

164

सर्वजनाः सुखिनो भवन्तु

THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

364
3

Vital in the treatment
OF GASTRO-INTESTINAL INFECTIONS

'THALAZOLE'
PHTHALYLSULPHATHIAZOLE

DOSAGE
For an adult the average dose is 8 tablets daily for 3 days, followed by 4 tablets daily for 4 days. The dose for children should be one-half and for infants one-quarter that recommended for adults.
Literature on request

- features* 485
- ① Low absorption — absence of crystalluria
 - ② Low dosage — absence of toxicity
 - ③ Prolonged action — high local concentration
 - ④ Economical

Indications

Bacillary dysentery • Colitis • Cholera
Enteritis • Secondary infections

Supplies

Containers of 25. and 500 tablets

MAY &  BAKER

MAY & BAKER (INDIA) LTD. BOMBAY • CALCUTTA • MADRAS • LUCKNOW

INDIAN MEDICAL ASSOCIATION, DELHI

Dated: 30th March, 1950

To

HON. SECRETARIES, ALL PROVINCIAL SECRETARIES,
Indian Medical Association.

DEAR SIRS,

Subject to the final approval of the Minister of Health of Eire, the Joint Board of the Grangegorman Mental Hospital, Dublin has agreed to appoint one Indian Doctor possessing qualification registrable in Great Britain and Ireland to the post of Clinical Clerk (out of six vacancies).

This hospital controls about 3,000 beds in and around Dublin and the place has been secured through the kindness of Dr. John Dunne the Chief Resident Superintendent of the Hospital and Professor of Psychiatry in the University of Dublin.

Terms of Appointment:—

SALARY: £ 150/- per annum, with board, lodging laundry and attendance
PLUS £ 20/- p. a. temporary bonus

TENURE: For six months from 1st August to 31st January.

This will be a very good opportunity for any doctor wishing to specialise in this branch of medicine.

Will you kindly forward the application of any suitable candidate from your area as soon as possible? The selected candidate will have to make his own arrangement for passage, pass-port etc., at his own cost and be prepared to reach Dublin before 1st August, 1950.

Yours faithfully,

(Sd.).....
Hony. General Secretary.

INDIAN MEDICAL ASSOCIATION, DELHI

Central office
Circular No. 77/49-50

Delhi, 29th April, 1950

HON. SECRETARIES,

All Provincial Branches of the I. M. A.

DEAR SIRS,

Further to this office letter of 30th March '50, confirmation has now been received that one Indian doctor will be accepted as Clinical clerk at the Grangegorman Mental Hospital, Dublin, with effect from 1st August, 1950 upto 31st January, 1951.

The person to be appointed must:

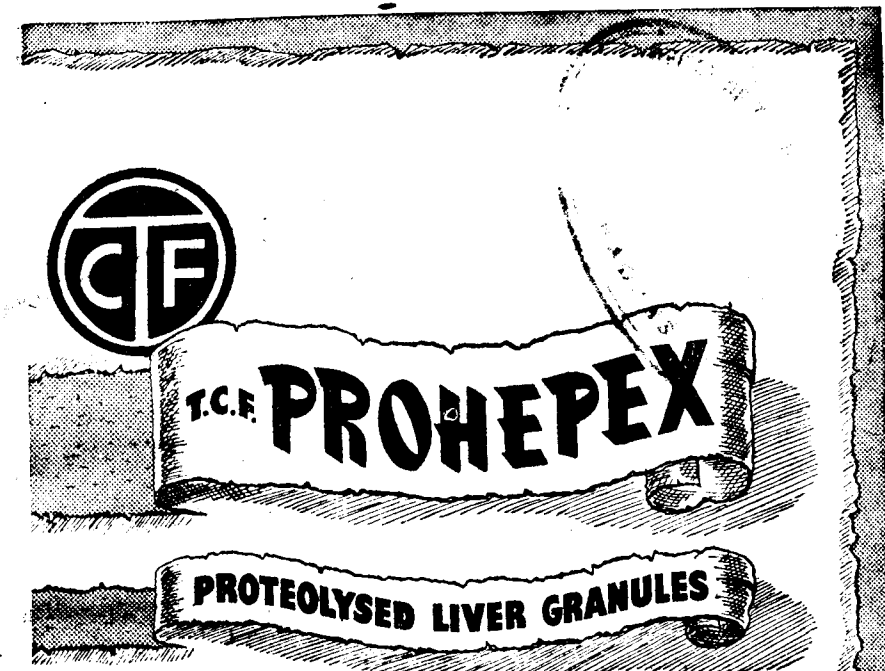
- (1) be of good character
- (2) have attained the age of 23 years on 1st July, 1950.
- (3) be of good health.

The candidate will be required to register with the General Medical Council in Ireland before taking up duty on 1st August next. For the present this post is open only to a male candidate.

A full statement of qualifications and experience of the candidate is also required. Applications should reach this office (through the Provincial Secretary) by the 31st of May, 1950.

Yours faithfully,

(Sd.) A. P. MITTRA,
Hony. Joint Secretary.



- ★ Containing entire anti-anaemic principles, Vitamin B-Complex and Proteoses as well as Folic Acid in natural proportion.
- ★ The T.C.F. proteolysation process greatly increases the anti-anaemic effect of liver.
- ★ Indicated in cases of Tropical *Macrocytic Anaemias* in general (particularly those refractory to liver injections), sprue, *Hypoproteinemia* before and after surgical operations and general debility.
- ★ Available in bottles of 2 ozs., 4 ozs., and 8 ozs.

A Product of
**TEDDINGTON CHEMICAL
FACTORY LIMITED**

Sole Distributors: W. T. SUREN & CO., LTD., P. O. BOX 229, BOMBAY 1.
Branches: CALCUTTA: P. O. Box 672. MADRAS: P. O. Box 1286.

Bivinal

VITAMIN B. COMPLEX

Elixir & Injections

THIAMINE
RIBOFLAVIN
NIACIN
PYRIDOXINE
PANTOTHENATE
YEAST

Beriberi, Pellagra,
Nutritional Oedema,
Neuritis and Allied
Neurological dis-
orders, Digestive
disturbances, certain
conditions of incr-

Bottles of 4 ozs. & 1 lb.
Bulbs of 20 C. C.



ALEMBIC CHEMICAL WORKS
COMPANY LIMITED, BARODA.

eased need such as
Pregnancy, Lactation,
Growth and increased
Metabolism. Also for
cases of subclinical
deficiency.

ADTS AL 366

THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
THE INDIAN MEDICAL ASSOCIATION

VOL. XVI]

APRIL 1950

[No. 10

PUBLIC HEALTH WORK AND THE GENERAL PRACTITIONER

BY

DR. K. R. KINI, M.B.B.S., *Mangalore.*

At the last Annual General Meeting of the Mangalore Branch of the I.M.A., it was decided that the members are to help the Public Health authorities by trying to implement the Public Health Act in such manner as it was possible for them to do. The work that was considered to be immediately feasible to do was (1) to help in the collection of vital statistics by properly reporting infectious diseases (2) to help in reporting the correct cause of death and (3) to carry out prophylactic measures in fighting diseases like typhoid, cholera etc. So, it was decided to formulate a scheme of work in consultation with the Health Officers in the District. Further stimulation was provided by (1) an extract from an appeal by the President of the I. M. A. and (2) an article in one of the latest issues of the Journal of the American Medical Association in which the Health Officer of Detroit U. S. A. has given a detailed survey of the working of the Detroit plan as it is termed, for the past few years. In this article the result of cooperation between the General Practitioner and the Public Health Staff has been given in detail, so much so, it is said that some diseases have become rare in Detroit. So, I chose the above heading for today.

At the outset let us know the different spheres in which the General Practitioner and the Public Health Staff can work together.

(1) Medical Inspection of school children and follow up.

(2) Industrial health, diseases and disabilities.

(3) Prophylactic measures against infectious diseases.

(4) Collection of Vital Statistics.

(5) Health education of the Public.

In Western Countries all the five items of work come under the Health Staff with medical men in charge of the first two. In this country the first item is still under the control of the curative side. The second is just now being considered by the Central Government with the enactment of the Employees' State Insurance Act. The last three are under the control of the Public Health Staff. The two sides of work being divided have tended to be in water tight compartments and there has been no mutual understanding between the curative and preventive work. Let us now break the barriers and work together for the benefit of human suffering. I shall now consider each aspect in detail.

(1) Medical Inspection of School Children and follow up :—

This work has been started since 1920. After a period of about seven years it was stopped by government for reasons unknown. The work was entrusted to the Medical Profession and the Public Health Staff had no contact with it. I was one of the Medical

Inspectors till the scheme was kept in abeyance. I made an attempt to interest the parents to take action in setting right the defects found. But the response was poor. The only work that I was able to do was compilation of statistics which, I doubt, has ever seen the light of day, not to mention whether ever made use of. At present some schools are doing this work voluntarily. Still there does not seem to be much enthusiasm among the public for action on the recommendations of the Medical Inspector. Now that we have an independant Medical profession with some kind of family practice attached to each practitioner, let us do the work of follow up. Let all Medical Inspectors and the family physicians meet together once in a year or more often, under the auspices of the Association, to find out the results achieved. Let the statistics collected be utilised to assess child health. In America Dr. Thomas Wood of Columbia has specialised in this work and has published his findings in a book of very useful information. Charts of standard height and weight for different ages have been published. Parents and children are encouraged to use them to find out the growth of the children. How could we do this work? Cards are sent by the school authorities for the defects found. Wherever parents bring them to any of us, let us keep a record in our books and note the action taken. When we meet for the discussion of the progress made, each one of us can produce his own statistics to correlate the results.

(2) Industrial Health, diseases and disabilities :—

Even in the highly industrialised countries of the West, this subject has been of recent origin. It is under the control of the Public Health Authority. In our country where industrialisation is still in the very early stages, this branch of medical science has yet to develop. The Government in the past one year has been collecting informa-

tion about facilities for treatment and welfare of Industrial workers. The Employees State Health Insurance Act has yet to be implemented. I would like to make a few suggestions for the organisation of industrial Medical Service. Health Insurance has been sanctioned by law. That medical personnel is quite inadequate to take full charge of the work is accepted. Under the circumstances, the aid of the Independant Medical Profession will have to be considered by the authorities. The industry that can afford a whole time medical man, will engage one. But the smaller ones can have a whole time medical man for a group or each one can have a part time medical man on suitable terms. I envisage such an organisation.

The medical man in charge will have an opportunity of studying at close quarters the reaction of the work on the health of the worker, the diseases peculiar to each industry and the general health conditions of the workers. There will be health cards for each worker and accurate records will have to be kept. It is this work that will have to be analysed periodically for the benefit of the industry, the profession and the worker. The defects found will have to be remedied to increase the efficiency of the workman. Such of us as will have opportunities for undertaking the work will, I am sure, give the profession an accurate account of their work and findings.

