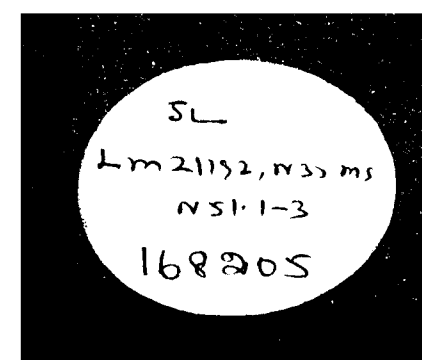




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# THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH  
INDIAN MEDICAL ASSOCIATION

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## GOVERNMENT OF MADRAS

PUBLIC (GENERAL C.) DEPARTMENT

### G. O. Re. Lease and Rent Control

(True Copy)

No. 1758/51—1.

SIR,

Sub: Madras Buildings (Lease and Rent Control) Act, 1949—Service of Members of Indian Medical Association—Declaration as essential.

Ref: Letter from the President, Madras Branch I. M. A. dated 5th May 1951 and the Memorandum dated 18th June, 1951.

By a notification published in the Fort St. George Gazette dated 1st May 1951, the services of all the employees of the State and the Union Governments are declared as essential for the purpose of section 7 (3-A) (i) of the Madras Buildings (Lease and Rent Control) Act, 1949. Such of the Members of the Indian Medical Association who are Government servants (including Honorary Medical Officers in the Government Hospitals) are protected by the above notification. As regards other Members who are Private Medical Practitioners it is open to them to approach the Government as and when they require protection from eviction and the Government will then consider the question on the merits of the case.

Yours faithfully,

(Sd.) A. E. ABRAHAM.

for Chief Secretary to Government.

## GOVERNMENT OF MADRAS

Health Department

Memorandum No. 323170/51—1—Health, Dated 9th July, 1951.

Sub: Medical Colleges—Selection Committee—Reservation of seats for children and Medical Men. Request—Declined.

Ref: From the President, Indian Medical Association, Madras Branch dated 18-6-51.

The Government regret that the request of the President, Indian Medical Association, Madras Branch in his letter in regarding to the reservation of seats for the sons and daughters of medical men in Medical Colleges cannot be complied with.

S. R. KAIWAR,

Secretary to Government.

genitals is an index of virility and sexual vigour is wrong; if anything the converse is true.

Normal potency therefore is a varying factor, and what may be considered normal by one man may be impotence to the other.

There is no difficulty in diagnosing impotence, the patient comes to you with the diagnosis himself—it is however for the doctor to take a detailed history and to examine the patient thoroughly and find out whether impotence is just one of the symptoms of a generalised disease, or is the only condition to be dealt with. I have come across a number of patients complaining of impotence and on examination they have been found to be suffering from tuberculosis, malaria with anaemia and other obvious lesions, and the impotence was one sign of the general weakness.

Impotence can be differentiated into organic impotence and psychogenic impotence. Organic impotence accounts for only 10% of the cases and complete investigation may be necessary before the cause is found.

Organic impotence may be due to lesions of the sex organs themselves. There may be a lengthy prepuce and phimosis, a too short frenulum causing painful erections, stricture of the urethra, a bilateral epididymitis, prostatitis, and a cystic disease of the neck of the bladder as described by Buerger. Weakness of the perineal floor has been considered a cause of impotence. Varicocele is sometimes associated with impotence, and a large hydrocele may interfere mechanically as also by causing pressure on the testis.

Orchitis, obesity, anaemia, high blood pressure, and malnutrition will cause impotence as also any debilitating disease as malaria, tuberculosis, etc.

Tabes and peripheral neuritis lead to impotence. Alcohol may lead to desire but excess is bad for performance and the peripheral neuritis it causes may also lead to the same result.

Major endocrinopathies associated with impotence are castration, eunuchoidism, infantilism, pituitary chromophobe adenoma, craniopharyngioma, acromegaly, diabetes mellitus, Addison's disease, adrenal neoplasm, myxoedema, thyrotoxicosis, and the male climacteric.

In castrated individuals, testosterone has a good effect even after a latent period of 20 years. Eunuchoidism or a condition of atrophy of the testes, may be genetic, or may follow mumps, typhoid fever, or follow torsion of the testes. Mumps are the commonest cause and the present treatment of giving stilbestrol in every male with mumps regardless of whether clinical orchitis is present or not, ought to reduce this complication. Eunuchoids have other features, as absent or poorly developed secondary sexual characteristics, hot flushes, sweating, migraine, and gynaecomastia may or may not be present. Infantilism includes infantile genitals, and may be associated with hypofunction of the pituitary gland. Impotence occurring in the course of tumours of the pituitary body, acromegaly and Addison's disease, is associated with other symptoms and signs and they should not be missed.

