the general practitioner cost the life of one of these five by labyrinthitis; and in another case mastoid operation had to be done for acute mastoiditis. Recently, I removed a foreign body from a child's middle ear, where it had no business to go but for the meddlesome surgery.

It must be the principle of every practitioner never to use any instruments to remove a foreign body in the ear, unless he sees what he does and that is only possible when a head mirror is used and an ear speculum is inserted and proper fine instruments are at hand. To add to this, he should have a full knowledge of the local anatomy. If these conditions are not fulfilled, it is a grave mistake to meddle with instruments specially in a child that is restless and unsteady. Try to remove by mild syringing with warm boric lotion. If you fail, send the case to a specialist unless you can remove it yourself under a general anaesthesia and using a head mirror and proper instruments.

Foreign body in the ear is a common condition. The removal is quite simple and easy but a false step is

fraught with grave danger. Suppuration in the middle ear is an extremely common condition in general practice. At the early stage, I suggest a few injections of penicillin G, 3,000,000 in 2cc of saline once in every 12 hours or 3,000,000 penicillin in oil and wax every 18 hours. In addition, instillation of penicillin ear drops every hour (1,000 unit per c.c.) and I like to stress upon the advisability of incising the drum when there is a bulging of the drum with strong suspicion of pus in the middle ear at the early stage. This simple procedure at the proper time with proper care and with a thorough knowledge of the local anatomy, is a factor much to be recommended and has a great influence in the further course of otorrhoea. The principle, "see what you do and know what you do" is to be strictly adhered to in all manipulations.

Facial paralysis is a symptom for which general practitioners are pretty frequently consulted. The routine treatment is application of blister below the pinna of the ear and drugging with potassium iodide and other medicines. Very few take the trouble to find out the cause of the condition. Whatever the prognosis of the symptom, one should not fail to find the root cause. Amongst the likely causes chronic middle ear suppuration is one. The practitioner is mostly ignorant of this. Always ask for such a history and if one is forthcoming, send the case to a specialist. A mastoid operation might be indicated in this case to prevent further troubles.

If a case of mastoiditis under your care, develops a high rise of temperature with rigour and perhaps vomiting, never fail to think of sinus thrombosis. An ordinary uncomplicated case of mastoiditis has hardly a temperature above 100-101 F. Immediate blood examination might be needed, to exclude malaria which it resembles and a grave error of diagnosis may cost the patient's life. In malaria,

you know there is leucopenia and specific parasites whereas presence of leucocytosis and absence of the parasites should put one on guard, specially when there is mastoid involvement.

Sometime back, I was called to see a case, an elderly lady of about 45 years, ten miles from my clinic. It appears a small growth in the external ear (no details as to its nature are available) was excised by a general practitioner and there was plenty of bleeding. In three days the patient had oedema and swelling near the mastoid region. There was high rise of temperature on the fourth day with rigor and vomiting and severe headache. This was diagnosed as malaria and a few quinine injections were given. On the eighth day when I was called to see her, the condition was very grave. There was a cordlike mass, the size of a lead pencil extending from the tip of the mastoid to the level of the of the sternoclavicular joint. There was history of blood stained stools. There was a boggy swelling of the mastoid region. It was a neglected case of sinus thrombosis with wider complications. She died within ten hours after I saw her. No treatment was possible.

In a case of suppurative otitis media if there is a sudden rise of temperature resembling malaria, do not fail to think of sinus thrombosis. In a country rampant with malaria, a general practitioner can be excused if he fails to think of this not too frequent a condition, but knowledge of this may help him to revise his opinion in certain grave cases of what he might call as cerebral malaria, fulminating dysentery etc.

"Polyps and granules" in the ear are not an infrequent malady of the ear in general practice. To go into the details of the pathology of this condition will be beyond the scope of my subject. But a few words of warning are necessary in the treatment. The

polyps do not as a rule give any trouble except for a little bleeding once in a way and slight deafness of varying degrees in proportion to the extent of destruction of the tympanic structures caused by the otitis media to which polyps and granules owe their existence.

But I would advise a general practitioner never to treat these cases lightly in spite of the fact that in most of the cases, it is a harmless procedure to pull them out with a forceps or a polyp snare. In one of the Medical Association meetings, a colleague said that the treatment of polyps of the ear is the easiest and can be done by any medical man. I have to disagree with this statement. That it is easy in over 90% of the cases I agree. That every doctor can treat it, I do not agree. It is no doubt simple; but once in a way, what we think is simple, is fraught with grave danger if you only know that careless handling of the case may set up labyrinthitis and cause the death of a patient in a few days. It is no use covering ignorance by attributing the death to some other causes. In all cases of polyps, it is necessary and imperative to make a test of the cochlear and labyrinthine functions before one decides to remove them by snares. When the functional test shows normal condition, the treatment is easy; but if the result indicates involvement of the labyrinth and cochlea, it is not permissible to do anything to the polyps by way of the external meatus. I, therefore, believe that the polyps of the ear should not be treated by a general practitioner very light heartedly if he is not well versed in the local pathology of the condition.

In general, however, removal of a pale, oedematous polyp is not fraught with danger and this fortunately is the case in over 90% of the patients. This type of polyp comes from the tympanic ring, whereas removal of the red, readily bleeding, highly vascular polyp may be dangerous as this type usually comes from the inner tympanic

walls having close connection with the labyrinth.

I have neither been too detailed in the treatment of any particular condition nor have I exhausted all the diseases of the ear, nose, throat, in so far as it effects a general practitioner. I have merely mentioned a few points with regards to the differential diagnosis and the treatment without being elaborate and exhaustive. Specialists

are very few in our country in any branch of medicine. The responsibility of a general practitioner is greater in this country than in the west where the patients choose their own specialists for all special diseases whereas in our country most of the cases have to pass through a general practitioner. Knowledge of certain conditions is therefore a necessary factor in the interest of the practitioner himself and of his patient.



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G. J. G.

(NOTE: These series contain no original matter and are only a compilation of well known useful therapeutic measures in a condensed form. They are published in the hope they will be useful as a ready reference for practitioners particularly in the mofussil.)

BURNS OF THE LIDS

1st degree: Sod. Bicarb. compresses to relieve pain.

Any emollient ointment.

2nd Degree: Clean with Saline.

Apply a pad soaked in cod liver oil. Sulphonamide power may be mixed with the cod liver oil.

Bandage lightly.

Keep the pad moist with cod liver oil dropped on it every 2 or 3 hours.

An oil silk covering the pad will be helpful to prevent drying, leakage and soiling.

Penicillin ointment or powder may also be used. Tannic acid not advisable.

Penicillin injections if necessary.