(3) Prophylactic measures against Infectious diseases :—

This is a field where fruitful work can be done by the Independant Profession in cooperation with the Public Health Staff. One of the main items in the Detroit plan is this work. Though vaccination against small-pox is carried out by the Health Staff, still there is a good section of the public who would like their family physician to do this work for them.

Prophylaxis against typhoid, cholera, diphtheria and other communicable diseases which can be protected against, could be done better by the members of the profession. Only in times of emergency is this work sometimes entrusted to the profession, along with the Public Health Staff. There is no well thought out programme. It is a work which the profession does only as an emergency measure. A regular programme of sustained work with plans ready to meet an emergency in times of an epidemic and to be put into force without delay, will have to be drawn up by the Public Health Department, along with the members of the Profession. Diseases like typhoid have to be tackled throughout the year. So, a programme of tackling the disease from all sides, such as prophylactic inoculation, disinfection of sources of water supply, stricter control and inspection of restaurants, eating houses and food hawkers, are some of the measures called for immediately. So, I earnestly request our Health Officers atleast in our District to draw out a comprehensive scheme of work on the lines suggested above and discuss the same with the members of the Profession, to take up the work in all earnestness.

(4) Collection of Vital Statistics :—

It is a well known fact that there are many shortcomings in the collection of vital statistics in our country. There being no compulsory certification of deaths required, the cause of death is not properly registered. It is within the knowledge of everyone that the cause of death as certified by the attending physician and as obtained from Public registers have no relation to each other, except where the medical man has reported it. The Public Health Staff have also their own difficulties to find the exact cause in every case. Notification of communicable diseases is not properly done. Some diseases like Diphtheria even if they

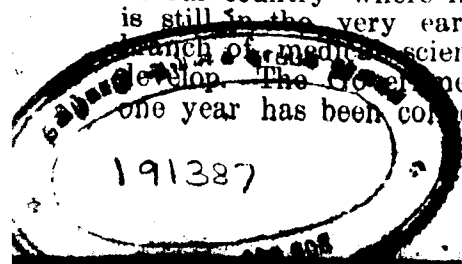
are notified, except for statistical compilation, cannot be tackled by the Health Authorities, due to reasons beyond their control. This state of affairs has to be rectified as early as possible. That is why this Association has now decided as a first step to notify such diseases and carry out prophylactic treatment against them, in close cooperation with the Health Authorities. This will be a fruitful field of work in this branch of public health activities.

(5) Health Education of the public :—

The Independant Profession can do a great deal in this field of work. As family physician he exercises a great deal of influence on the public. Sound advice on health matters, nutrition, sanitation and other allied matters will help the public to lead a better and healthier life. more than public lectures, the close intimacy of the members of the Profession with their patients, will carry greater conviction with the public, when the family physician educates them. To help the profession in the discharge of such duty, the public Health Workers should provide the necessary literature in suitable quantities and on all subjects for the information of the practitioner who will in his turn disseminate such knowledge among his patients.

Discussion :—

I have attempted to place before you the different fields of work in which the Independent Profession and the Public Health Worker can profitably work together in improving Public Health. In this country, the two branches have so far not been cooperating with each other. This Association has always been trying to bring the two together without any success so far. In all Western Countries, particularly in America I am told, unless the Health Officer in any Municipality or District, becomes a member of the



local Medical Association and identifies himself with the members of the profession, he cannot hope to get any cooperation from the members in his work. At least even now it is not too late for the two branches to cooperate. The Government should ask from the Health Department a report of the work done in cooperation with the Medical Profession. Wherever such cooperation exists it must be encouraged and wherever there is none, it should be instituted. All facilities required to be provided for by the Government will have to be given once we approach them with a workable scheme. In the Detroit plan the General Practitioner is paid for all the prophylactic treatment rendered by him. In the early days the State had to spend huge sums of money. Now as the scheme has progressed the financial commitments of the State has been reduced, there is better demand for prophylactic measures from the public and the general level of health has improved. To rely for all Public Health work on Government alone is not a desirable way to advance it. It is up to the Public, the curative and the preventive side of the profession to work hand in hand. Bigger schemes like protected water supply, drainage, supplies of medicines required and such other costly items are to be met by Government. Now that there is a well organised medical profession in the country with Central Provincial and Local Branches, it is up to the Government, the Health Department and the public to utilise the services of the profession to the fullest advantage, by detailing a workable scheme of Public Health to be implemented immediately with alterations and additions gained with experience.

That the child is the stage at which all care is to be bestowed by the nation for a healthy and virile race, is an accepted fact. Careful inspection with facilities for attending to defects found

either by the family physician, the specialists or public institutions should be the primary duty of both the Public and the Government. In the early days a sort of persuasive compulsion may be necessary or even desirable. Once the advantage of the work is well known the public will cooperate.

Industrial health, hygiene, diseases and disabilities have not been attended to and unknown in this country. In the early stages or even later, it may not be possible to have enough medical personnel to work out the scheme, instituted by the Government. So the aid of the General Practitioner with proper remuneration which is very useful for a practitioner starting his life, the scheme can be made to work well.

Prophylactic measures against communicable disease is an accepted fact. That the Public Health workers are unable to undertake the measures due both to inadequate training and want of time to attend to such work, is well known. With suitable remuneration, an attempt may be initiated for a nation-wide attack on these disease, through the General Practitioner. Control, both voluntary by the Medical Association and by the authorities, can be exercised for the proper working of the scheme. Both in the collection of vital statistics and Public Health education the General Practitioner will be the most suitable person to disseminate knowledge. Here remuneration will not be necessary. Only supplies of material will be the requirement.

Having given an idea of the immediate directions in which the General Practitioner can work out a Public Health Programme, I wish to emphasize that this is only a beginning. I am sure that there are more avenues in which such cooperation can be usefully utilised. The curative and preventive sides of the Medical Profession working together can make the people live a

healthy and happy life. So, cooperation between the two sides in an increasing measure will bring about better results in this sphere. I am sure such cooperation will be the endeavour of all of us from the Government down to the worker, in all Public Health spheres, so that the nation may be healthy and happy.

Summary.

(1) An attempt has been made to find out the lines of cooperation between the General Practitioner and the Public Health worker.

(2) The lines in which such cooperation can be immediately undertaken has been mentioned.

(3) With suitable remuneration the General Practitioner can be made to handle Public Health work. This will relieve the Health Department for other more responsible work.

(4) An appeal has been made to the Government and the Health Department to take advantage of the organised Independent Profession with Central, Provincial and Local Organisations in implementing Public Health Work.

A lecture delivered at the South Kanara Branch—Indian Medical Association on 25-6-1949.



HYSTERIA
INSOMNIA
NEURASTHENIA
OVER-EXCITABILITY

COMPOSITION: Bromide salts, chloral hydrate, valerianic acid, deodorised valerianic extract, aromatic and flavouring substances.
DOSAGE: 1-2 teaspoonful three times a day.

THIS TESTED SEDATIVE—

Elixir
BROMO-VAL

DETAILED LITERATURE AND FREE MEDICAL SAMPLES ON REQUEST.

Cipla REMEDIES OF SUPREME QUALITY

CIPLA SALES DEPOT, 1/186, Mount Road, MADRAS

USE OF THE DERIVATIVES OF DIAMINO-DIPHENYLE SULPHONE IN LEPROSY.....A GUIDE

BY

A. T. RAY, M. O.

Leprosy Home & Hospital, Purulia, Bihar.

A medicine is known for its efficacy, which can be availed of to its highest standard when handled rightly by the medical men. Reverse action is also not seldom met with when the particular drug is administered without observing the annexed instructions or for some such causes. As a striking instance B. C. G. Vaccine may be mentioned. This vaccine which is so popular now and which is hoped to-day to be saviour of so many lives was the cause of killing all the 75 German children where it was first used in 1908 without the preliminary Tuberculin test. This is what is being apprehended to-day with the Sulphone treatment in leprosy. This apprehension makes the author encouraged to write this, with the hope that the members of the medical profession will not rush in to use this poisonous drug without being fully acquainted with its bad effects and without having the knowledge of combating the ill effects which are almost the sure outcome of its use.

In this paper a short description of the derivatives of Sulphone, their doses, action in leprosy and experience of Leprologists have been mentioned. Special stress has been given to their toxic effects.

Diamino-diphenyle Sulphone was first reported by Froman and Whitman in 1908. Promin, a derivative of Sulphone, on the successful treatment of experimental tuberculosis by Feldman, Hinshaw et al Faget, Pogge, Johansen et al reported on the successful treatment of leprosy with Promin in 1943. After Faget et al, the different derivatives of Sulphone-Promin, Diasone, Sul-

phetrone etc. are being used in different institutions of India and in other places of the world mainly in Africa and America. With the advancement of knowledge and interchange of opinion after the experiments which are still being carried on, the Leprologists still think that the Sulphones, though they have definite place in the treatment of leprosy, are not the drug for leprosy and the use of these poisonous drugs should be limited and left to the members of the medical profession, who have special interest in treating leprosy. Types of leprosy cases in which the derivatives of Diamino-diphenyl Sulphone should be used:—

The Committee of Therapy of the 5th Int. Congress of Leprologists, Havana, reports "The existing evidence shows that these drugs are of great value in lepromatous (infectious) leprosy". "There is no reason why Sulphones should not be of value in the treatment of active cases of leprosy irrespective of types as all leprosy lesions are caused by lepra bacillia" says Dr. Lowe. It can be stated that the Sulphones can be recommended in all types of leprosy and the author from his experience recommends these strongly in tuberculoid cases which either do not yield to Hydnocarpus treatment satisfactorily or come back as relapsed. This kind of relapse, tuberculoid to tuberculoid, is not very uncommon. We have ample proof to show that Sulphones are the drugs of choice in cases which either do not respond to the routine Hydnocarpus treatment or show active signs of the disease after remaining inactive for some time.

Mode of action of Sulphone in leprosy:—

Sulphones have got direct action on acid-fast bacilli in vitro and in experimental animals its action in human being either bacteriostatic or bacteriocidal. Speculations have been brought forward to defend both of them. There is no doubt of the fact that under Sulphone treatment the following are observed:—

1. Slow subsidence of the clinical activity of the disease.
2. Slow disappearance of the acid fast bacilli from the lesions.

Though the mode of action is not definitely known, it is being used on a rational basis.

Doses.—Certain phenomena while treating the cases of leprosy with the Sulphone and its derivatives e.g. lepra-reaction, exacerbation of old patches and appearance of new ones are almost sure to happen. Bearing these in mind along with some toxicity which will be described afterwards—one should regulate the dose. *Systematic* study has not yet been sufficient to permit dogmatic statements regarding doses. (Int. Congress 49).