Diabetes mellitus causes impotence very commonly, and the possible causes are the endarteritis affecting the vascular

mechanism of erection, or the peripheral neuritis involving the presacral and other nerves. Control of the diabetes may or may not influence the impotence, and testosterone is usually ineffective. Impotence due to myxoedema can be controlled by thyroid extract.

The male climacteric may occur at any time between 40 and 60, and there is a great decrease or loss of potency, and a decrease of libido. Examination of the testes in these cases has shown a great reduction in activity of seminiferous tubules, and in the size and number of Leydig cells. Many of these cases benefit from testosterone, but in old people testosterone should not be given, unless with great care, as it leads to retention of fluid, an increase of metabolism, and aggravation of existing myocardial inefficiency.

The larger group of cases of impotence nearly 90%, the source of interference is psychic, and the condition is labelled "psycho sexual impotence" and the common cause is anxiety. Several types of this group may be considered:—

Impotence due to masturbation anxiety. Many men labour under the belief that the adolescent habit of masturbation leads to impotence. The feeling that he has committed a sexual offence makes him think that a suitable punishment will result, and what is a more suitable punishment than symbolic castration or impotence.

A homosexual may be impotent in a heterosexual relationship.

Impotence due to fatigue met in successful professional men. A person who works hard the whole day, and up to the late hours of the night should

not feel surprised if he does not have energy left over for love making.

**Impotence due to boredom.** There is a disposition on the part of married people to feel that certain methods of love making are right and proper and others are illegitimate and degrading. This is not the right attitude, and anybody who studies the Kama Shastra will find enough variations in the love acts to prevent boredom causing impotence.

**Diagnosis.** It is important for purposes of treatment to differentiate between the types of impotence and to ascertain if possible the exact cause of the condition. Impotence being a symptom of some condition that may be either physical or psychological, requires complete examination to determine the cause. Urethroscopy will be necessary in some causes to reveal lesions of the verumontanum, posterior urethra, and the neck of the bladder.

**Treatment.** Impotence due to such obvious causes as a lengthy prepuce, a large hydrocele, or hernia, can be easily treated by operation. Stricture of the urethra requires gradual dilatation. Lesions of the posterior urethra and the verumontanum, made out by urethroscopy are treated by gentle massage of the prostate, twice a week, passage of a sound, and the instillation of a weak solution of silver nitrate. The neck of the bladder and the verumontanum can be touched with 5% silver nitrate once or twice a month through an urethroscope or penendoscope.

Testosterone propionate is of real value in organic impotence due to a deficiency or absence of secretion of

testosterone by the testes. It is of no value in psychological impotence, or when there is a mechanical obstacle to the potency mechanism. The effects of this therapy only last as long as therapy is continued. If given by injection 25 mgm. testosterone daily, or 50 mgm. on alternate days will usually prove effective. Methyl testosterone by mouth is effective when given as a 10 mgm. tablet three times a day. A 30% higher dosage is said to obviate the necessity for allowing the tablet to dissolve slowly under the tongue, or between the cheek and the gums. 8 pellets of 100 mgm. each, may be implanted subcutaneously under local analgesia, and the effect lasts some 6 to 8 months, when a further implant may be necessary. As mentioned before, in the elderly, testosterone must be employed with caution, as they are generally suffering from multiple pathological conditions. In cases of prostatic enlargement, exhibition of testosterone may lead to sudden retention of urine. In children and adolescents, testosterone may lead to large genitals, and abnormal eroticism.

In psychic impotence, it is of the first importance for the medical man to carry out a thorough examination and assure the patient that he is normal. He must be told that masturbation, which is almost universal, is not followed by impotence. The busy professional man complaining of weakness, must be advised to take a long holiday away from his work. For those, who are suffering from various complexes, proper psychoanalysis may be found necessary.