Cibalgin, Veramon or Codeine by mouth or morphia subcutaneously if pain is severe.

3rd Degree: Treatment as in 2nd degree. Later, skin graft.

BURNS OF CONJUNCTIVA & CORNEA

If from a splash of hot water or oil or from any spark or from hot cigarette ash, etc., wash the eye immediately with water. Apply any emollient ointment, castor oil or cod liver oil whichever is available immediately. The following ointment also may be applied:—

Ietham. 3 gr.

Sod. Carb. 1½ gr.

Mag. Sulp. 1½ gr.

Oculent Simp. ad. 100 gr.

If iris requires rest, a drop of Atropine sol. 1% or 1% or Homatropine sol. 1% (the latter in older people).

Cibalgin or Veramon orally, when pain is severe.

CHEMICAL BURNS. Wash the eye immediately with water—to remove from the eye every bit of irritating substance. Don't waste time in trying to ascertain whether it was an alkali or an acid, for using a neutralising solution.

After the wash, apply castor oil or cod liver oil or milk.

If the patient is in the hospital, after the first immediate wash, ascertain whether it is an alkali or an acid and irrigate the eye with Lotio Sod. Bicarb. 3% in case of acids and Lotio Acid Boric or vinegar in the case of alkalies.

Follow it up with any emollient ointment, cod liver oil or cod liver oil with any sulpha drug ointment.

If there is damage to the conjunctival membrane, daily go over the affected area with a smooth glass rod to prevent adhesions and symblepharon.

Prognosis should be guarded.

LIME BURNS. Irrigate with water immediately. Apply castor oil.

When the patient is brought to the hospital, free instillations of 10% sol. of Neutral Ammonium Tartrate 3 or 4 times a day, for 10 to 15 days. (The solution is to be freshly prepared). Sol. Ammonium Chloride 4% may also be used.

If there is incrustation of lime in the cornea, try to remove them and instil the above drops.

Any bland emollient or sedative ointment.

All children in school during the season should given 2 drops of Zinc sulph. sol. in each eye twice daily.

Clean castor oil or gingly oil may be lightly smeared over the margin of the lid of normal children, to prevent mosquitoes coming to the eye.

• In the home, the other children should not be allowed to play with the patient or use his clothes, towels, etc.

(To be continued)

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British Encyclopedia of Medical Practice Vol. 1 to 12 with surveys and abstracts for 2 years and cumulative index for 2 years.

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Correspondence

SIR,

When I gave a talk under the auspices of the Pudukottah branch of the Indian Medical Association three years ago on "Acute Abdominal Emergencies," a question was put to me if "Penicillin had a place in the treatment of Peritonitis of appendiceal origin." I was unable to answer the question then and said that time would give an answer one day. Today I am able to give an answer to that question and solicit the columns of our journal to do so.

It is my clinical impression that Penicillin does improve the outlook in peritonitis of appendiceal origin. This clinical impression however is not explainable on the basis of bacteriology because in vitro Penicillin has no action either on *Bac. coli* or *Streptofaecalis*, two of the principal causes of enterogenic peritonitis. Perhaps Streptomycin and still better Aureomycin will be more effective.

Yours,

(Sd.) P. V. KARAMCHANDANI,
Dist. Med. Officer, Vellore.

21-3-50

March, 1950]

ASSOCIATION NOTES

SOUTH INDIAN PROVINCIAL BRANCH

Proceedings of the meeting of the Council of the Indian Medical Association, South Indian Provincial Branch, held at 2 p.m. on 18-3-50 in the premises of the Coimbatore District Medical Association Buildings, Coimbatore.

Members Present:

1. Dr. P. A. S. Raghavan	President	Trichinopoly
2. Dr. D. V. Venkappa	Jt. Secretary	Madras
3. Dr. S. Chandrasekaran	Member	Cuddalore
4. Capt. A. B. Dass	"	Calicut
5. Dr. S. R. Rajaram	"	Salem
6. Dr. L. Muniswami	"	Coimbatore
7. Dr. K. V. Subramanyam	"	"
8. Dr. C. V. Ramaraj	"	"
9. Major N. Krishnaswami	"	Perundurai
10. Dr. B. S. Viswanathan	"	Trichinopoly
11. Dr. R. Ganesan	"	"
12. Dr. T. S. Balasubramania Iyer	"	Virudunagar
13. Dr. S. N. Ganapathy	"	Madura
14. Dr. K. G. Ramabhadran	"	Erode
15. Dr. C. H. Sivaraman	"	Vellore
16. Dr. T. M. Kumaraswami	"	"

Dr. P. A. S. Raghavan, the President took the chair.

1. The following resolution moved from the chair was unanimously passed.

"The South Indian Provincial Branch of the Indian Medical Association notes with supreme satisfaction, the unanimous election of Dr. Rajendra Prasad, as the first President of the Republic of India and prays for his long life, health and continued service to the country". Resolved to communicate the above resolution to President, Rajendra Prasad.

2. Minutes of the annual meeting held at Annamalaiagar on 9-10-1949 and published in the *Miscellany*, were adopted.

3. Statement of accounts upto quarter-ending December 1949 was read and approved.

4. All circulars from the Central Office were read and recorded.

5. Dr. B. S. Viswanathan of Perundurai, who will be in England in July, was elected as a delegate of the Indian Medical Association for the annual conference of B. M. A. to be held in Liverpool in July 1950.

6. Resolved to call for the present rate of printing Indian Medical Association Journal and call for quotations from printers in Madras, Trichinopoly and Coimbatore.

7. Regarding the suggestion of the Malabar Branch to take up with the Government, the question of unification of the Civil Medical Service and the suggestion of the South Arcot Branch, regarding the raising of pay and status of the L. F. Medical Officers on a par with those in Government service, the President informed the house that he had recently submitted a memorandum to the Government on the subject and was awaiting their reply for fixing a date.

8. Regarding the question of drug control rules, and the request of various branches that the council should take up the matter, the President informed the Council that the Joint Secretary Dr. D. V. Venkappa and some representatives from Madras had interviewed

the Commissioner for Ex. who had promised to look into the matter. The President was authorized to pursue the matter and do the needful.