(1) Promin (Di-amino diphenyl sulphone dextrose sodium sulphone). It is given daily intravenously 2 gm in 5 c. c. for 1 to 2 weeks increasing by 1 c. c. of the solution daily, after 1 to 2 weeks, to 12.5 c. c. Most of the workers have stopped using Promin for various reasons: (2) Diasone (Sodium formal dehyde sulph oxolate of Diamino diphenyl sulphone).

1st week	0.3 gm	(1 tab.)	daily
2nd "	.6 gm	(2 tab.)	"
3rd "	.9 gm	(3 tab.)	"

The doses may be increased upto 6 tablets (1.8 gm) according to tolerance.

Sulphetrone—(Tetra sodium 4.4 bisy—Phenylprophyl amino diphenyl Sulphone). Two tabloids of .5 grms each

daily can be given as an initial dose. It can be worked upto 12 tablets daily according to tolerance. A rest period is recommended after 6 months continuous treatment. A concentration of 5 m. gm. per 100 c. c. of blood in ambulatory patients is recommended and for this 3 to 6 gm. (6 to 12 tablets) daily dose is necessary. This is freely soluble and available for parental use. 1 to 5 c. c. daily of 50% solution can be given subcutaneously and intramuscularly. This is the least possible toxic derivative of the sulphone.

Toxic effects.

Acute toxicity of sulphone and its derivatives have not been observed.

Chronic Toxicity.—(1) Slight but continuous hoemolytic anaemia marked by a concurrent reticulocytosis.

(2) Progressive anaemia due to lack of Iron owing to depletion of alimentary Iron by Sulphetrone, with which Iron forms non-absorbable complex and which may be prevented or treated by administration of Iron orally.

(3) An anaemia of slower development but of precipitate onset which seems to be nutritional in origin, can also be treated and prevented by simultaneous exhibition of Brewer's yeast.

These were observed when diet containing 4% Sulphetrone was given to rabbits. An essentially similar condition developed in man is implicit in the case reported by Madigan, Anderson, Strachan, Clay and Clay (L. R. page 124, 49).*

Observing the anaemia after sulphone and its derivatives and following the diminution of haemoglobin every week we are of opinion that these drugs can be safely given in conjunction with iron till the hoemoglobin goes down to 50%. When it is below 50%, the sulphones should be withdrawn and only restarted when it is at a satisfactory level.

* Toxic Symptoms such as.....Nausea, Vomiting, Haematuria, some deterioration in the blood picture, Anaemia, Occipital headache, and Cynosis have been observed by many workers after administration of Diasone and Sulphetrone.

Iron can also be given from the start of the treatment as a prevention of haemoglobin going down.

Observation of regularity of bowels is one of the most important points for continuation of sulphone treatment. With constipation the absorption of the sulphone in the system is increased as a result the blood level goes up. This may result in dim vision, dizziness and fainting. Brain symptoms have also been mentioned. A strong adult—had been taking 3 tablets of sulphetrone daily. As a result of constipation for 3 days—he felt dizzy—and could hardly see anything clearly and also became very weak. It is believed that constipation tends to produce increased blood concentration owing to the fact that the drug is accumulating in the gut and is retained if the bowels are not kept open. (Cochrane et al. L. R. page 57, 49). The anaemia produced by sulphones is always more severe and treatment more difficult with liver disfunction. (L. R. Page 134, 48. M. Smith.)

Recommendation. With the symptoms which are apprehended to be met within sulphone treatment I would like to suggest two lines of treatment:—

(1) For the cases who do not reside in hospital or in colony.

(2) For the cases who reside in hospital or in colony.

(1) Patients who do not reside in hospital or in any colony usually live far away from the attending physician and for most of them the doctor cannot be sent for an emergency. The sulphone treatment should be given to such patients with great caution. I do not

recommend a dose more than 1.5 gm (3 tablets of sulphetrone) a day. In these cases the improvement, though delayed according to some, is good. The dangers which are likely to be met with are comparatively less. They may be asked to see the doctor once in a fortnight for the haemoglobin test and the Hydnocarbus oil injection. When the importance of the oil injection is relaxed I have often seen the patients to be very irregular to see the doctor either for the Haemoglobin test or for further advice for his condition. I never advise the patients to be given more than 50 tablets at a time if they have ample supply in their hand they go on taking the tablets without consulting the doctor and also without caring for the weakness etc. and the covering of the haemoglobin percentage.

(2) For the colonial and hospital patient more drastic dose upto 12 tablets of Diasone and Sulphatrone is quite safe. These patients are seen everyday and the tablets are also given everyday according to their tolerance and variations of haemoglobin test.

Conclusion

Derivatives of sulphone specially sulphatrone can almost safely be given to the cases of leprosy, irrespective of types. Iron and yeast should also be given in adequate doses. Special attention should be given to the haemoglobin percentage and constipation. With good diet haemoglobin does not deteriorate so rapidly as that of the poorly fed patients. As a symptomatic treatment of leprosy eyes, throat and nose troubles, sulphone and its derivatives are excellent.

(Paper read at the 37th Conference of the A. I. M. L. A. on 21-4-'50)

ASSOCIATION NOTES

COIMBATORE BRANCH

President: Major N. Krishnaswamy
Vice-President: Dr. N. R. Narayanaswamy Naidu
Secretary: Dr. A. G. Leelakrishnan
Associate Secretary: Dr. S. V. Subramaniyan
Treasurer: Dr. T. V. Sivanandam

The Silver Jubilee celebrations of the Coimbatore District Medical Association were held in the association buildings at Krishnaswamy Mudaliar Road, Coimbatore on the 17, 18, and 19th March 1950. The celebrations commenced in a spacious pandal specially erected for the purpose in front of the association buildings. A very large and distinguished gathering comprising the elite of the district and of the members of the medical profession from all over the province were present. The guests were received by the president and the secretary and other members of the jubilee committee. Delightful music was provided by the Union High School Orchestra.

Prominent among those present were: Dr. A. L. Mudaliar, Vice-Chancellor Madras University, Dr. J. C. David, Surgeon General with the Government of Madras, Dr. P. A. S. Raghavan, President, Indian Medical Association, S. I. P. B., Dr. P. Kutumbiah of Vellore, Dr. P. N. Ramasubramanian of Madura, Dr. Ratnavelu Subramanian of Madras and many others.

Punctually at 9 A.M. the celebrations commenced with prayer. Dr. C. Nanjappa, the president of the association took the chair and called upon Dr. N. K. Sampath to give a short history of the association buildings. Then Sri. R. Venkataswamy Naidu, Chairman, Southern India Mill-owners' Association was requested to declare open the new extension to the Mr. R. V. Swami, declaring open the building, said that it had been a great pleasure to the

mill-owners of Coimbatore to contribute to the growth of the Coimbatore District Medical Association and also gave his assurance that any additional help required by the association will be met by them. He also complimented the association on the very useful work that it has been doing. On behalf of the association, he also presented a gold medal to the building contractor, Mr. J. Swaminathan for his sincere and unostentatious work.

Then Dr. C. Nanjappa, the president presented an address of welcome to Dr. Sir A. L. Mudaliar, on behalf of the Association, in which he paid fitting tributes to Dr. Mudaliar for his services in India and in the international field. The address stated that the members of the profession were watching with admiration his courageous and bold stand in the legislature never once flinching in calling a spade. His services in the cause of education in general and medical education in particular were praised.

Dr. A. G. Leelakrishnan, the Secretary presented the Silver Jubilee report. He traced the origin of the Coimbatore District Medical Association from 1924, and its development through these twenty-five years. He mentioned that the Coimbatore District Medical Association was the only one of its kind which could claim to possess such beautiful buildings of its own. He thanked the mill-owners of Coimbatore for contributing generously to the Association buildings. The report also mentioned about the various activities

of the Association. They also possessed the nucleus of a good library and the secretary appealed to the distinguished visitors present to help the association in enlarging the library.

Messages of good wishes were received from several distinguished individuals and organisations from all over India. These included Dr. T. S. S. Rajan, Sri. P. S. Kumaraswami Raja, Chief Minister, Madras, Sri. M. Bhaktavatsalam, Raja Sir Muthia Chettiar, Mr. G. D. Naidu, Dr. Chamanlal Mehta, President of the I. M. A., Dr. T. S. Thirumurthy, and others.

Then Dr. Sir A. Lakshmanaswamy Mudaliar delivered his inaugural address. Dr. Mudaliar in an address that was remarkable for its lucidity of thought and expression, at the outset congratulated the Coimbatore District Medical Association at the successful completion of twenty-five years of its existence. He said that the Association stands to-day as one of the foremost of the district medical associations in this State and has the support of the overwhelming majority of the medical profession in this district. He uttered a warning against attempts to lower the standards of Medical Education. He expressed the opinion that it was not practicable to teach both modern medicine and indigenous medicine at the undergraduate course in a medical college, and that if the two systems were to be integrated, those who had a deep knowledge of one should take up the study of the other system of medicine and then come forward with their own views as to how these systems could be integrated. Dr. Mudaliar then put in a fervent plea for the retention of the English language as the medium of instruction in the universities, particularly in the faculty of medicine and that they should continue to have international standards in all fields of scientific thought and endeavour. Dr. Mudaliar concluded by appealing to medical men to study the many problems confronting

them and contribute their best for the development and progress of this great land where opportunities for service were great with the dawn of freedom.

Then after a vote of thanks by the Secretary, Dr. A. G. Leelakrishnan to Dr. A. L. Mudaliar, Mr. R. V. Swamy, and other distinguished guests and to the medical men from all over the province who had so kindly and in such large numbers responded to their invitations, the morning session terminated.

The members and guests then adjourned for Lunch at "Woodlands" so generously provided for by Dr. P. A. Natesan of Coimbatore.

The afternoon's functions began at 2 A.M. in the Association premises. Dr. C. Nanjappa, the president, in welcoming Dr. J. C. David, Surgeon General with the Government of Madras, at the outset congratulated him on his appointment as the head of the medical administration in the State and requested him to inaugurate the scientific session. Dr. David thanked the Coimbatore District Medical Association for having given him an opportunity to take part in the jubilee celebrations of their association. He said that gatherings, such as these were necessary for the profession, since medical science was not static, and they could exchange their ideas at such meetings. The two problems that faced the profession were scarcity of medical men for work in rural parts, and also unemployment among medical men. Service under local bodies at present was not attractive and it was upto private bodies to find ways and means of encouraging medical men to settle down in villages. The Surgeon General strongly opposed the idea of a synthesis of the modern and indigenous systems of medicine. Dr. Nanjappa proposed a vote of thanks.