It is in this group of patients, that general measures, like improving the

health, distractions like riding, theatres, rowing, travelling etc, may help. Aphrodisiacs and aphrodisiac articles of food are also helpful in this type, especially when the man is told that they are of such value. Heaps of products have been extolled as aphrodisiacs. Yohimbine is considered a specific by many in a dosage of 5 mgm. T.D.S. In some it helps, but in others it is of no use, and it is likely to do harm in persons afflicted with any kind of circulatory disturbance. Nux Vomica is considered superior, and 5 to 25 drops of the tincture or 1 to 2 mgm. of strychnine two or three times a day (or 1/20 gr. of strychnine every four hours for four doses) give good results. The following articles of food are also considered aphrodisiac—saffron, mustard, cinnamon, carrots, turnips, nutmeg, cardamom, arrowroot, ginger, onions, cloves, pepper, oysters and fish. A penile splint has been mentioned to help in penetration, by keeping the organ erect; the mere possession of a splint may give the patient confidence in himself and make him potent.

Premature ejaculation, an anxiety symptom, may be relieved by a dose of bromide, or a glass of beer just before sexual intercourse. 1% cocaine ointment or Nupercainal ointment on the glans, may prevent premature ejaculation, by desensitising the glans. The newly married couple should not worry about the condition, as it generally tends to right itself.

Operative procedures. One of the earliest procedures carried out was Steinach's operation of ligature of both vasa. This simple operation might have benefitted a few, because of its suggestive effect, but it is of no value.

This procedure is carried out routinely prior to prostatectomy, and no urologist has seen any increase of potency following this operation. The next operation that came into prominence was Voronoff's implantation of ape's testes; this also had a boom, but the effects were short lived, and the same results can be obtained at the present time by the implantation of pellets of testosterone.

A new operation has been devised by Dr. O. S. Lowsley of New York. By experimental surgery on dogs, he has shown that contraction of the ischiocavernosus and bulbocavernosus muscles causes erection, and according to him, any interference with these muscles as in trauma to the perineum, inflammatory lesions, or even lack of muscle tone of these muscles, as may occur in people who have masturbated or have had excessive sexual activity will lead to impotence. The principle of the operation is that the perineal muscles are plicated thus taking up the slack of the relaxed muscles and thereby also retarding the venous return during erection.

The technic of this operation is as follows:— The anaesthetised patient is placed in the exaggerated lithotomy position, and a No. 19 F sound passed into the urethra. An incision is made in the bulging part of the perineum, extending from a point about 4 inches from the anal margin down towards that structure for about 2 inches. A branch is then made laterally on each side, to a point just above the point of attachment of the crus penis, the completed incision resembling an inverted Y. The incision is deepened through

fat and areolar tissues, until the bulbocavernosus and the ischiocavernosus muscles are exposed. At this stage, an atraumatic needle with chromic ribbon gut about 1½ inch wide is inserted into the lateral edge of the bulbo cavernosus muscle, pulled across the belly of the muscle and passed through the other side and tied with just sufficient strain to plicate the muscle and produce the exact amount of pressure to reinforce any contraction necessary to aid in producing erection. Two more similar stitches may be required to tighten the whole muscle. A figure of eight ribbon gut suture is inserted into the ischiocavernosus muscle on each side, taking care not to injure or unduly compress the fairly numerous nerves and bloodvessels in this area. By tightening this suture, the muscle is approximately shortened by about an inch. The wound is closed in layers without drainage. (Instead of the chromic ribbon gut employed ordinary chromic catgut No. 1 on an atraumatic needle may be used.)

An additional procedure was found necessary, as although the impotence was relieved at first, later it became less efficient due to the fact that the dorsal veins became enlarged and allowed the collateral circulation to carry of the stasis to freely. An incision two inches long is made over the suspensory ligament of the penis which is exposed and freed by blunt dissection. A compression suture is placed in the two leaves of the suspensory ligament, causing a moderate persistent compression which prevents a too rapid flow of blood out of the organ.

This operation has given good results in the hands of its originator. It must

be carefully performed in such a manner that the sutures are not placed too tightly nor too loosely. In the former case, oedema of the penis will result; in the latter, the proper erections will not be maintained.

Summing up, impotence in a young and newly married person should be very carefully and thoroughly investigated and all possible help given, but the old rake who comes to the medical man asking for renewed vigour, the correct advice would be to ask him to realise that he has got old, and the pleasures of youth are not for him and he should now confine his activities to those of a higher order.

### SPERMATORRHEA

SPERMATORRHEA, or morbid pollution is the discharge of seminal fluid containing spermatozoa and other elements, without erection or desire. The few cases I have seen have been in young men in their early twenties, and the condition causes a great deal of anxiety, mental suffering and physical ill-health.