9. Resolution of the Andhra Provincial Branch regarding compulsory refresher course was read and recorded.

A. K. RAJAGOPALAN,
Secretary.

D. V. VENKAPPA,
Jt. Secretary.

P. A. S. RAMAIAH,
President.

SOUTH ARCOT BRANCH

President: Dr. S. Sankararama Ayyar
Vice-President: Dr. S. Nataraja Jitavallabhar
Hony. Secretaries: Dr. V. Viswanathan
Dr. N. Ramachandran
Hony. Treasurer: Dr. P. Mahendramath Singh

The South Arcot Branch of the Indian Medical Association held its monthly meeting in the premises of the Govt. Head-Quarter Hospital, Cuddalore on 18-2-50 at 5 p.m. with Dr. S. Sankararama Iyar in the chair. Thirty-one members attended the meeting and the members were introduced to Dr. M. B. Prabhu, M.D.M.R.C.P.M.M., Superintendent Retd., Government Maternity Hospital, Madras, the chief guest and lecturer of the evening. After tea, the minutes of the last meeting were read and adopted.

Then Dr. M. B. Prabhu addressed the members on "Some observations in the treatment of diseases of Children". The learned lecturer, in the introductory portion of his talk emphasised on the extreme importance of clinical examination of the sick children and also examination of the urine and motions as the procedure affords valuable information for diagnosis. The diagnostic accessories such as laboratory tests and X-Rays should be assigned only a second place to the methodical clinical examination.

Then the lecturer spoke on common ailments of new-born, such as swelling

of the breast in both sexes due to deposit of maternal oestrogen, umbilical stump ulcer, constipation in children, hypertrophied sphincter of the anus as a painful and distressing condition in children, and anuria for 24 to 36 hours after birth due to delayed functioning of the tubules of the kidneys.

The lecturer described his vast experience in these conditions and their management with simple remedies.

In the discussion about diet of children, the lecturer said that it is extremely desirable that every mother should suckle her baby for at least seven months after birth. He enlightened the audience on various points about artificial feeding with proprietary food products in the market.

Finally in discussing about tympanites in children, Dr. M. B. Prabhu said that it is due to paralytic illness and is often the background of basal pneumonia or perforated appendix.

The meeting came to a close with a vote of thanks to the chair and to Dr. M. B. Prabhu for having readily agreed to our request to address our Association.

MADHURAI BRANCH

President: Dr. P. Vadamalayan
Vice-President: Dr. T. S. Renga Iyengar
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 25th March in the Erskine Hospital, Madurai. About 70 members attended.

After tea, which was provided by the Proprietors of the SP. S. S. Medical Hall, Madurai, the meeting commenced with Dr. P. Vadamalayan in the chair.

The minutes of the monthly meeting held on 21-1-1950 and the Annual Conference held on 25-2-1950 were read by the Hony. Secretary and adopted. The Hony. Secretary then gave a gist of the cholera reports sent by the Municipality. The president then introduced the lecturer of the evening.

Dr. S. Shanmugam, then read an exhaustive paper of "Polio" to the Enquiring Doctor. He discussed in detail the aetiology, the signs and symptoms, diagnosis and differential diagnosis and the treatment of this condition. He referred in particular to the latest trends in this disease collected from recent American literature.

The lecture was followed by an interesting and highly useful discussion in which Doctors T. R. Muthuramgam, T. V. Venkatesan, K. S. Krishnan, A. Unapathi Mudaliar, K. Balasubramaniam, K. Ramachandran, M. K.

Thyagarajan, and the President took part. The points discussed included the influence of convalescent serum and natural human serum in modifying the course of the disease, the optimum period in which to start physiotherapy, the necessity for the use of the Iron Lung in bulbar type with respiratory paralysis, the beneficent effect of Diathermy to the back within the first 10 days, the value of drugs like Vit. B complex, Prostigmine and strychnine in this disease, and also the use of 1% zinc sulphate solution applied to the nose and throat as a prophylactic during an epidemic. The lecturer also answered a number of questions. After the concluding remarks of the President, the Hony. Secretary proposed a vote of thanks.

The gathering then adjourned to the adjacent lawn to see the following films which were kindly lent by the kind courtesy of the United States Information Service.

1. DYNAMICS OF RESPIRATION.
2. WE WILL SEE THEM THROUGHER.
3. DEVELOPMENT OF NERVOUS SYSTEM.

The meeting ended at 8-45 p.m.

RAMNAD BRANCH

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

Minutes of the meeting held on 18-3-50 in the O. V. C. High School, Manamadurai.

About 35 members were present. The meeting commenced under the Presidency of Lt. Col. Parthasarathy. The

Minutes of the Annual Meeting held at Ramnad was read by the Secretary and approved.

Lt. Col. Parthasarathy delivered a Lecture on the Common Fractures and their Treatment. He showed the modern appliances for reduction of the Fractures and appealed to the mofussil

practitioners to dispense with the old method of using Splints (wooden) and advised them to use P.O.P. slabs.

The meeting concluded at 6-30 p.m. with Tea arranged by the Association. The Secretary proposed a vote of thanks to the lecturer, the Head Master of the school, and the others members.

TIRUCHY BRANCH

President: Dr. G. Joseph Gnanadickam
Vice-President: Dr. T. V. Srinivasan
Secretary: Dr. V. K. Ranganathan
Treasurer: Dr. T. V. Sundaram

The 21st Inaugural meeting of the association was held on Monday the 20th March 1950 at Cafe De Light, Trichinopoly. About 50 members were present. After a delightful Tea provided by Dr. G. Joseph Gnanadickam the new President, Dr. J. C. David, M.B.B.S., Ph. D. the Surgeon-General was introduced to the members and requested to preside over the meeting. Some of the difficulties of the members of the profession in the working of the Prohibition Act were represented to the Surgeon-General to which he gave a clear and satisfactory explanation.

He said Government were gradually provincialising the Local Board Medical services as they could not provincialise the service all alone on account of finance. Regarding control of some tinctures like Tr. Zingiberis and Tr. Card Co., he pointed that they were of therapeutic use and we should help government in their policy of prohibition. Dr. R. Sambasivam, M.B.B.S. then gave a "Review on Vitamins" which was followed by the usual discussion.

After a vote of thanks to the Surgeon-General, the lecturer and the host, the meeting terminated.

INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION TINNEVELLY

The 13th Annual gathering of the Independent Medical Practitioners Association, Tinnevely was held on 11-3-50, when there was a record gathering of Medical men, numbering over 40 coming from Tinnevely, Palamkottah, Melapalayam, Tuticorin, Sankarankoil and Nazareth. Dr. A. R. Viswanathan, the Hon. Secretary read the annual report. Dr. C. Ragavachari, M.S., F.R.C.S., Professor of Sur-

gery, Stancely Medical College, Madras delivered a lecture on "Medical Practitioner and Modern Surgery." Dr. N. Vydyanathan, M.D., District Medical Officer, Tinnevely delivered a lecture on Psychology and Medicine.

Resolution congratulating Dr. J. C. David who hails from Palamcottah on his appointment as Surgeon General with the Govt. of Madras, was passed

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unanimously. After dinner on the terrace of Dr. Kantayya's X-Ray Institute and a vote of thanks, the gathering dispersed.