A symposium on 'Fevers' was then held, Dr. M. N. Menon, Honorary Physician, H.Q. Hospital, Coimbatore presiding. Dr. P. Kutumbiah, M.D.,

April, 1950]

ASSOCIATION NOTES

M.R.C.P., of the Christian Medical College, Vellore talked on 'Typhoid Group of Fevers Clinical features, Diagnosis and Treatment.' Dr. Rathnavelu Subramaniam, B.Sc., M.D., M.R.C.P., of Madras talked on 'Fevers of Long duration.' In the discussion that followed a large number of practitioners took part. Dr. M. N. Menon, concluding appealed for increased facilities of laboratory and scientific aids in diagnosis, and thanked the learned lecturers for their valuable addresses.

The members and guests had Tea given by Dr. N. Jagannathan and Dr. N. Velappan at a function organised in connection with the opening of their tuberculosis sanatorium.

Dinner at night was provided by the Coimbatore District Chemists' and Druggists' association at Woodlands.

A symposium on 'Thoracic Medicine and Surgery' was organised on Saturday, the 18th March 1950 at the premises of Messrs Srinivas Theatre, Coimbatore. Dr. P. N. Ramasubramanian, of Madura presided. Dr. R. Mahadevan, M.S., F.R.C.S., of the Stanley Hospital, Madras addressed on 'Lung Abscess.' Dr. Reeve, H. Betts, M.D., Thoracic Surgery Department, Christian Medical College Hospital, Vellore talked on 'Indications for Pulmonary Resection.' Dr. K. S. Sanjivi, M.D., Superintendent, Tuberculosis Hospital, Royapettah, and Tambaram Sanatorium, spoke on 'The Physician in a Thoracic Surgery Team.' Dr. P. N. Ramasubramanian the president of the session summed up the discussions and thanked the various learned lecturers for their interesting contributions.

Lunch in the afternoon was provided for the members and guests at the premises of the Devanga High School by the kind courtesy of Messrs. East India Pharmaceutical Works Limited.

In the evening on the same day a symposium on 'Forceps' was held under

the presidency of Dr. Mrs. Anna Vareed, F.R.C.S. of Coimbatore. Dr. R. K. K. Thampan, B.A., M.B., F.R.C.S., M.R.C.O.G., Superintendent, Government Hospital for Women and Children, Madras talked on 'Forceps in Midwifery'. Dr. P. Madhavan, B.A., M.D., Professor of Obstetrics and Gynaecology, Stanley Medical College, Madras spoke on 'Forceps Delivery'. Dr. B. Jayaram Naidu, M.B., B.S., L.R.C.P. & S., T.D.D., (Wales) Senior Surgeon, Mysore, who was expected to take part in the morning's symposium on 'Thoracic Medicine and Surgery' but could not do so on account of the late arrival of his train, was requested to address on 'Tuberculosis Problems as observed from a Survey at Mysore'. Dr. Mrs. Anna Vareed who presided concluded the discussions and thanked the various lecturers for their addresses.

The guests and members then adjourned to the Surgical Nursing Home at Tatabad for Tea arranged by Dr. T. V. Sivanandam and Dr. C. V. Ramaraj in connection of the Silver Jubilee celebrations of the Coimbatore District Medical Association. Dr. T. V. Sivanandam welcomed Dr. A. L. Mudaliar and other guests and members. After a sumptuous tea, Dr. A. L. Mudaliar, addressed the gathering on the value of nursing home to the community and congratulated Drs. T. V. Sivanandam and Ramaraj for their enterprise. Dr. C. V. Ramaraj then proposed a vote of thanks to all the guests for having responded to their invitation.

That night in the association premises interesting scientific films were exhibited. The films shown were 'Prevention of Infection in Surgical Dressings' by the kind courtesy of Messrs. Imperial Chemical Industries (India) Limited, 'Peptic Ulcer' by Messrs. John Wyeth and Brother, and 'A Tiny Thing Brings Death' by Messrs. Imperial Chemical Industries (India) Limited, and these were very much appreciated by the audience.

The Association Dinner was at Woodlands that night which was largely attended.

On the morning of Sunday the 19th March 1950 was arranged the symposium on 'Fractures' under the presidency of Dr. T. V. Sivanandam, Honorary Surgeon, Head Quarters Hospital, Coimbatore. Lt. Col. V. R. Thayumana-swami, M.S., M.Ch., (Orth.), F.R.C.S. (Eng.), Othopedic Surgeon, General Hospital, Madras talked on 'Fractures about the Elbow', Dr. C. S. Sadasivan, M.B., M.S., General Hospital, Madras on 'Fractures of Spine' and Dr. Paul W. Brand, M.B., F.R.C.S. (Eng.) of The Christian Medical College, Vellore on 'Compound Fractures'. After a lengthy discussion in which several members and guests took part. Dr. T. V. Sivanandam, the president of the session summed up the discussions and proposed a vote of thanks to the learned lecturers.

Lunch was provided that noon by a committee of hosts consisting of the following members at the premises of the Devanga High School:

1. Dr. Anna Vareed, Mrs.
2. „ Balasubramanian, S.
3. „ Kalyanaraman, P. K.
4. „ Leelakrishnan, A. G.
5. „ Munuswamy, L.
6. „ Narayanan, K.
7. „ Narayanan, T. K.
8. „ Narayanaswamy Naidu, N. R.
9. „ Ramaswamy Naidu, P. N.
10. „ Sivanandam, T. V.
11. „ Srikanthan, S. R.
12. „ Subramanian, K. V. (Path.)

The Annual General Body Meeting of The Coimbatore District Medical Association was held that evening at 4 P.M. in the Association premises. Tea was provided by the kind courtesy of Messrs. The South Indian Manufacturing Company, Madura. After tea the meeting commenced with a prayer by Dr. R. Sundararajan. Dr.

C. Nanjappa, the president was in the chair. Dr. A. G. Leelakrishnan, the Honorary Secretary presented the annual report which detailed the various activities of the association during the year. The annual report and the auditor's report and statement of accounts of which were appended to the report were adopted.

The office-bearers for the year 1950 were elected unanimously:

President

Major N. Krishnaswamy.

Vice-President

Dr. N. R. Narayanaswamy Naidu.

Honorary Secretary

Dr. A. G. Leelakrishnan.

Associate Secretary

Dr. S. V. Subramanian.

Honorary Treasurer

Dr. T. V. Sivanandam.

Managing Committee Members:

1. Dr. Anna Vareed, Mrs.
2. „ Chandrasekharan, G. A.
3. „ Dorairaj, S.
4. „ Iyer, R. G.
5. „ Munuswamy, L.
6. „ Nair, M. G.
7. „ Nanjappa, C.
8. „ Pai, M. P.
9. „ Ramaraj, C. V.
10. „ Saradhambal, R. Mrs.
11. „ Sengottayyan, K. N.
12. „ Subramanian, K. V. (Path.)
13. „ Vasudevan, Y. P.
14. „ One member from Erode

(To be elected from Erode members)

Members to the Council of the South Indian Provincial Branch of the Indian Medical Association:

1. Dr. Arumugam, C.
2. „ Ganapathy, S.
3. „ Kandaswamy, N. G.
4. „ Krishnaswamy, N. (Major)
5. „ Nair, M. G.
6. „ Ramaraj, C. V.
7. „ Sundareswaran, D.

8. Dr. Visvanathan, B. S.
9. „ Leelakrishnan, A. G. Secretary, (Ex-Officio).

Members to the Central Council of Indian Medical Association:

1. Dr. Appaji, S. V.
2. „ Sampath, N. K.
3. „ Saraswathy, M. K. Miss.

Dr. C. Nanjappa, the retiring president then thanked the members of the managing committee, of the Jubilee committee and of the Building sub-committee for their co-operation and help.

Dr. K. Narayanan then proposed the following resolution which was passed unanimously:

"This annual general body meeting of the Coimbatore District Medical Association places on record its appreciation of the services rendered to the association by the managing committee, building sub-committee and the silver jubilee committee, and to all the members, individuals and institutions who helped in making the jubilee celebration a success"

Major N. Krishnaswamy, the new president then thanked the members for having elected him as President. After singing of national anthem by Dr. Sundararajan, the function terminated.

MADHURAI BRANCH

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

Proceedings of The combined monthly and General Body meeting held on 30th April 1950

The combined monthly and General Body meeting was held at 4 p.m. on Sunday the 30th April 1950 in the Erskine Hospital, Madhurai. About 75 doctors attended. Dr. P. Vadamalayan, the President, presided.

The Hon. Dr. T. S. S. Rajan, Minister for Public Health, who was camping in Madhurai was present by invitation.

After tea, addressing the members, the Hon. Minister said that he was taking all steps possible to start a Medical College in Madhurai and was of the opinion that the college together with the excellent hospital, they were having would make Madhurai a great centre of learning in Medicine and Surgery.

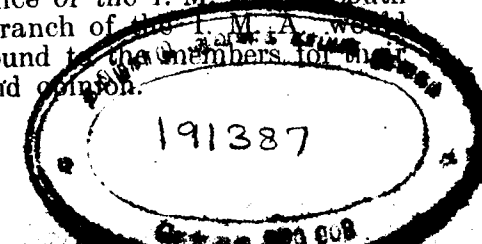
He then left the meeting to inspect the proposed sites for the medical college and the Tuberculosis sanatorium.

The following condolence resolution was moved from the chair and passed all standing.

"This meeting of the Madura Medical Association places on record its deep sense of sorrow at the untimely demise of Dr. S. Pichumani, M.B.B.S., of Periakulam, an active member of the Association."

The Secretary was asked to forward copies of the resolution to the members of the bereaved family.

The minutes of the meeting held on 25-3-1950 were read by the Hony. Secretary and adopted. The Hony. Secretary then announced that some of the circulars received from the central office of the I. M. A. and South Kanara Branch of the I. M. A. would be sent round to the members for their perusal and opinion.



The President then moved the following resolution :

"The general body of the Madura Medical Association authorises the President to purchase out of the Building fund, the plot of land of about one acre in front of the Taluk Office from the Madhurai Municipality at the rate of Rs. 50/- per cent as fixed by the Municipal Council."

Dr. A. S. Annamalai moved an amendment adding the following words after the resolution: "and sanction expenses upto Rs. 6000/- towards the same."

The resolution as amended was passed unanimously after some discussion. The president then introduced Dr. R. Subramaniam, M. D., M. R. C. P. Physician, Stanley Hospital, Madras to the members.