Pollutions or emissions, are physiological or pathological. Physiological, are those that are accompanied by a vigorous erection; erotic dreams, and by the natural sensual gratification, and it must cause a sensation of well-being and relief. This can be met with in any adult who is not leading a normal sexual life and any man complaining about the condition must be assured that he is all right.

Morbid pollutions or spermatorrhea, may occur during sleep, when they are more frequent than normal, occurring every night sometimes, and there is an absence of erection, erotic dreams,

or voluptuous sensations, associated with the normal emissions, Pollutions also take place during waking hours in consequence of trifling mechanical irritation, such as friction by a tight garment. Patient may lose semen during micturition, defaecation, and also when he is in the company of the fair sex.

Spermatorrhea is nearly always due to previous masturbation. Phimosis may predispose, and if present should be corrected. Chronic inflammation of the posterior urethra, and seminal vesicles also causes spermatorrhea. Examination of the seminal fluid coming out in these cases often shows sperms which are not fully developed. Examination with a panendoscope is necessary in many cases, both for diagnosis and treatment. Generalised swelling and redness of the verumontanum and the posterior urethra can be made out through this instrument and application of 5 to 10% silver nitrate to the area is of great help. In some cases instillation of solutions of silver nitrate (strengths from 1% to 10%) into the posterior urethra is beneficial. One case of spermatorrhea had been treated as prostatitis, and given streptomycin, autovaccines and various other treatments, without any benefit and he responded to the above treatment.

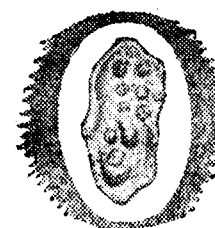
The sufferer from spermatorrhea must also be advised to regulate his life. He must be advised to abstain from indigestible and spicy foods in the evenings, supper must be finished at least three hours before sleep, the bladder must be emptied just before sleeping, constipation should be relieved, and he should preferably sleep on a

hard bed and the head end of the bed may be lowered to reduce congestion of the lower part of the body. It is also advisable not to be covered too warmly and sleeping on the back is to be avoided. Needless to say the patient should not excite himself sexually unnecessarily.



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## ASSOCIATION NOTES

### MADURA MEDICAL ASSOCIATION

#### Proceedings of the Combined Extraordinary General Meeting and Monthly Meeting held on 23rd June 1951 at Erskine Hospital, Madurai.

The above meeting was held on 23rd June 1951 at 5-30 p.m. with about 45 members present. Dr. M. N. Rajan, President was in the chair. The Building Plan submitted by Building Sub Committee was approved and the action of the Governing Body in this regard ratified. Proposed by Dr. A. K. Rajagopalan and seconded by Dr. G. A. Naidu, Dr. T. S. Tirumurthy was nominated to the Presidentship of the Indian Medical Association for 1951-52. The following were nominated to the Vice-Presidentships of the I.M.A. for the same year.

1. Dr. P. N. Ramasubramaniam
2. Dr. Capt. P. B. Mukherji
3. Dr. Chamanlal Mehta

The minutes of the last monthly meeting were read out and adopted. The letter from Dr. B. R. Venkatasubramaniam, M.O., Thevaram was read out by the President and the resolution passed on the subject by the Governing Body on 31-5-51 was completely amended. The following resolution was passed for being sent up to the Government of Madras.

"This meeting of the Madura Medical Association requests the Government to permit medical officers in Local Fund and Municipal Dispensaries to attend the District Medical Association monthly meetings and that their period of attendance at these meetings may be considered as "on duty".

It was decided to participate in the joint conference of the several District Medical Associations called for at Courtallam on 27th and 28th of July 1951 by the Thirunelveli Dt. Medical Association. It was decided not to hold the monthly meeting in July.

Dr. M. G. Varadarajan, M.B.B.S., D.M.R., Radiologist, Erskine Hospital, Madurai read an exhaustive paper on "X-RAY THERAPY IN THE TREATMENT OF NON-MALIGNANT DISEASES". He drew attention to the physical properties of X-rays, described the structure of the Choules Tube and referred to the biological effects of X-rays on such phenomena as phagocytosis hyperaemia, decalcification etc. etc. Dr. Varadarajan next dealt in detail with the pathology, pathogenesis and rationale of X-ray therapy in Supraspinatous Tendinitis. He concluded by a rapid reference to the indications and application of X-ray therapy in a wide variety of non-malignant diseases. Drs. A. Narayana Menon, K. A. Kalyanam, and G. A. Naidu took part in the discussion that followed. Dr. Varadarajan winding up the discussion replied to various points raised and said that X-ray therapy could very remarkably supplement other forms of treatment such as with antibiotics etc. and had a wide field of usefulness, more so, in a poor country like ours.