The 13th Anniversary of the Rev. G. N. Kantayya memorial X-ray Institute, was celebrated on 13-3-50 when all the doctors who attended the annual gathering of the Independent Medical Practitioners Association were also present. After tea, provided by Dr. S. N. Kantayya, and dance recital by Kamala Kumari and Pritha Kumari aged 8 and 6 respectively, daughters of Dr. Kantayya, the function commenced. Dr. Kantayya read a report that the Institute was opened on

15-3-37 by Lt. Col. T. S. Shastry, I.M.S., the then Dist. Medical Officer, Tinnevely and named after Dr. Rev. G. N. Kantayya, B.A., L.T. Masulipatam, the father of Dr. G. N. Kantayya. In the course of the report Dr. Kantayya said that this was the only private X-Ray Institute in the District, and was doing the Local Govt. Hospital work till 2½ years back when the hospital was equipped with its own X-ray. He also said, that the Institute was equipped with a portable X-ray Unit and short wave machine, ultra violet and infra red ray lamps. It had also a branch at Tuticorin which was equipped with a 100 M.A. X-Ray plant and was being visited on Wednesdays of the week by Dr. Kantayya.

GOVERNMENT OF MADRAS

PUBLIC WORKS (INFORMATION AND PUBLICITY) DEPARTMENT

PRESS NOTE No. 38.

Dated Fort St. George, the 27th February 1950.

[Toor dholi, bengalgram, etc.—Artificial colouring]

It has been brought to the notice of Government that toor dholi, bengal gram and other pulses and flours, whether sold to the public or supplied to Government institutions, have been found to be adulterated with an artificial soluble yellow colouring matter which is poisonous. The consumption of articles of food admired with poisonous colouring matter, presumably to make the articles more attractive, will be injurious to health. The Government have therefore decided in public interests to prohibit such artificial colouration and are accordingly promulgating new rules under the Madras prevention of Adulteration Act, prohibiting the addition of colouring matter to certain edible articles and the possession and sale of such adulterated articles of food. Contravention of the rules will render offenders liable to prosecution both under the Prevention of Adulteration Act and section 108 of the Madras Public Health Act.

Stockists and prospective importers of adulterated pulses, grams and flours and fats and oils including hydrogenated vegetable products are warned not to sell or purchase them.

[Issued by the Director of Information and Publicity]

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

OINTMENT FOR TINEA CAPITIS—

The Practitioner—Dec. 1949.

The formula of an ointment for use in the treatment of ringworm of the scalp is given by H. Haber, R. T. Brain, and J. W. Hadgraft *British Medical Journal*, (Sep. 1949).

"Sallylanilide ... 5 g.
Crisol No. 6 ... 10 ml.
Solution of citric acid 2 per cent.
and sodium propionate 1 per cent. 2 ml.
Carbowax 1500 to 100 g.

Melt the carbowax 1500 over a water-bath, add the Crisol No. 6, dissolve the sallylanilide in the mixture, add the solution of citric acid and sodium propionate, and allow to cool, stirring occasionally."

The hair of the entire scalp is cut very short; the scalp is washed every morning with soap and water, the affected parts being scrubbed with a soft nailbrush; and the ointment is applied to the lesions with a toothbrush and spread over the scalp. A linen cap is worn day and night.

Of twenty-seven cases treated—20 *M. f. lineum*, 6 *M. audouini*, 1 *T. sulphureum*—75 per cent. were cured, the cure period ranging from six to sixteen weeks. The case of *T. sulphureum* proved resistant to the treatment.

* * *

CANDY TO STOP TOOTH DECAY—

You will be protecting yourself against toothache and tooth decay with every place of candy you eat and every lump of sugar you drop in your coffee in the future, if a plan proposed by the American Public Health Association goes into effect.

The plan calls for addition of a simple, tasteless chemical to all sugar at the refineries. It was proposed, as a means of banishing tooth decay, by Dr. L. S. Foadick of Northwestern University Dental School.

It is hailed by Dr. Hamilton Robinson, editor of the *Journal of Dental Research*, as "the greatest hope for mass control of caries (tooth decay)" yet found.

* * *

DRUG TO TREAT INFANTILE PARALYSIS—

Encouraging results in America.

The very encouraging results obtained at the University of Rochester Medical School, U.S.A., in the treatment of infantile paralysis by the new drug Myanesin, are now confirmed by wider experiment.

Reporting in the *Journal of the American Medical Association*, Dr. R. Plato Schwartz and Frank M. Berger say that of 59 patients given the drug by mouth all but one have shown improvement. Since their report was prepared, more than 30 additional patients have been treated and all but a few have shown improvement, some in the remarkably short time of ten to fifteen minutes.

Discovered in Britain, Myanesin, which is a synthetic chemical compound derived from glycerin, was first discovered in England in 1946 by Dr. Berger, a native of Czechoslovakia and now assistant professor of pediatrics and Rochester. It was originally used by injecting it into the patient's veins, but the present treatment by mouth seems much more effective.

The drug, according to a University of Rochester release, "effective & relieves or sometimes completely overcomes the muscle spasms which affect victims of infantile paralysis and the spasm plus inability to control movements often present in cerebral palsy sufferers."

Myanesin relieves, but does not cure. It cannot help those whose nerves have been destroyed, or whose condition is complicated by certain factors involving the central nervous system. The drug is not available to physicians generally, its use being still restricted to clinical investigation.

* * *

SULPHONE DRUGS FOR LEPROSY

—Research in Calcutta.

Three new drugs of the sulphone group, promin, diasone and sulphetrone, have been tried out in the treatment of leprosy by the leprosy research workers at the School of Tropical Medicine, Calcutta, with very encouraging results. Although these drugs have certain limitations, they have proved

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particularly valuable in the treatment of those cases of leprosy which cannot tolerate injections of hydnocarpus oil.

VITAMIN B₁₂ IN TROPICAL MACROCYTIC ANAEMIA—*L. C. Patel, Br. Med. Journal—2. 11. 48.*

Patel reports on the excellent results obtained by him in the treatment of two cases of macrocytic anaemia, with Dester Smith's crystalline anti-pernicious anaemia factor (Vitamin B₁₂). The diet given to the patients consisted of milk, bananas, vegetables, rice bread and dal, "as the author had found in his earlier work that this diet did not produce any haemopoietic effect. The patients received single injections of a solution containing 80 mg. of the substance and this was followed by pronounced reticulocyte responses. The bone marrow which was megaloblastic before the injection had become normoblastic in a week after the injection. T. N. S. R.