Dr. R. Subramaniam, delivered a clear and instructive lecture on Suppurative diseases of the Lung. He dealt mainly with non-tuberculous lesions and dealt in detail with lung abscess. He discussed the causations, signs and symptoms, pathology, complications, differential diagnosis and treatment. He also discussed the incidence of primary and secondary amebic

abscess of the lung. Illustrating his lecture with reports of a number of cases met with in his practice, he emphasised the need for taking skiagrams in anterior, postero-lateral, oblique and various other postures to demonstrate the fluid level. Dealing with treatment, he divided the lung abscess into four stages, and said that penicillin and sulpanamides have greatly facilitated the treatment of this condition. He also mentioned the optimum stage at which a lung abscess should be drained surgically and said that a chronic lung abscess with very thickened walls could only be treated by Lobectomy or Pneumonectomy. He finally demonstrated a number of skiagrams to illustrate the points mentioned in his lecture.

The lecture was followed by a discussion in which some members took part. The President demonstrated skiagrams of a few cases of lung abscess successfully treated by him and mentioned the value of gold injections after the treatment of acute stage with penicillin and sulphanamides.

With a vote of thanks by the Hony. Secretary the meeting ended at 6-25 p.m.

MALABAR BRANCH

President : Dr. N. Achuthan
Vice-President : Dr. T. Bhaskara Menon
Secretary : Dr. C. V. Narayana Iyer
Asst. Secretary : Dr. A. P. Kunhiramanunni

To meet Hon'ble Sri. P. S. Kumaraswamy Raja, the Chief Minister to the Government of Madras, and Hon'ble Sri. K. Madhava Menon, Minister in charge of Law and Education, a reception was arranged on Friday 28-4-1950 at 8-30 p.m. at the Beach Hotel, Calicut which was largely attended. The distinguished guests were welcomed by Dr. N. Achuthan, President, in a short speech and garlanded. Mrs. Madheva

Menon was also garlanded. Dr. C. V. Narayana Iyer, Secretary presented the following Memorandum:—

We, the members of the Malabar Branch of I. M. A. extend to you a most hearty welcome to this old and historic city of Calicut. We deem it a honour and a privilege that in the midst of crowded programme, you have consented to accept our invitation.

You are aware that as a result of continued representations to the Government a new District Hospital is being built in this town. The yearly allotment for this construction is too meagre and that it will take many years for the completion of this hospital. This being a very important and essential matter concerning the health and welfare of the whole district, we request that such allotment of funds may be made available that the work be completed speedily and during your present term of office.

We take this opportunity to represent to you that all of us are anxious that our children should take to our profession if they are found fit and we request that a few seats may be made available to sons and daughters of medical men in the selection of candidates for admission to the Medical Colleges.

We further beg to state that we are greatly handicapped on account of the restriction of the Prohibition Act in stocking tinctures containing alcoholic spirit for our daily work. These preparations are essential for ordinary

mixtures in daily use. We request that medical men may kindly be exempted from the operation of the Prohibition Act in this respect.

Owing to the restriction of import on essential drugs like Streptomycin, Penicillin etc., there is acute shortage of such useful drugs and the medical men are greatly handicapped in their work. We request the Govt. of Madras may be kindly pleased to bear pressure upon the Central Government with a view to relax or remove the restriction placed on such important and-essential drugs.

The Chief Minister in his reply thanked the Association for the reception and said that he having personally seen the bad condition of the hospitals would do his best for the early construction of the new hospital. Hon'ble K. Madhava Menon also spoke a few words. This was followed by an enjoyable dinner wherein in addition to the members the Chairman, the District Board President, the Collector, the Dt. Superintendent, M.L.As., Press etc. were present. After a vote of thanks by the Secretary the function ended at 10-15 p.m.

SOUTH KANARA BRANCH

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

Resolutions passed at the meeting of the South Kanara Branch of the Indian Medical Association on 23-4-1950.

In the absence of the President and Vice-president, Major, W. E. Mascarenhas was unanimously elected to the chair.

The Honorary Secretary then read the notice of the meeting and the agenda was considered.

I. The question of restrictions on the supply of Tinctures and other spiritous preparations under the Prohibition rules was considered and the following resolution was passed.

Whereas the Government of Madras have adopted and enforced total Prohibition for the past one year and a half and as such, placed restrictions on the sale by chemists and possession by medical men for their professional use of spiritous preparations, medi-

cated wines, mythelated and denatured spirits and medicaments containing self generated spirits, the Medical Profession welcome this policy in the interests of the public and gives its support to the policy. But in the working out of this policy the restrictions placed on the above preparations have not been conducive for the proper discharge of the professional responsibilities of the medical men, as orders are passed without giving the profession a chance to express its views on the difficulties of such restrictions and bring to the notice of the Government for consideration before final orders are passed. This Association therefore hereby resolves as follows:—

(a) That the medical profession be given a chance to represent its views on all matters restricting the supplies of preparations required for its use in their daily avocations before final orders are passed.

(b) That the licences to dealers in these medicaments be granted and/or renewed in time before the commencement of the official year to avoid the present difficulty of non-availability of the preparations due to want of these licences.

(c) That immediate steps be taken to reconsider the policy of the Government with regard to the sale by chemists and possession by medical men of spiritous preparations, tinctures, medicated wines, mythelated and denatured spirits and all such preparations which come under the Prohibition Act, by medical men in their day to day professional work, in consultation with the members of the profession.

Moved by Dr. K. R. Kini, seconded by Dr. U.P. Mallya-passed unanimously.

2. Difficulty of availability of essential drugs like Penicillin etc.

Whereas the Government of the Indian Union has adopted the Modern Scientific System of Medicine as part of its programme of medical relief

and whereas some of the essential medicine in the Pharmacopoeia of this system such as Chemo-therapeutic preparations, Vitamins, Antibiotics, Organo therapeutic drugs and certain chemical salts are indispensable to the members of the profession in the pursuit of their practice from day to day and whereas these are not manufactured in the Union and as such are in short supply due to restrictions on foreign exchange facilities, this Association therefore, resolves as follows:

(a) That sufficient foreign exchange be allotted for the import of these essential medicaments so that they may be available freely.

(b) that while granting licences for the import of these essential drugs the policy of issuing licences freely to importers who are already in the line and/or who are manufacturers representatives, be adopted and no new licences be given facilities to import.

(c) That essential drugs like chemo-therapeutic preparations, Antibiotics, organo-therapeutic drugs, vitamins and other organic and inorganic salts which are not yet manufactured in the Union be given licences freely and in adequate quantities, while indiscriminate import of non-essential proprietary preparations be discouraged from being imported.

(d) That the medical profession of the modern scientific system be directed to prepare and submit a list of essential drugs required by the profession. Proposed by Dr. E. G. Acharya and seconded by Dr. M. Rangappa Kamath and passed unanimously.

3. Restrictions on supply of Streptomycin.

In view of the restrictions having been removed no action is considered necessary.

4. Restrictions on service medical men in attending Medical Association meetings.

Whereas in the interests of advancement of the Scientific system of medicine, Associations of Medical men have been working in all parts of the Presidency with membership of both service men and Independent practitioners and whereas monthly clinical meetings of these Associations are held to discuss subjects of clinical interest which are instructive and useful to the members and whereas the Government have directed service men to take casual leave to attend these meeting, even if it be that they travel at their own expense, except when meetings are held on Government holidays and not treat such attendance as duty, this Association therefore resolves as follows:

That this meeting of the S. K. Branch, Indian Medical Association requests the Government of Madras to encourage service men to attend meetings of the medical Associations of which they are members, by treating their absence from their Head Quarters as part of their duty and not casual leave, so that the pro-

fessional lectures and discussions at these meetings may enable them to improve their knowledge and thus the Associations may serve their members, usefully and successfully.—Moved by Dr. K. S. Amrita Rao, seconded by Dr. B. G. Baliga and passed unanimously.

5. Resolved that the Honorary Secretary is authorised to communicate the above resolutions to the proper authorities, to the South Indian Provincial Branch with a request to consider these resolutions at the next meeting of the Council on behalf of this Branch for consideration and adoption and to all District Associations in the Madras State for consideration and adoption of these or similar resolutions for being communicated to the authorities and to the medical M. L. A's in the State Assembly and to local M. L. A's of the District for necessary action. Moved from the chair and passed unanimously.

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

TANJORE BRANCH

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

The monthly meeting of the Tanjore District Medical Association, Branch of the Indian Medical Association was held at 4-30 P.M. on 26-2-50 in the premises of R. M. Hospital, Tanjore. Dr. Mohamed Ismail, President of the Association presided over the meeting. 35 members attended the meeting. After tea provided by Dr. P. Narayana Rao, the meeting commenced with the lecture by Dr. P. A. K. Nair, D.M.S. & T.D.D., Tanjore, on "Chemotherapy in Pthisis".

The usefulness of gold, sulpha drugs, streptomycin and Para-Amino Salicylic acid in the treatment of tuberculosis

was discussed in detail.

Demonstration of X-ray films before and after treatment was shown to the members.

The President of the day advised practitioners to be very careful in the choice of the cases and remarked that drugs should be used only for certain types of cases with good indications for that particular drug like streptomycin, Para-Amino Salicylic etc.

The meeting terminated with a vote of thanks by the Secretary to the lecturer for the valuable lecture and to the host of the day for the tea provided.

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

MEDICAL FITNESS FOR AIR TRAVEL—*The Clinical Journal—July-Aug. 1949.*

With the rapid increase in air travel, the practitioner may frequently expect to be called upon for advice as to whether or not his patients are fit to undertake journeys by air.

In a comprehensive review of this problem, H. Whittingham, A. Buchanan Barbour and J. C. Macgown, present the facts as they stand to-day. Their experience has been gained from both civilian and service aviation, and there are probably few doctors better competent to speak with authority.

They state that every case must be assessed on its merits, with particular reference to (1) the medical condition and psychological make-up of the patient; (2) the effect of the patient's disability on fellow passengers; (3) the necessity or otherwise for a qualified attendant; and (4) the conditions of air travel.

The article includes a table in which the conditions in each system which may make air travel undesirable are listed. In general, the conditions in which special care is necessary are those in which either changes in pressure or low oxygen tensions would have an adverse effect. Thus, anaemic patients will become distressed at high altitudes, and the haemoglobin should be raised to a minimum of 50 per cent. by blood transfusion before air travel is advised. In acute leukaemia journeys by air are particularly contra-indicated, as such cases readily suffer from anoxia and haemorrhage. If it is essential to transport such cases by air, the haemoglobin should be raised to 80 per cent. by transfusion. Patients with cardiovascular disease should not travel by air unless oxygen is available, and in hypertensive cases a blood pressure of 200 systolic and 120 diastolic is considered the highest at which flying is considered advisable.