The meeting terminated after a vote of thanks.

Dr. P. KRISHNA MENON

Hony. Secretary.

July, 1951]

### ASSOCIATION NOTES

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#### MALABAR BRANCH

President : Dr. N. Achuthan  
Vice-President : Dr. R. Hermon  
Treasurer : Dr. K. Seetharaman  
Hon. Secretaries : Dr. C. V. Narayana Iyer, & Dr. A. B. Das

A meeting of the Malabar Branch was held on 28th April 1951 at the Mission High School Hall, Tellicherry, with Dr. N. Achuthan in the chair. The members were treated to light refreshments by the medical men of Tellicherry. The President appealed to all the members of the Association to take more interest and enlist more members to the I.M.A.

Dr. C. K. Menon read a paper on "Scope of Radiology in General Practice". Dr. A. Gopala Menon, Civil Asst. Surgeon, Tellicherry, demonstrated a few interesting cases.

The Secretary proposed the vote of thanks.

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A meeting was held on Saturday 9-6-51 at 5 P. M. at the West Coast X-Ray Institute, Calicut with Dr. N. Achuthan in the chair. Dr. C. K. Menon entertained the members to tea.

Dr. V. Govindan Nair, Retired Professor of Dermatology addressed the members on "Modern Conception of Syphilis and its Treatment." The same was illuminating and instructive and many members took part in the discussion which followed the lecture.

Lt. Col. T. S. Sastri was nominated for the Presidentship of I.M.A. for 1951. 52 and Dr. T. S. Tirumurti, Dr. P. A. S. Raghavan and Dr. V. Govindan Nair were nominated for the Vice-Presidentship.

The Secretary proposed the vote of thanks.

### The Sixth South Indian Provincial Medical Conference,

TO BE HELD AT

THE GANPAT HIGH SCHOOL, KOZHICODE

on 14, 15 and 16th September, 1951

The following items are being arranged:

1. A scientific session where papers by eminent medical men will be read and discussed.
2. An Exhibition of Medical, Surgical and allied products.
3. A "Souvenir".
4. Entertainments.

Arrangements for the stay of delegations are being made and details will be announced later

DR. C. V. NARAYANA IYER  
DR. T. BALAKRISHNAN  
Hony. General Secretaries.

DR. N. ACHUTHAN  
Chairman, Reception Committee.

## ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

## Athletics and the Heart—(Contd. from last month)

*The after-effects.*—The problem arises in retrospect. In middle life it is not infrequently asked by men who have been athletic in youth whether or not some harm may not have been done. It may be that the patient has fallen, rather early, a victim to coronary disease or to hypertension.

The athlete is of a physical habitus that in many cases tends to run to fat when he gives up his athletics for marriage and parenthood. He is probably better fed than when he was a bachelor, and his opportunities for exercise are likely to be less. Some men frankly degenerate physically in middle life, and run to seed, truly an instance in which "*Corruptio optimi pessima*". There is very little evidence that the most severe forms of athletics lead to premature cardiovascular degeneration. In years past, the longevity of the Boat Race crews has been studied, and nothing has been found to show that their expectation of life was not quite normal. There is no doubt that a thoroughly healthy and efficient heart is necessary to anyone who indulges in the severer forms of sport, and it does not suffer any harm therefrom.

## The diagnosis of the Healthy Heart

One final aspect of the matter still needs consideration. Often one meets patients in middle or later life who give the story that their hearts were strained in youth and athletics forbidden. In these days with diagnosis more accurate and appreciation of certain errors or fallacies more widespread, such mistakes are far less likely to occur. The most usual error to be made will be the faulty interpretation of some trivial physical sign, found perhaps on routine examination. The two most common are the harmless systolic murmur and the physiological third sound. Also a nervous

overaction of the heart may give the spurious impression of enlargement. But if any systolic murmur is carefully examined in the erect and recumbent postures, and its relationship to the phases of respiration noted and its place in the cardiac cycle marked, its harmless character should easily be decided. When there is any doubt at all, an expert opinion should be sought. It is a far worse mistake to label a healthy heart as diseased than to overlook the early onset of a lesion. The former error may never be corrected—such a label is very hard to get rid of—whilst in the latter case the right view is not as a rule long delayed. In the former case the adolescent may be deprived of activities essential for his proper development and suffer psychological trauma that may take a long time to heal.