RADIO-ACTIVE SODIUM IN LEUKAEMIA AND ALLIED DISORDERS—

Am. Journal of Roentgenol—April 48.

Evans *et al.* tested radio-active sodium in 24 cases of chronic myelogenous leukaemia acute and chronic lymphatic leukaemia in polycythemia vera and in single cases of various generalized malignant conditions. The results justified the conclusion that the administration of radio-active sodium is an effective means of giving protracted whole body irradiation. The response was poor in acute leukaemia and in cases where the haematopoietic system was already damaged. In other cases the results were very good. Radio-active sodium is quite effective when administered orally and avoids some of the complications observed in intravenous applications.

In view of its short half-life (only 15 hours) its use is necessarily limited to institutions situated near to the source of supply. T. N. S. R.

* * *

FOOD VALUE OF HONEY—

B. M. J. April 48.

Honey is reported by Charley (in *Chemistry and Industry* 1947) to contain on an

average: Moisture 17.7% Inert Sugar 75%; Sucrose 2.0% Dextrin 1.5% Ash 0.18% with traces of pollen, wax and nitrogenous matter. Other authorities give a range as follows:—water 8.25%, glucose 30.42%, fructose 23.40%. The sugars in honey are readily absorbed. It does not give rise to gas in the intestine. It can be used in place of glucose or cane sugar in diets. It is slightly laxative. There is no foundation for the belief that it promotes the formation of Haemoglobin in the blood. Its iron content is only 0.11 mg. per ounce. Honey adulterated with cane sugar loses its natural flavour and taste. A wide range of figures has been recorded for the Vitamin C content of honey but it is usually of the order of 5 to 20 mg. of ascorbic acid per 100 grammes, so that even the unusually rich honey will not contribute much to the daily requirements when taken in moderate quantities. Convincing evidence for the presence of aneurin, riboflavin or nicotinic acid in honey, in useful amounts is not available. A solitary reference to the presence of Vitamin A in the honey-comb does not justify our regarding it as a source of this vitamin. There is no trustworthy record of the presence of B-carotene in honey as consumed. T. N. S. R.

RIGHT HANDED OR LEFT HANDED

—The Practitioner—June, 1949.

In a review of "handedness", R. S. Eustis (*New England Journal of Medicine*, February 17, 1949 240, 249) points out that at the present time approximately 95 per cent. of the adult civilized world is right-handed. There has been a steady diminution in left-handedness throughout the ages about 50 per cent. of stone-age implements were made for left-handed use, compared with only about 25 per cent. of bronze-age implements. There is a similar diminution in left-handedness with age, 20 per cent. of kindergarden children, 10 per cent. of school children, and only 5 per cent. of adults. Both environment and heredity probably play a role in the production of left handedness. It is also suggested that "there is some relation between a tendency towards ambidexterity and comparative weakness in the use of language". Left-handedness and ambidexterity are both said to be more common among children, the mentally retarded, criminals and

geniuses. The explanation in the case of the last is that "geniuses by and large are extremely individualistic and hence more likely to resist successfully the external pressures toward right-handedness". It is considered that the chances of producing stuttering by teaching an apparently left-handed child to write with the right hand have been exaggerated. All such children should be so taught when writing begins because "the use of the right hand fits in better with the left-to-right direction of writing and also because it conforms to the custom of the majority and hence is easier psychologically." Only if signs of nervous strain develop, such as stuttering, should the attempt be given up. In teaching the child who is to use his hand, it is important that the paper should be properly placed, i.e. slanted with the top border to the right. Such children should also be allowed to write with a slight back-hand slant, if they so prefer.

ACTION OF NEUTRALISING AGENTS ON GASTRIC ACIDITY—

Duften and Abel in Review of Gastroenterology—New York—Vol. 7.

Acidimetric titration of the gastric juice from 30 normal persons, showed that milk of magnesia, and tablets of effervescent magnesium hydroxide have the same immediate action as antacids but the action of the effervescent preparation lasted longer.

T. N. S. R.

SUBDELTOID BURSITIS WITH CALCIFICATION—*Med. Ann. of Columbia—July 1948.*

Pelland and Hoffman advocate the surgical approach to the treatment of acute subdeltoid bursitis with calcification. The procedure is very simple, rapid and dramatic in effect and consists in the evacuation of the bursa through an incision 3 cm. long or less, and the exploration of the musculotendinous rotator cuff of the shoulder through the floor of the bursa.

The presence of pains and X-ray demonstration of a calcification in the region of the shoulder, are the main indications for this operation. The authors performed it in 38 cases in all but one of which it

produced complete and marvelous rapid relief.

T. N. S. R.

FECAL IMPACTION—

Question: Is there a more satisfactory method than manual removal of pasty stools which remain in the rectum of bed-fast patients? Oil emulsions by mouth and warm oil or soap enemas seem useless. Sometimes the finger cannot reach or entirely remove the stool.

Answer: The following measures have been found helpful in the removal of fecal impactions and the control of conditions such as that which is described. Warm saline irrigations given every two to three days with the patient in the knee-chest position will suffice in milder cases. The instillation of warm liquid petrolatum, 1 to 3 ounces at a time, at bedtime is helpful. The instillation of a weak peroxide solution helps to break up the fecal mass. This is prepared by adding one part of peroxide to three or four parts of warm water. It should never be stronger than that because of the possibility of a so-called peroxide proctitis. In spite of the measures, it may still be necessary to have the mass broken up manually.

J. A. M. A.

Question: What is the explanation of the relief from headache obtained by some patients by chiropractic adjustments?

Answer: A few headaches may be due to sustained contraction of the muscles of the scalp and neck. The application of and massage may tend to produce temporary or even permanent relief. Experimental data clearly indicate that the mechanism of the pain is due to sustained muscle contraction. Cervical arthritis per se usually does not cause headache.

It is erroneous to assume that relief of headache following chiropractic treatment is due to realignment of supposedly misplaced cervical vertebrae. The psychic factor in headaches must invariably be considered.

J. A. M. A.

THE TREATMENT OF THREATENED ABORTION—*S. G. Clayton, MD, MS, FRCS, MRCOG—The Practitioner—December, 1949.*

About 80 per cent. of miscarriages occur during the first third of pregnancy, and the third month is the most critical time. After the twelfth week the placenta is fully localized, and the anchoring villi of the chorion become more securely attached to the maternal decidua. From this time onwards the placenta is a more important source of oestrogens and progesterone than the corpus luteum, and the third month may be a transitional period during which the placental function is still uncertain.

Some Causes and Their Treatment—

Those cases of miscarriage due to the rejection of a malformed embryo are usually inevitable. If a threat does not materialize the chance of foetal abnormality is small, and it is quite unjustifiable to refuse treatment for fear of the retention of an abnormal foetus.