Oxygen should be available for all cases of respiratory disease and the maximum height allowed is 5000 ft. Pulmonary tuberculosis presents a special problem, and in active disease air travel should not be permitted unless the sputum is free from

tubercle bacilli, and any cavity is controlled by collapse therapy. Where there is an artificial pneumothorax this should not have been filled within a week, and if there is a fixed mediastinum, the lung should be at least three-quarters expanded. In cases with a pneumoperitoneum the refill must have been more than a week previously and must not have been more than 2,000 c.c. at each site.

Air travel is contra-indicated within three months of lobectomy or pneumonectomy.

In active gastric or duodenal ulceration there is a danger of gaseous distension causing a haemorrhage or perforation, and patients who have had either of these complications of a peptic ulcer should not travel by air within two months of its occurrence.

Pregnant women should not travel by air beyond the eighth month of pregnancy, and any history of eclampsia or travel sickness should preclude this mode of travel altogether. Pregnant women should be advised to ensure that the retention belt is round the pelvis and not the abdomen at take-off and landing and, furthermore, where possible, they should sit in backward facing seats so that the belt need not be too tight.

The subject of air-sickness is briefly discussed, and it is stressed that it is particularly important that expectant mothers, diabetics and those suffering from gastro-intestinal diseases should not be air-sick.

It is pointed out that such factors as fatigue, over-loading of the stomach, noise, vibration and cold predispose to air-sickness and patients should be warned of these points, and advised to take a good night's rest before a flight, take a light meal about an hour before taking off, and wear suitable clothing. It is also wise to prescribe hyoscine hydrobromide gr. 1/100 to be taken one hour before taking off, to be followed by the same dose two hours later if necessary.

**

**

**

THE HEMIPLEGIC PATIENT IN GENERAL PRACTICE—*The Clinical Journal—July-Aug. 1949.*

In discussing this important subject, Harold Dinken points out that recent advances in preventive and therapeutic aspects of medicine have resulted in a greater expectancy of life for the general population, and that physicians are therefore called upon to treat an ever-increasing number of patients with chronic diseases common to latter life. Cerebrovascular lesions are prominent in this group, and yet the problems of the patient left with a residual hemiplegia remain largely unsolved.

It must be recognized, however, that much can be done for the hemiplegic patient if treatment is started early.

The aims of treatment are—(1) to improve motor function, (2) to increase functional capacity and to prevent or correct deformity, and (3) to provide for the adjustment of the hemiplegic patient to the demands of daily life.

Physical medicine, occupational therapy and rehabilitation may all be used to achieve these aims.

In planning treatment the three basic aims are—(1) to start physical treatment early, (2) to measure the degree of disability and assess progress, and (3) to select, properly, the methods of treatment to be employed.

With regard to the time of starting treatment, it cannot be over-emphasized that the early institution of passive movements can do more to prevent the subsequent developments of deformities than any other measure. Although accurate assessment of the degree of muscular involvement may be difficult, the physician must make at least a rough assessment in order to follow progress and response to treatment. The ideal method includes the determination of muscle strength, the range of joint movements, and the functional testing of the factors inherent in daily living.

The various methods of physical therapy include heat, massage, electrotherapy, exercises, and the use of appliances.

Heat is indicated in the presence of pain, spasticity or oedema. Moist heat in the form of hot, wet packs is often most use-

ful. Massage may be helpful after heat, especially in the presence of oedema, but otherwise it should not be used in the treatment of the hemiplegic patient.

Electrotherapy has only a very limited place, although the interrupted galvanic current may occasionally be used when flaccidity persists. Electrotherapy should never be used in spastic conditions.

Movement re-education is of prime importance, and every attempt should be made to make the patient ambulatory as soon as possible. Postural and balance training may also be required.

Pully exercises are of great value, especially in the stretching of contractures, should these have developed.

Splints are especially useful in preventing contractures of the wrist and fingers and also in preventing foot-drop.

Occupational therapy, where properly prescribed, is invaluable as a morale booster and as an outlet for the patient's useless anxieties, as well as being useful as a method of movement re-education. In this respect it is wise to remember that it is more important for the patient to learn left-handed writing or shoestring tying than it is for him to learn how to weave a rug. Finally, the physician must help his patient to plan a rehabilitation programme which will help him to return to society as a productive, rather than a dependent citizen.

**

**

**

ENEMAS—*Margaret Loudon, F.R.C.S.—The practitioner—August 1949.*

It is the evacuant type of enema which will be discussed in this article. There are certain retention enemas in use, but except possibly for starch and opium, which is a soothing symptomatic treatment for diarrhoea, they are not concerned here. Other retention enemas, such as nutrient enemas, have fallen into disuse as it is recognised that the nourishment is not absorbed. Water is the important substance freely absorbed by this route and is widely used in the form of "rectal saline". It is best given as plain water, and large quantities of this life-saving fluid can be absorbed by this method when properly used. It is perhaps appropriate to mention here that the way to achieve this is

to have a minimum and even pressure of fluid.

The rectal tube should be of good-sized bore (not less than $\frac{1}{2}$ inch and should if possible be attached direct to a small funnel 3 to 4 ounce [85 to 115 ml.] capacity is convenient) containing about an ounce (28.5 ml.) of water. If any connexions are necessary in this part of the apparatus they must be equal of bore and not narrower. The funnel is arranged 1 to $1\frac{1}{2}$ feet only above the level of the anus, is open to atmospheric pressure, and is replenished from a large reservoir suspended above, from which the fluid drips slowly through a drip chamber into the funnel. If the patient coughs and the intra-abdominal and therefore intra-rectal pressure is raised, the fluid in the funnel can be seen to rise markedly. Even respiratory movement can be seen in the funnel fluid level, which demonstrates that no increased pressure can be corked up in the bowel when this method is used, and experience shows that using it makes the absorption of up to 9 pints (5 litres) or even more in twentyfour hours a practicable matter.

Indications for use:—Evacuation of the bowel may have to be assisted or ensured: (1) when constipation is present; (2) when it is wished to make an endoscopic examination of the bowel; (3) when an operation on the bowel is intended; and (4) when obstruction is suspected and information sought as to whether the lower bowel is being filled from above. In the first three groups the employment of either enemas or aperient may be considered; in the fourth group it is essential to avoid aperients and employ only enemas.

Experience shows that it is still necessary to continue emphasising the grave risk of perforation if an aperient is given in the presence of *obstruction*. An enema, on the other hand, is both safe and informative. If no result is obtained the diagnosis of obstruction becomes probable; if there is a result with the first enema the administration of a second, one or two hours later, with no result will have the same significance. It is just worth bearing in mind that something depends upon the person administering the enema. An inadequate enema may not empty completely the bowel below an obstruction and a second will therefore still produce a re-

sult, whilst an over enthusiastic enema may cause such a clearance that a patient with no obstruction may produce nothing with the second attack. The importance of such fallacies is relative only to the difficulty of diagnosis, and should not of course, be taken too seriously when all other evidence points in one direction.

Whether or not an enema is used for *constipation* depends in part upon the degree. In an acute, severe case, for example, a patient with a fissure-in-ano, whose rectum has become choked up with hard faeces on account of the pain of evacuation the more comfortable method of assistance is by enema (occasionally digital evacuation under anaesthetic is required). Oil run in by catheter overnight to soften the faeces, followed by gentle repeated washouts to break away small pieces at a time, is the kindest treatment. In chronic constipation from atony, commonly seen in the aged, and in cases of adult megacolon, it may be essential to use enemas, at least occasionally.

Preoperative Bowel Evacuation:—For many operations purgation is not necessary, and is indeed a harmful disturbance. Pre-operative enemas are therefore not now employed so extensively as previously although it should be noted that the practice dies much harder among the nursing than the medical profession. Inquiries reveals surprisingly often that the most trivial and irrelevant cases are prepared in this way. When it is necessary to have an empty bowel, of course the matter is different. Resections of the large bowel are safest when the bowel is both out of use and empty. A preliminary colostomy ensures the former and wash outs the latter. Such washouts are best carried out through and through from colostomy to rectum, but before this can be achieved rectal washouts may be necessary. It is not often that a wash-through cannot eventually be obtained, as the final completion of an obstruction is usually by a faecal plug in a narrowed lumen rather than complete obliteration of the lumen itself. Before such operations as haemorrhoidectomy or sigmoidoscopy the choice between aperients and enemas for clearing the field is a matter of individual preference. Some think that enemas may cause too much disturbance of the bowel, leading to an irritative diarrhoea which is

anything but helpful; moreover if any fluid has been retained it may be returned when the bowel is manipulated and this is equally trying. On the whole I am in favour of moderate aperients with sometimes a low rectal washout for haemorrhoids and often no preparation at all for sigmoidoscopy. If the view is obscured by faeces the examination is repeated after whatever preparation seems suited to the case.

Choice of substance and method:—Consideration needs to be given to the substances and methods used when enemas are ordered. There are two mechanisms where by evacuation may be produced, chemical irritation by the substances dissolved in the fluid, or the physical pressure of the fluid itself. Both factors operate with the ordinary soap enema. However, a very effective irritant and may cause a marked hyperaemia of the bowel as well as a painful tenesmus. Soft soap properly dissolved in not too great concentration minimises these effects, but even so a little soap in the eye or the nose demonstrates the irritation it can produce on mucous membranes. Many consider that its routine use should be discouraged. It is obviously undesirable to inflame the colon by the simple and natural method of raising the intraluminal pressure which will produce results. It is true that an obstinate case may not respond to a gentle slow raising of the pressure such as occurs when water is run in through a tube and funnel; but rather than add soap there is something to be said for the much criticised Higginson's syringe. If a catheter is slid over the bone nozzle there should be no risk of perforation, and the sharper rise in pressure it is possible to produce is most helpful. It is not always necessary: tube, funnel and water alone will often work, as evidenced by the number of returned rectal salines when given this way. If there is an objection to soap—and there is—there is an even greater, one to turpentine for the same reason. Of the irritative substances ox bile is perhaps the least offensive; it can be given in small bulk (10 oz. [285 ml.]), often a very useful point, and is effective and yet too not too irritating. Enemas such as those of oil and gruel gain their effect by the pressure of an adequate quantity, they are very comfortable as they lubricate at the same

time.

Fashions change in enemas as in most things, but if the principles of their administration are considered it is not difficult to apply them in their right context.

PENICILLIN IN THE TREATMENT OF INFECTIONS OF THE NOSE AND SINUSES—I. Simson Hall, M.B., F.R.C.P., F.R.C.S.—*The Practitioner*—June, 1949.

In planning the treatment of *acute nasal infections* it is necessary to keep clearly in mind the stages in the development and resolution of these infections. Acute coryza is a virus infection, and obviously penicillin treatment cannot have any effect on its progress. It is believed, however, that the virus infection is merely the earliest stage of a "cold". The symptoms which give rise to the greatest discomfort are those due to the secondary infection by pathogenic organisms to which the virus infection affords the opportunity of invasion. Although the virus infection is unaffected by penicillin, the secondary infection can in many cases be expected to respond to penicillin treatment, provided the organisms causing the infection are penicillin sensitive.