Another point which nowadays does not often cause difficulty is an arrhythmia. Sinus arrhythmia in young people is usually recognized, and its enhancement by expiration, and its abolition by acceleration of the heart make it easy to diagnose. Occasionally premature beats are found; these are not common in the young and one should regard them as a hint to seek for sources of irritation or toxin outside the heart; they are almost always abolished by exercise; just occasionally they may indicate a mild rheumatic carditis which has been overlooked.

*The exercise tolerance test.*—This test has a certain value if carried out in a standard way. The principle is to find out what the response of the heart is to exertion. The rate of the heart should first of all be noted, recumbent and then standing. When it has steadied, the subject should mount a low chair some twelve to twenty times in the course of a minute. The heart rate is then recorded, a mental note being made

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every quarter minute; it is not difficult to carry four or five figures in one's head, and usually it is found that the initial acceleration rapidly changes in the third quarter; at the end of a minute, in the normal person, the rate is much the same as the standing rate. If the rapid beating is prolonged, it is an indication of a poor response.

It is just as important to notice the development of dyspnoea, and this, too, should be recorded. In a healthy young adult the increase in breathing is almost negligible. If there is a nervous tachycardia at the onset, exercise will often reduce it to a rate nearer the normal.

Wide conclusions must not be drawn from such a test as this, but it is useful as an indication of how that particular heart responds to a particular test. The test can always be made more severe by prolonging the exercise or increasing the height of the step to be mounted.

The general demeanour of the subject is often very informative, as well as his breathing and pulse rate.

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## THE URGE TO PURGE—SUPERSTITION AND PRINCIPLE IN SURGERY—

V. J. Kinsella, M.D., Ch. M., F.R.C.S., F.R.A.C.S.—*The Practitioner* April, 1950.—The theme which binds together the elements of this article is the management of the bowels after abdominal operations and in peritonitis.

Centuries before Hippocrates, centuries even before the sons of Æsculapius tended Ajax and Achilles, it was written in hieratic script upon the Papyrus Ebers that ileus was to be treated by active purgation. Expulsion of the evil thing would cure. In more modern times Hippocrates wrote that "all diseases are resolved by the mouth, the bowels, the bladder or some other such organ". In view of these expulsive ideas,

we may well shudder at the thought of the many patients through the ages whose sufferings from peritonitis and intestinal obstruction were made more dreadful by the primitive efforts of those who sought to heal.

But help was on the way. Hippocrates himself attempted the method of establishing principles by inductive reasoning. Observation convinced him that purgation not infrequently caused harm. He often tried to distinguish the circumstances in which purgatives should be given or withheld. He describes one type of fever, coming soon after food, with pain in the side, when the patient should lie quiet and purgatives should not be given earlier than the fourth day, and the diet should be water and oxymel, later supplemented by non-residue foods. Perhaps among these patients were sufferers from appendicitis. But, on the whole, his directions were vague and often incomprehensible. Aristotle may have had him in mind when he wrote that "a man strictly and properly speaking *knows*, when the principles are known to him; for if they are not better known than the conclusion, such knowledge as he has will be merely accidental". But, as generation succeeded generation, the data for establishing principles were gradually accumulated. Anatomists laid the foundation. Contributions came from physicians and, in more recent times, physiologists, pathologists and surgeons. In Padua, Oxford, Dublin and Boston torches were lit, and the sufferer from appendicitis owes more than a cock to Vesalius, to Harvey, to Graves and Stokes and to Fitz. Through their efforts we may now "strictly and properly know". But the truth and newly born principles must still struggle to survive. They encounter a bitter opposition from the ancient superstitions. The urge to purge or to be purged has a great fundamental force, and resembles those instincts which possess man, both individual and herd, sometimes even to destruction.

### The Functional Pathology of Distension

The facts and the principles cannot be stated too often, and to secure their recognition it is necessary to set them out clearly; this is done.