Uterine abnormalities, such as fibroids, deep cervical lacerations, and minor congenital defects, may cause abortion, but are obviously untreatable during pregnancy. Although abortion in a first pregnancy is sometimes due to a minor degree of uterine hypoplasia, oestrogenic treatment would not be recommended at the actual time of bleeding, as the blood level of oestrogens is usually normal in cases of abortion, and there is no evidence that the uterus will respond any better to additional oestrogens. Such cases often succeed without treatment in a second pregnancy. In cases in which a retroverted uterus is discovered, correction is not advised while bleeding is in progress, unless there is retention of urine. It is doubtful if uncomplicated retroversion is a cause of abortion, and manipulative correction while bleeding is in progress will increase rather than diminish the risk of abortion.

In those cases in which abortion is due to some maternal illness, foetal death usually precedes expulsion, so that treatment is impossible; the damage is already done.

There remains the majority of cases in which the cause of abortion is obscure or hypothetical, and I shall discuss these more fully. The decision whether or not to perform a vaginal examination is important. This should never be done without reason in cases of abortion, and always with full aseptic technique. If the patient is already known to be pregnant, and has only slight bleeding without pain, vaginal examination

should be deferred until bleeding has ceased. If there is pain or severe bleeding the abortion is usually inevitable, so that examination will make matters no worse, and should be done both to assess the size of the uterus and dilatation of the cervix, information which will assist in the further management of the case; and also to exclude an ectopic gestation. In all cases in which bleeding, however slight, continues for more than two weeks, the cervix should be examined with a speculum, when some other cause of bleeding may be found, such as a cervical erosion or polyp.

General Treatment.—Complete rest in bed remains the most important, if not the only, effective measure, and should continue for not less than five days after the loss ceases. The true importance of this must be impressed upon the patient, who so often imagines that some injection or vitamin is of greater or alternative value. Sedatives have no specific purpose save to allay apprehension and restlessness. Morphine is often prescribed to inhibit uterine contractions and although large doses may do this temporarily, smaller does increase uterine action, and it is doubtful if the ultimate outcome is affected by its use.

Hormone Therapy.—The value (or danger) of corpus luteum hormone in cases of threatened abortion has been much discussed. Until recently it was thought to inhibit contraction of the uterus. Although this is the case in certain species it is not true for the human uterus, and many clinicians have remarked on the increased uterine activity and expulsion of the ovum that may follow its use. It might still be useful for quite another reason that it is essential for the maintenance of the decidua; and it may reasonably be prescribed in cases that have miscarried in previous pregnancy, but are not now bleeding. If bleeding is actually occurring it cannot be recommended; for it would not alter the decidua quickly, and if it increases uterine activity the total effect will be more harmful than useful. Progesterone is excreted in the urine as pregnanediol, but estimations of this substance have not assisted in either estimating the probability of abortion or of the need for progesterone. If it is decided that the corpus luteum hormone is to be given to maintain the decidua (which I would not recommend

allowance for the congestive element may render it tempting to rely on simple catheterization in the home with apparently satisfactory immediate results. It cannot be emphasized too strongly, however, that complete retention is rarely brought about by congestion alone, and that an occult obstructive element with more serious potentialities usually exists. If catheterization is adopted, a covering course of chemotherapy should be prescribed to minimize the risk of infection, and even if apparently normal micturition is restored the case should be subjected to full urological review at an early date. In no circumstances is it justifiable to proceed with hormonal therapy or other palliative measures until complete investigation of the case has been carried out.

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HIRSUTIES OF THE UPPER LIP—
F. Ray Betley, M.D., M.R.C.P.,—*The Practitioner*—December 1949.

I should greatly appreciate advice in the case of a woman patient, aged forty-seven, single, who has suffered for many years from a growth of hair on the upper lip. She has always been self-conscious about it, but she now says that it is "getting her down." Otherwise she has led a normal life in business.

A growth of hair on the upper lip in a woman of this age is sometimes a familial affliction, but more often develops about the menopause, when it presumably results from the diminution in the production of female sex hormones. In a few cases, disease of some part of the endocrine system can be identified. The existence of an abnormal endocrine state should always be considered, but endocrine treatment is not indicated, nor is it likely to succeed, unless there is clear evidence other than the hirsuties of endocrine upset. Even when endocrine imbalance can be demonstrated, treatment with hormones is not always successful.

In the great majority of cases the treatment consists of suitable physical measures. When individual hairs are thick and strong a permanent epilation with electrolysis is the most satisfactory treatment. It is tedious, and as only a limited treatment can be given at each session, the whole period of treatment usually extends over a few months. It has the advantage of

being permanent. When growth of hair is fine and downy, electrolysis is not usually possible. In a dark-haired person it is often sufficient to bleach the hairs with hydrogen peroxide every few days. In other cases the hairs may be removed either by cutting with scissors or with clippers, or with an electric razor. It is extremely unlikely that either of these procedures encourages the growth of hair. There is no great objection to the use of depilatory creams, but they must be used with care in order to prevent irritation of the skin. Shaving with an ordinary razor, plucking, or epilation with wax are better avoided, as they may perhaps actually stimulate the further growth of the hair.

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THE BLADDER IN PARAPLEGIA—
Clinical Journal—Nov. Dec. 1949.

How much can be done to help the state of the bladder in the paraplegic patient is discussed by H. Donovan in a recent review of this subject.

The normal reflex act of micturition depends upon a local reflex arc involving the second, third and fourth sacral nerves, the afferent and efferent impulses passing through the nervi erigentes of these nerves. The voluntary control of micturition descends from the cortex in the lateral columns. This control is partly inhibitory and partly a mechanism to initiate micturition which is thought to occur as a result of an initial voluntary relaxation of the perineal muscles.

If the bladder remains intact below a transverse lesion of the cord it is at first atonic and then begins to act automatically after a varying period of time, the latter depending chiefly upon the site of the lesion. Lesions of the cauda equina do not as a rule permit of development of an automatic bladder, but lesions above that level do.

The types of bladder commonly met with are firstly the atonic paralysed bladder, or the atonic neurogenic bladder; secondly, the reflex or automatic bladder; and thirdly, the bladder in cauda equina lesions.

The atonic type is encountered in the initial phase of any cord injury and in

certain neurological disorders, and the reflex type is encountered in the recovery phase when the cord is interrupted above a surviving bladder centre.