Local Therapy—In all local treatment with penicillin two circumstances are essential; first there should be good access of the drug to the part containing the organism, and secondly, the organism must be proved to be penicillin sensitive. In acute coryza the congestion and oedema of the mucous membrane rapidly block the nose, rendering the effective application of any drug difficult, if not impossible. Therefore if penicillin is to be useful it must be used in the earliest stages while the nose is still open. If this condition is to be satisfied it is obviously impossible to wait for a bacteriological report before applying the drug, and therefore it must be used in a somewhat empirical fashion. To summarize, penicillin, to be effective, must be used in the earliest stages of the malady, before the onset of the symptoms caused by the invasion of the secondary infection, and before it is possible to obtain any information regarding the bacteriology of the condition.

Methods of administration. There is a large number of methods of applying penicillin. It may be applied in the simpler

methods as a snuff, as a spray, or as drops; or as aerosols, either in solution or powder. The latter are very fine mists or powder, which require specialized and expensive equipment for their application and cannot therefore be regarded as convenient methods for general practice unless there happens to be an outfit available.

Of the more easily used forms, sprays and drops have the disadvantage that ciliary action removes them so rapidly from the nasal mucous membrane that it is almost impossible to obtain and keep up a sufficient concentration of the drug to maintain bacteriostatic levels. As a *snuff*, however, by using a suitable vehicle, it is possible to retain the penicillin in the nose for longer periods. In a concentration of 500 to 1000 units per gramme of powder such a snuff will be found effective in many cases, if taken frequently—say, once every two hours. It must again be emphasized, however, that its use is limited, for it requires an informed patient to use it properly.

Immediate availability is essential and the patient must recognize the earliest symptoms, such as tickling of the soft palate, irritation of the nasopharynx, or the sensation of dryness in the nose. If the patient has to wait until next day to go to the doctor for a prescription and then take it to the chemist, it is probable that the time for use will have passed and disappointment will result. The greatest use for this type of treatment will probably be found in institutions and industrial undertakings where medical service is constantly available.

Acute Sinusitis—Inflammatory reactions within the sinuses can be said to occur in most cases of acute coryza. Until there is obstruction either within the sinus itself or to the outflow of secretions, symptoms of headache, and the like, do not become manifest.

When an acute infection becomes obvious, intramuscular injection of penicillin is in all probability the most effective method of administration. Nevertheless, direct treatment can have some value and may be applied by direct injection into the affected sinus, or the penicillin can be introduced by displacement, i.e. by sucking air out of the sinuses and replacing it with penicillin solution as suggested by

Proetz. In such cases treatment must be accompanied by instillation of ephedrine in saline to ensure sufficient shrinkage of the nasal mucous membrane.

It has been found that when the ostia of sinuses are patent it is possible to obtain sufficient concentration of penicillin within the sinuses by a somewhat similar procedure of alternate suction and pressure, using an aerosol mist. Treatment by this method has to be carried out several times daily and requires the special equipment already referred to.

Chronic Nasal Disease—In general, it may be said that the local use of penicillin in chronic nasal disease is rarely effective. One of the chief reasons for this is the frequency with which there is an associated allergy. In such circumstances there can be nothing but a transient effect, even when sensitive organisms exist.

Occasionally some effect may be obtained in chronic nasal congestion by the use of drops (5,000 to 10,000 units per ml.) When this is tried, the patient should be in the supine position with head fully extended and should remain in this position for some minutes. The treatment should be repeated every four hours. If nasal congestion is marked, this procedure should be combined with instillation of ephedrine and saline drops to give the penicillin access to every part of the nose. If this form of treatment is not practicable the penicillin may be given as a spray, but in the majority of cases it has proved ineffective.

In *chronic sinusitis* the same principles hold good. When there is allergy, or marked oedema, or polyposis of the mucous membrane, penicillin will almost certainly fail, but when antral washouts show the presence of penicillin-sensitive organisms, then the introduction of penicillin either by puncture, displacement, or aerosols, will in most cases give good results.

Side-Effects—A word should be said about reactions to penicillin. These must be expected in a small proportion of cases and may consist of urticaria or dermatitis of the nasal vestibule. This responds to the usual remedies and the withdrawal of the penicillin. Another form of idiosyncrasy which is encountered is oedema of the soft palate and the fauces. This is

extremely uncomfortable and, if not recognized early, takes a considerable time to clear up and leaves a sensitiveness of the mucous membrane of the mouth even after the oedema has subsided.

Conclusion—The advice given can be summarized by saying that penicillin treatment of acute infections of the nose does not lend itself to scientific control such as is desirable with this drug. To be effective, it must be used in the earliest stages. The best results are obtained with special apparatus, whilst of the simpler forms, a snuff is probably the most useful. In general, results of local nasal treatment, except in certain specially favourable circumstances, have been disappointing.

* * * * *

FRECKLES—E. W. Prosser Thomas, M.D.
—*The Practitioner*—July, 1949.

Ephelides, or common freckles, are small flat pigmentary spots mainly of irregular or serrated outline and of a characteristic yellowish colour. Typical unilateral freckles have been recorded, but their usual distribution is symmetrical with a tendency to grouping in areas exposed to sunlight, namely the forehead, nose, cheeks, backs of forearms and hands, and sometimes the shins; they occur occasionally on covered parts (so-called cold freckles). Freckles are much more common in fair than in dark skins and are mostly correlated with red hair or red-blond hair. The spots become intensified and conspicuous in the summer because of the stimulating effect of ultra-violet light on the formation of pigment. But freckles do not, as is sometimes supposed, disappear completely in the winter; although many have apparently vanished or are visible only as faint stains in ordinary light, their presence can be demonstrated at all times when the skin is examined under ultra-violet light filtered through Wood's glass, which shows up the small circumscribed hyperpigmented areas quite clearly.

Ephelides are not congenital but appear in early childhood, usually between the sixth and eighth years; they tend to diminish with the years. Histological examination of an ephelides shows no abnormal changes apart from a simple excess of melanin pigment in localized groups of epidermal cells, mainly of the basal layer.

Origin and Nature of Freckles—There is a strong hereditary basis for freckling. For example, in 46 pairs of uniovular twins studied by Siemens (1924) both members were free in 15 pairs and both freckled in 30 pairs, and the degree of freckling was the same in both members of a pair. Only in one pair was one member freckled and the other not. Siemens observed a strong relationship between freckles and red hair but found scarcely any between freckles and the colour of the iris. Freckles are not rare with black-brown hair; these persons, however, may be genetically red-haired but have the red pigment masked by excessive quantity of melanin (Cockayne, 1933). The direct descent of freckles has been noted in many cases; for example, for five generations in one pedigree (Meirowsky, 1919). In a marriage between a freckled and an unfreckled parent the expectation of freckled to unfreckled children appears to be 1:1, and in that between two freckled parents it is 3:1. Cockayne regards freckling as probably due to a single dominant gene which is linked with that for red hair, both being in the same chromosome.

The nature of freckles is in dispute and the literature is confused. Darier regarded them as in every way comparable with naevi, despite their not being classed as such by the majority of authors. Meirowsky (1942) believes that the former distinction between freckles and naevi is not justified and that freckles represent the simplest form of pigmented naevus; the term naevi including all diffuse or circumscribed anomalies of the skin which are inherited, become visible at various times of life, and are composed of elements, such as pigment, blood vessels, lymph vessels, non-striated muscles, nerves, glands and hair, which are quite normal in themselves but are abnormal in their proportion. Thus, no sharp differentiation is possible between common freckles, naevi spili (flat pigmented moles) and lentigo, and from the anatomical point of view there is a gradual evolution from the feebly pigmentary freckle to naevus spilus and from that to the most striking hairy, warty and molluscoid moles. Meirowsky affirms that the normal, excessive or deficient manifestation of the single elements of normal skin, as well as microscopical naevoid features, are all determined by the germ plasm.

Differential Diagnosis—Even if both ephelides and superficial lentigines are simple naevoid pigment hypertrophies, there are well-marked clinical differences between the two which are not sufficiently recognized in some dermatological textbooks. Lentigines, which are present in almost everyone, appear much earlier in life than do freckles—usually in the second and third years—and are small annular or lenticular macules more deeply pigmented and of more regular outline. All are familiar with the isolated flat facial lentigo the so-called beauty spot. Lentigines occur in dark as well as in fair skins and their pigment is fixed and independent of sunlight, although some intensification may take place in the summer. In contrast with freckles, lentigines are discrete and of haphazard and asymmetrical distribution, occurring on covered parts of the body, such as the trunk and genitalia, as well as on exposed areas. The various differences between ephelides and lentigo have been enumerated by Brown (1943), who has studied the incidence of lentigines in children and discusses their possible significance, especially in regard to their appearance, sometimes in profusion, after infections in early childhood, such as pertussis, common colds, broncho-pneumonia, sinusitis and otitis media. He ascribes juvenile superficial lentigines to temporary toxic damage to the adrenals with consequent disturbance of melanin formation.

Histologically, superficial lentigo, like ephelides, consists of a loading of epidermal cells in a circumscribed area with melanin pigment, but in deeper lentigines there is in addition some thickening of the epidermo-dermal junction with proliferation of the rete-ridges and also evidence of an inflammatory reaction in the cutis.

Apart from the scattered pigmentary spots which occur sometimes in the elderly on the face, neck and dorsa of the hands in association with involutionary changes in the skin, there is a special and fortunately rare type of lentigo known as *lentigo maligna*, which appears usually, but not exclusively, in later life. Malignant lentigo, which was described by Hutchinson under the name *infective melanotic freckles* and later by Dubreuilh as *melanose circonscrite precancereuse*, usually occurs on the face and at first resembles an ordinary

flat, very dark lentigo. But instead of the hyper-pigmentation remaining localized and stationary it extends peripherally, and satellite foci of pigmentation often appear in the adjacent skin. Eventually the lesion becomes proliferative, vegetative and vascular constituting a pigmented carcinoma which metastasizes by lymphatic spread to the regional lymph nodes or via the blood stream to distant organs.

Malignant lentigo requires early and wide surgical excision with minimum manipulation of the tumour-removal with the line of excision close to the edge of the lesion is inadequate and dangerous. Neither this nor any other variety of flat or slightly raised smooth pigmented mole should be treated with acids, carbon dioxide snow, electrolysis or electro-desiccation.