The data contributed by the anatomists is obvious enough. The contribution of the physiologists is shown by the two sets of arrows. One set points downwards and represents fluid poured into the gastrointestinal tract, some ingested and some secreted by the liver and pancreas and other glands. Even if nothing be given by mouth, the downward pointing arrows represent a daily volume approximating 2 gallons (9 litres) of liquid containing an ounce (30 g.) of salt. But, in spite of this daily in-pouring, distension does not occur, even if the bowels remain at rest. It is apparent that absorption by the intestinal epithelium preserves the balance. Not only liquids, but also gases, are exchanged through the mucosa. Absorption is represented by the set of arrows which point upwards. The balance is a basic requirement for our existence, and it is preserved with delicate efficiency by the epithelium. But there are two factors, either of which may so completely upset this balance that absorption becomes inadequate; One is the presence of irritants in the intestinal tract. The epithelium, for its own protection, responds to irritants by an increased secretion. Not only do the irritants stimulate secretion and hurry on the contents, but they interfere with absorption and with gas exchange by damaging the epithelial cells. The second factor is the distension of the bowel which, in surgical diseases of the abdomen, is usually caused by injury or disease of a segment lower down. The distension compresses the venules in the bowel wall so that the arterioles become a pressure pump, as stressed by Wangensteen. Blood is forced into capillaries faster than it can be removed, and the bowel wall becomes congested. Fluid is forced out of the capillaries,

causing oedema of the bowel wall, and it transudes into the lumen, causing more distension, and into the peritoneal cavity. Either one of these factors, the irritant or the distension, or both together, can cripple absorption and endanger the life of the patient.

The data contributed by pathology is the nature and extent of the gross organic changes in the bowel. Part of the intestinal tract, marked in the diagram by shading, is inflamed and more or less crippled. The bowel wall loses its sheen and is perhaps covered by fibrin. It becomes swollen, oedematous and congested and, after operation, studded with petechiae and small hæmatomas. It is flabby in texture, and may be stuck and kinked by exudate. Dysfunction results. Absorption and propulsion are impaired. The nature and distribution of these changes are very much the same, although varying in degree, whether their cause be trauma (even exposure to air causes a peritonitis) or infection, operation or disease, appendicitis, salpingitis, complicated hernia, or rupture of a peptic ulcer. The involved zone, usually the ileocaecal loop, is the middle zone. Above this is the upper zone, the duodenum and the greater part of the small intestine, which lie unaffected in their sheltered position under the parietal peritoneum, mesocolon, transverse colon and omentum. In peritonitis, the upper zone bears a heavy responsibility. It is left single-handed to deal with the bile and pancreatic juice and other fluids, and to maintain the fluid and gas balance. Fortunately, with its rich blood supply, villi and valvulae conniventes, it is the part of the alimentary tract best fitted for the burden. The lower zone, below the damaged loop, is of little importance in the pathology and treatment of peritonitis.

### Postoperative Management

The term "peritonitis" is used in its widest sense, and extended to include even

the mild inflammation which follows an interval appendicectomy. It is used in a pathological rather than a clinical sense. Such extended use of the term encourages a desirable consistency in after-treatment in all cases, mild or severe. From these simple facts, the correct methods of post-operative management follow inevitably.

*Elective alimentary rest.*—During the period of inflammatory crippling, often lasting for a week or more, the middle zone must be left at rest, for rest is the greatest healing agent for inflamed and injured tissues. At the same time, in the upper zone, the excretion-absorption balance must be preserved. The patient's anorexia and the consequent diminution in the flow of digestive juices, the natural immobility of the inflamed and injured intestine and of the intestine above this, conduce to these ends. It remains for us to abstain from any impatient or irrational steps which may frustrate nature's efforts.

Only those fluids may be taken by mouth (and milk is not among them) which need no digestion and can be readily absorbed—water with glucose and lemon juice, or with yeast extract ("vegemite"), and sometimes with amino-acid preparations ("hepavite"). They must be sipped in small quantities at frequent intervals, to avoid exciting gastro-ideal and gastro-colic reflexes. Later, perhaps after four to six days, when nature has established with more security her local defences in the middle zone, bread and butter, chocolate, butter-scotch and other non-residue foods may be taken, in small quantities at a time, and eaten slowly. In practice, the use of this system is facilitated by giving precise typewritten instructions covering the whole of the postoperative period. These may appear unnecessarily rigid, but they are preferable to leaving important details to the untutored whims of the nurse. It is impracticable, and unnecessary except in the very severe cases, for the surgeon

to give detailed instructions for each patient. But he can easily direct variations should the necessity arise.

Thus, before the end of the first week, the patient takes a diet, with all the elements necessary for life, using only the upper zone, resting the diseased middle zone and having no bowel actions. Patients and nurses who have not been educated to the method need reassurance that the absence of bowel movement is "according to plan", even after two or three weeks. Under this regime, described as "elective alimentary rest", patients recover smoothly and without distension from severe degrees of peritonitis, even that found many hours after the reapture of a gangrenous appendix. Mild distension disappears spontaneously.