In the case of the atonic neurogenic bladder suprapubic cystostomy is advised. The bladder should be drained directly into a Kiener, and should be washed out with a suitable antiseptic twice a day. Tidal drainage is liable to be followed by pyrexial attacks, and the urine is not so clean as when drainage is direct. The suprapubic tube should be changed weekly, and it is essential that the tube should not become blocked, as this is frequently followed by a pyelonephritis.

Suprapubic drainage is regarded as better than a catheter for the atonic bladder as the urethra is frequently damaged by the catheter, and in any case infection can rarely be prevented.

If the atonic bladder later becomes the reflex type closure of the bladder may be carried out, and when good reflex micturition develops the patient no longer suffers from constant re-infection, and it may become possible to eradicate organisms from the urinary tract.

In the case of the autonomous bladder it has been found almost impossible to close the bladder, attempts at so doing being followed by severe pyelonephritis, necessitating re-opening.

The most important recent advance in the treatment of the paralysed bladder is the operation for resection of the bladder neck. This operation often brings considerable improvement in bladder evacuation, although the mechanism of why it should do so is not very clear. It has, however, been suggested that in the course of the resection the external sphincter becomes dilated by the drag of the resectoscope, and that this weakening facilitates evacuation.

The importance of adequate treatment of the paraplegic bladder cannot be overstressed in view of the complications which may occur. The most important of these are severe ascending urinary infection, leading to prolonged pyrexia, stone formation, and where the urethra has been instrumented, urethritis with stricture, sloughing of the floor of the urethra and epididymitis.

Prevention of ascending infection depends chiefly upon unobstructed drainage and on an active urinary excretion, in addition to particular care of the patient's general health. Stone formation is a minor matter if it occurs in the bladder, but should be prevented from forming by adequate fluid output and frequent movement of the patient.

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THE DIFFERENTIAL DIAGNOSIS OF PALPITATION—*Samuel Oram, M.D., F.R.C.P.,—The Practitioner August 1949.*

By palpitation is meant consciousness on the part of the subject of the beating of his own heart. The word comes from the Latin *palpitare* to throb. The purpose of this short article is not to adduce a list of lesions which may at times cause palpitation, but to emphasise that although such causes are legion the symptom is almost always a harmless one, and only exceptionally a sign of serious heart disease. To this end the following clinical classification is suggested:—

(1) No disease is whatever is present. This by far the largest group.

(2) Disease other than of the heart is present. This group accounts for most of the remaining patients.

(1) Cardiac disease is present. This is a most uncommon group, and even here it is distinctly unusual for palpitation to be the presenting symptom in a patient suffering from cardiac disease.

No organic disease.—J. C. Williams of Edinburgh, over a century ago, clearly recognised the frequent absence of disease in cases of palpitation, as is shown by the title of his book "Practical Observations on Nervous Sympathetic Palpitation of the Heart, Particularly as Distinguished from Palpitation the Result of Organic Disease" (1836). In sensitive individuals consciousness of the heart beat may arise from physiological causes such as exertion, and as a result of a sudden fright. It is common during convalescence from debilitating disease. The sensation is commonly described as being rather unpleasant, but it is never associated with pain. There may be no disturbance of cardiac rhythm present, or if an arrhythmia is responsible for it, it is an important one such as

extrasystoles of supraventricular paroxysmal tachycardia. This type of palpitation may occur when the patient is worried and is apt to be troublesome when the subject is just falling off to sleep. The patient with extrasystoles may complain that his heart stands still, or he may be conscious only of the forceful contraction following the pause. Similarly, the patient may be conscious only of the onset or offset of about of paroxysmal tachycardia. It is not yet sufficiently widely appreciated that paroxysmal tachycardia, after extrasystoles, is the most common arrhythmia, and that the supraventricular type, which is so much commoner than the ventricular variety, is only exceptionally the result of heart disease. Often no cause is discoverable and the outlook is excellent. Excessive smoking and over-indulgence in tea or coffee may give rise to palpitation, and a simple tachycardia is usually found. Alcoholic excess may lead to palpitation, and it is being increasingly recognised that this may be due to a transient bout of auricular fibrillation. Samuel Levine recently discovered a few such cases among interneers!

Non-cardiac Disease.—By far the most common of these conditions is the effort syndrome. This is best regarded as one of the many facets of an anxiety state. Its synonym of "irritable heart" is a poor one—it is the patient who is irritable. Sometimes the palpitation is associated with a stabbing pain beneath the left breast.

Of the organic diseases, flatulent indigestion heads the list. Broadbent's advice was that when a patient complains of the heart, examination of the stomach should be made; and, of course, examination of the gall-bladder must not be omitted in such a case. Anaemia of any severity is commonly accompanied by palpitation. This is closely associated with exertion and may, in fact, be the presenting symptom. Pulmonary tuberculosis, with or without anaemia, may also present in this manner. Masked thyrotoxicosis also must always be carefully excluded. This is particularly so if auricular fibrillation without obvious cause is present; but simple tachycardia may be sufficient. The diagnosis of thyrotoxicosis is suggested if extrasystoles occur together with tachycardia. Any condition embarrassing the

heart by local pressure, such as a pneumothorax of pleural effusion, or tympanites, ascites or even pregnancy, may result in palpitation. Palpitation is very common during the sudden hypertensive crises due to the outpouring of adrenaline from the rare pheochromocytoma of the medulla of the suprarenal. Because it is accompanied by tremour and sweating it may easily be attributed to an anxiety state, but there is also migrainous headache, and sometimes anginal pain appears.

Cardiac Disease.—So rarely does a patient with heart disease give palpitation as the main complaint that in any case offering it as such it is almost an assurance that the heart is healthy! Nevertheless, patients with auricular fibrillation do occasionally complain of palpitation and in a few of these the sensation can be extremely unpleasant. Auricular flutter, with or without a varying block, may cause similar symptoms and an electrocardiogram is often required to distinguish it from auricular fibrillation. Heart block is another rare cause and the patient may complain that his heart beats too slowly and too forcibly, although it is more common for him to be aware of occasional dropped beats. Again, it is the sensitiveness of the patient that counts and not the degree of slowness of the heart or the number of beats dropped. Very rarely, the hypertensive patient will complain of "pounding" in his chest and head and a patient with an aortic reflux may do so. Following lumbo-dorsal sympathectomy for hypertension, palpitation may be associated with transient postural hypotension.

Treatment:—From what has been said regarding the etiology of palpitation it follows that a complete examination is required in every case. Although in the majority of cases no disease will be discovered, its reassurance value to the patient is without equal. A simple explanation of his symptom is all that is required. The administration of sedatives is to some extent an admission of defeat, but it may be justified for a short time, perhaps to tide the patient over a period of particular stress. With a frank anxiety state it may be advisable to seek the help of a psychiatrist.