Treatment—Freckles have been regarded from ancient times as a cosmetic defect. In some places it was believed that they could be cured by transfer to animals or to other persons and the various herbal and other folk-lore remedies employed for their removal ranged from a decoction of Solomon's seal made into soap to the application of the saliva of a fasting person (Rolleston, 1940).

Modern treatment is hardly more satisfactory because no applications to the surface can permanently remove pigment deposits within the skin, except at the cost of producing a scar. Freckle remedies of bleach lotions contain mild irritants which aim at exfoliating the horny layer and thus mechanically removing surface pigment in the scales. The chemicals employed for this purpose include ammoniated mercury, 3 to 8 per cent.; mercuric chloride, 3 to 6 per cent.; lactic acid, 0.5 to 1 per cent.; potassium hydroxide, 0.5 to 1.5 per cent.; and salicylic acid, 3 to 6 per cent. Other remedies consist of oxidizing agents, such as hydrogen peroxide or the perborates, incorporated into creams with the object of bleaching the melanin, but these probably act also as exfoliatives and have little bleaching effect. According to Schwartz and Peck (1947), the monobenzyl ether of hydroquinone will prevent the formation of melanin in the portion of skin to which it is applied, but takes from two weeks to two months to act because the melanin already present must be cast off before the skin loses its colour. A cream

containing 2 to 5 per cent. of hydroquinone monobenzyl ether may be used for whitening a large area, or smaller areas may be painted with the same percentage in collodion. Allergic contact dermatitis may result from the use of this chemical and also from the skin-peeling agents.

A formula for a so-called bleach freckle lotion is:—

Potassium chlorate	15 grains (1 g.)
Potassium carbonate	60 grains (4 g.)
Borex	15 grains (1 g.)
Glycerin	120 minims (7.2 ml.)
Water, enough to make	3 ounces (85 ml.)

Although there is no satisfactory means of eradicating freckles completely, their exaggeration in the summer can be prevented to some extent by screening them against sunlight with so-called sunshade preparations. It must be remembered that skin pigmentation is increased by rays of different wavelength from those causing erythema; hence *suntan* preparations which filter out the sunburn rays but allow the longer pigment-forming rays to pass, are useless for preventing freckles. For

example, the darkening of freckles cannot be prevented by applying p. amino-benzoic acid ointments and lotions, which are effective against sunburn. All heavily pigmented cosmetics (liquids, creams or powders) will prevent or reduce the passage of ultra-violet rays, or a "sunshade" ointment such as the following can be tried:—

Calamine	15 per cent.
Laurelin	12 per cent.
Yellow soft paraffin	38 per cent.
Water	35 per cent.

In freckled persons there is an aberration of the pigmentary properties of the skin as a whole, so that under the influence of sunlight only the small freckled areas acquire pigment, the intervening skin responding either with a feeble production of pigment or with none. Thus the non-freckled areas of skin become red and irritable in bright sunlight and such persons should avoid undue exposure and should not as a rule receive artificial ultra-violet treatment. It should be noted also that freckles are aggravated by other forms of radiation, such as X-rays, and on the whole indicate a generally sensitive skin.

SOLOMON GRUNDY

Pick up

Solomon Grundy was born, they say,
As all of us were on labour day.

And since he was born in a sleeping car,
Was berth-marked as such children are.

He tipped the scales (at eight and a quarter),
So did not need to tip the porter.

Through boyhood years no fruit he ate
Until at twenty he got a date.

He kissed the grass widow at her request,
And got hay fever as you have guessed.

An especially dangerous osculation
Since the widow's name was Polli Nation.

He railed at the lady: "Ah-chee, ah-choo"
Ragweed is the widow's weeds for you!"

So he married the widow the following Sunday,
And that was the end of Solomon Grundy.

—J. A. M. A.



IODISAL

An active recipe of easy absorbable, non-cumulative combination of iodides, mercury and arsenic with salicylate, specific for the treatment of all forms of syphilitic conditions and chronic skin and rheumatic conditions.

ALUMAG TABLETS

A combination of non-reactive colloidal Aluminium hydroxide and Magnesium trisilicate for the effective control of hyperacidity of the stomach without the induction of alkalinity or secondary rise of acid, like the usual antacids.

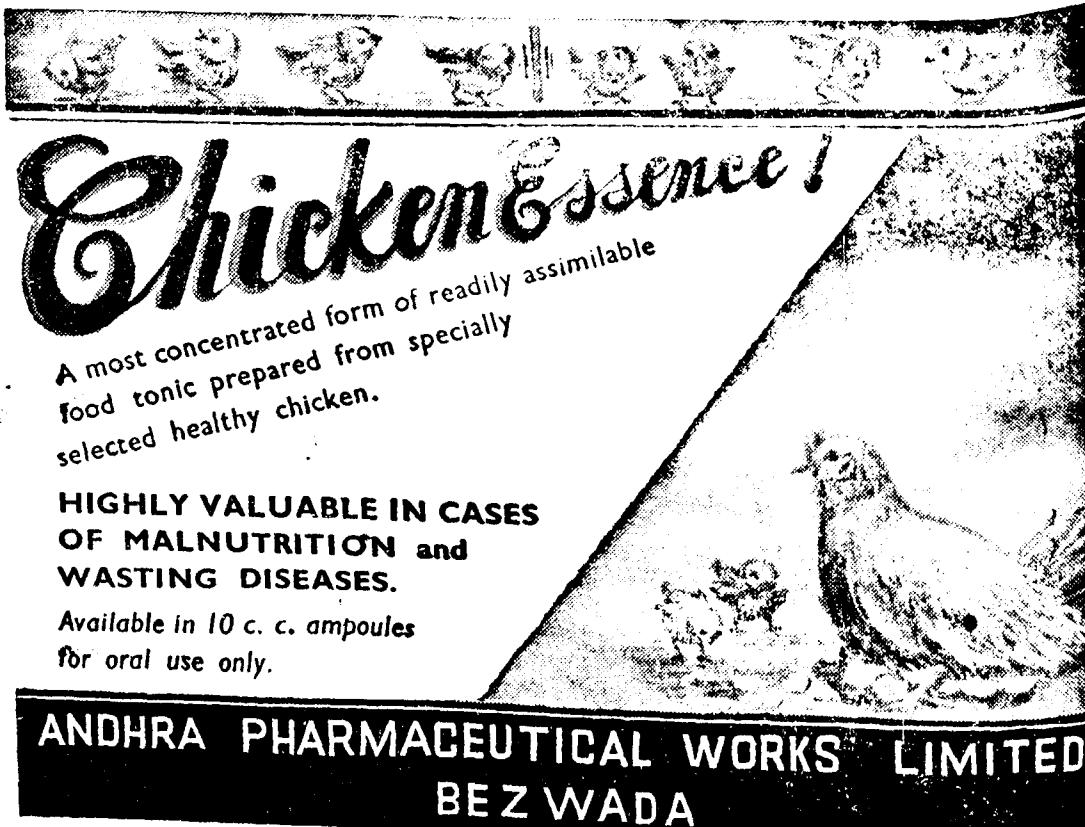
For further technical information and samples

Write to:—

THE SOUTH INDIAN MANUFACTURING CO.,

Pharmaceutical Manufacturers,

MADHURAI (S. India)



Chicken Essence!

A most concentrated form of readily assimilable food tonic prepared from specially selected healthy chicken.

HIGHLY VALUABLE IN CASES OF MALNUTRITION and WASTING DISEASES.

Available in 10 c. c. ampoules for oral use only.

ANDHRA PHARMACEUTICAL WORKS LIMITED
BEZWADA

The twelve principles of Social Security adopted by General Assembly in Geneva, 1948

Whenever Medical care is provided as part of Social Security the following principles should govern its provisions:—

1. Freedom of choice of physician by the patient. Liberty of physician to choose patient except in cases of urgency or humanitarianism.
2. No intervention of third party between physician and patient.
3. Where medical service is to be submitted to control, this control should be exercised by physicians.
4. Freedom of choice of hospital by patient.
5. Freedom of the physician to choose the location and type of his practice.
6. No restriction of medication or mode of treatment by physician except in case of abuse.
7. Appropriate representation of medical profession in every official body dealing with medical care.
8. It is not in the public interest that physicians should be full-time salaried servants of the Government or social security bodies.
9. Remuneration of medical service ought not to depend directly on the financial condition of the insurance organisation.
10. Any social security or insurance plan must be open to the participation of any licensed physician and no physician should be compelled to participate if he does not wish to do so.
11. Compulsory health insurance plans should cover only those persons who are unable to make their own arrangements for medical care.
12. There shall be no exploitation of the physician, the physician's services or the public by any person or organisation.

December, 1948.

CHANGE OF ADDRESS

- Dr. P. B. MENON, L.R.C.P. & S. from Kozhikode to Coonoor.
- „ P. RAGHAVAN, L.M.P. from Kozhikode to Badagara.
- „ K. K. NAMBIAR, L.M.S. from Cannanore to Edakkad, N. Malabar.
- „ M. C. RAMA IYENGAR, B.A., M.B.B.S.
from Tellicherry to Gudiattam, N. Arcot.
- „ A. T. JOHN, L.M.P. from Cherpulcherry to Quilandy.
- „ K. A. KRISHNA MENON, L.M.P. from Valapad to Tirurangadi.
- „ C. K. KARUNAKARAN, L.M.P. from Tirurangadi to Nadapuram.
- „ K. S. MENON, L.M.P. from Taliparamba to Alathur.
- „ A. RAMASAMY IYER, L.M.P. from Sendurai to Cuddalore N. T.

ODDS & ENDS

Acidosis is a frequent cause of post-operative hiccup.
Sod. Bicarb by mouth or intravenously relieves it.

∴ ∴ ∴

The Two critical periods in a man's life are when his voice changes and when his choice changes.

∴ ∴ ∴

The Working Committee of the I. M. A. is likely to meet in Coimbatore on 29th October 1950.

∴ ∴ ∴

The 1950 gold medal "for exceptional service by a general practitioner" has been awarded to Dr. Andy Hall of Mount Vernon by the American Medical Association.

∴ ∴ ∴

"What is your fee, doctor?"

"Five rupees for the first and three rupees for subsequent visits."

"Let me then have the subsequent visits, doctor."

∴ ∴ ∴

"May I ask what your son is doing?" one club woman asked another.

Reply: "He's a naval surgeon."

"Goodness," cried the 1st, "how doctors specialise." *J. A. M. A.*

∴ ∴ ∴

A man who wanted to be a centenarian was told by his doctor to give up drinking and smoking.

"Will I live to be a hundred?" asked the patient.

"No," said the doctor, "but it will seem like it."

∴ ∴ ∴

A MICROBE swimming along a vein, come face to face with another microbe who looked extremely ill. "What is the matter with you," it asked.

"Oh! Don't come near me," it replied. "I am afraid I have caught a little penicillin."