Extrasystoles are a common cause of the

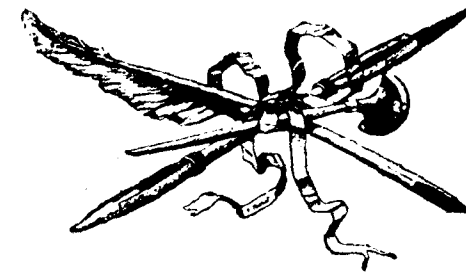
patient's discomfort and they can usually be regarded as, to use Wenckebach's phrase, "harmless nonsense of the heart". Unfortunately, at times they may result from serious heart disease, and it is for that reason that it is recommended that an electrocardiogram be taken. In health the form of an extrasystole remains remarkably constant for many years, down to the smallest notch. In disease, ventricular extrasystoles may be variform or they may alternate in shape and direction. Sometimes a hint that cardiac infarction has occurred may be gained from their appearance. Rarely, after a bout of extrasystoles, the diseased ventricle may show transient electrical alternation of the QRS complexes or, still more rarely, of the T waves. Even if extrasystoles are the result of cardiac disease, the decision whether or not to use quinidine for the prevention of this type of palpitation is not easy. I am of the opinion that it should not be employed without some definite indication, and three types of patients fall within this category. The most definite of these is the patient who develops numerous ventricular extrasystoles following cardiac infarction. Here quinidine is given, not so much to abolish palpitation but with the object of preventing the onset of ventricular tachycardia or ventricular fibrillation. Another instance, although rare, is the non-neurotic patient who is experiencing such frequent extrasystoles that they are causing giddiness and faintness. Finally, in a patient known to have mitral stenosis, the appearance of auricular extrasystoles sometimes presages auricular fibrillation. In such a case quinidine may be given in the hope of postponing fibrillation.

DESTROGENS IN THE TREATMENT OF ECZEMA OF THE NIPPLE—*The Practitioner*—August 1949.

From their observations in 100 cases of eczema of the nipple and areola seen at the Kasar El-Ainy Hospital, Cairo, A. H. Shabban and Hassan Seif El-Nasar (*British Journal of Dermatology and Syphilis*, June 1949, 61, 216) consider that endocrine factors play a predominant role in those cases occurring: (a) in the early years of menstruation; (b) during pregnancy and lactation; (c) and following the menopause. In their 20 cases in young girls, and 10 cases over the age of forty rapid recovery followed the local application of an ointment containing 2 mg. of stilboestrol in 25 g. of lano-vaseline: complete cure resulted within a fortnight in 80 per cent. of the girls and in 60 per cent. of the menopausal women. In those cases which did not respond completely to local treatment, oestradiol benzoate (10,000 I.B.U.) was also given intramuscularly every fourth day. In cases occurring at other times during the menstrual life of the patient a stronger local application was required, and the following formula was found of value:—

Stilboestrol	250 mg.
Crude coal tar	5 g.
Zinc Oxide	50 g.
Talc	50 g.
Liquid paraffin	20 g.
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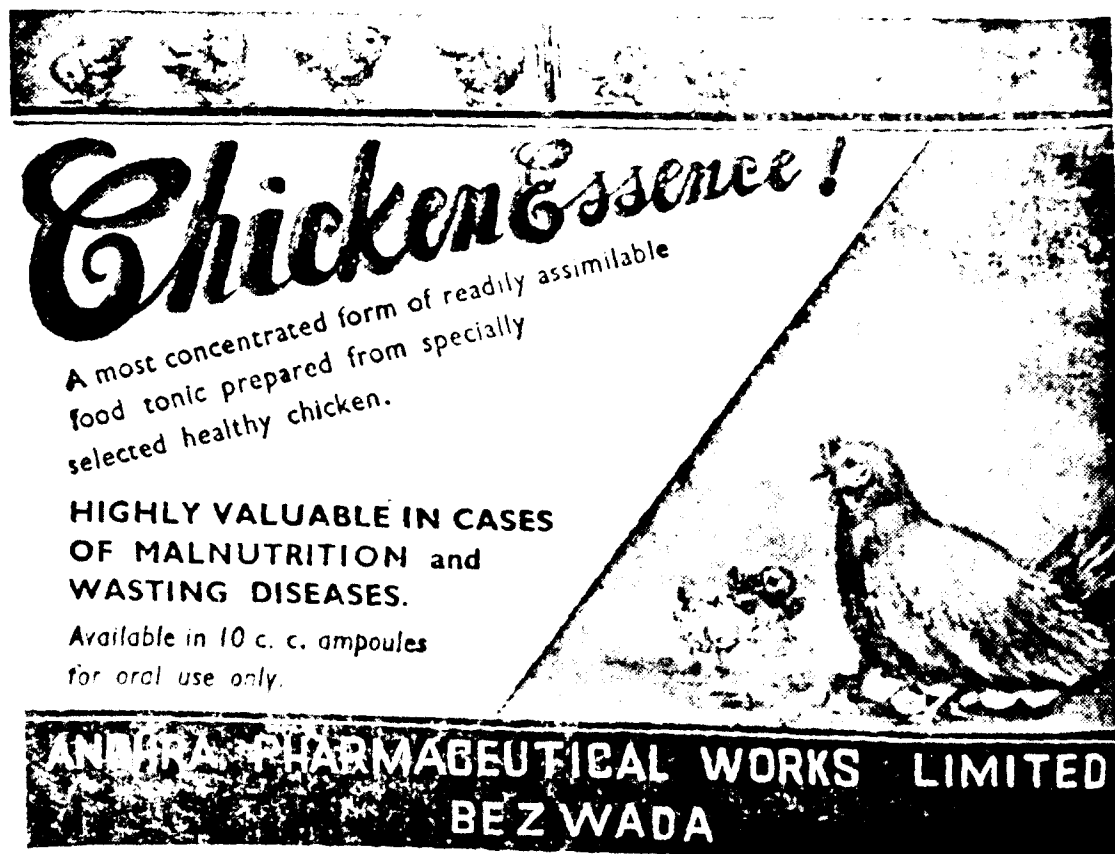
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"Bad sighted! Why at the zoo, I saw him looking at the Hippopotamus through a magnifying lens."

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Didn't you claim when you sold me this car that you would replace anything that broke or was missing?"

"Yes, Sir, What is it?"

"Well, I want four front teeth and a collar bone."

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"Take a hot bath before retiring and you will sleep well."

"Before retiring, doctor? I shouldn't be retiring for five years more!"

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"Did you see any one about this pain in the leg?"

"Yes doctor." "I consulted a native physician next door."

"He must have asked you to do some stupid thing eh."

"Yes doctor, he asked me to go and see you."