In the first week the food intake does not measure up to normal requirements and weight is lost. But, as a rule, this is of little consequence, because most patients undergoing operation are well nourished, and the interruption of their normal feeding is but of short duration. They can easily draw on their reserves. The work of Carlson (1914) is of fundamental importance in this respect.

The patient in a state of malnutrition, usually due to a carcinoma of the alimentary tract, presents a different and a special problem, the solution of which is a task for the preoperative and not for the immediate postoperative period.

*Banishing the bedpan; the economical use of the nurse.*—The method of "elective alimentary rest", combined with a scheme of early ambulation, achieves a salutary revolution in the surgical wards. The bedpan practically vanishes. As a rule, patients have their first postoperative bowel action, a natural movement, during the second postoperative week, and by this time they are easily able to go to the toilet. Many of the patients after appendicectomy have their first action after their return

home on the fifth postoperative day. Relief is thus afforded to the nursing staff from the unpleasant task of securing and disposing of unnecessary and artificially provoked evacuations. The Saving in embarrassment for the patient and in discomfort for his neighbours can best be appreciated by one who has been a patient in a ward devoted to aperients, enemas, liquid motions, and bedpans.

Fæcal impaction occurs but rarely, and chiefly in old people admitted to hospital in an acute abdominal emergency with bowels already overloaded. But it is a small price to pay for added safety in peritonitis.

### The Abuse of Purgatives

The principles of treatment outlined are simple and effective but unfortunately there are still practitioners who have vague ideas expressed in vague terms, such as "paralytic ileus", and who are obsessed with the old expulsive superstition. They insist upon purging their patients. The purgative upsets the fluid and gaseous exchange at the surface of the mucosa in the upper zone, so that this part becomes a predominantly excreting, instead of an absorbing, organ, and vainly tries to empty itself of its excessive contents by battering against the immobile and stricken middle zone. Distension results, and this causes vascular congestion in the wall of the gut, which further hinders absorption and encourages transudation, thus establishing a vicious circle. The potential obstruction is converted by the medical attendant into an actual obstruction, because the diseased middle zone can deal with a trickle from above, but not with a torrent. Moreover, in the middle zone, damage is done by breaking down the early efforts at repair.

The giving of enemas is an irrational procedure because a little gas or fæces in the lower zone is of no importance in the disease, and the enema itself is dangerous

and damaging to the middle zone, just as are aperients. Perhaps if the enema is a very small one, and of normal saline, it may not do much harm, because it may not flow round to the cæcum. But the rectosigmoid loop, inflamed by the peritonitis, may suffer harmful disturbance in the insertion of the tube and the injection of fluid. In any event, the issue is decided in the upper and middle zones, not in the lower.

Parasympathetic stimulants and pituitrin should be avoided; so also should aperients during the forty-eight hours before operation.

One of the pernicious beliefs entertrained by many is that abdominal distension is an indication for violent expulsive therapy. Such beliefs menace the life of the patient. Mild distension nearly always steadily disappears under "elective alimentary rest". If the distension is marked, or if it fails steadily to disappear, or if the vomiting of brownish fluid or its aspiration through a stomach tube shows that absorption and secretion have become unbalanced then continuous aspiration and intravenous infusions must be used. Purgatives, enemas and the like, never!

### Textbooks and a New Explosive

Unfortunately, dangerous practices in the postoperative period receive encouragement from the ridiculous and contradictory teachings included in many modern textbooks, some of which I have quoted in a previous article (Kinsella, 1946.) Some of my surgical colleagues have tried to reassure me that the actual practice of surgeons is more enlightened than that described in the textbooks. I know this to be true for surgeons who have given thought to the physiological bases of abdominal surgery. The methods employed by those with special knowledge and skill are always in advance of those described in the textbooks. The great bulk of surgical practice

however, is not in such hands, but in the hands of those who, from their student days, remain very much under the influence of their textbook, and this not always the latest edition. It behoves the writers of textbooks to set their house in order. Since my last publication on this subject, there has appeared in Great Britain the fourth (1947) edition of an otherwise very fine textbook which in this matter provides a further example of that confusion and contradiction which are so often presented to the student.

In acute peritonitis the surgeon is advised to keep the bowels at rest for a week or more, but to give turpentine enemas for distension. But, of course, distension occurs in most cases. So the surgeon must keep the bowels at rest and give turpentine enemas at the same time! In the non-operative treatment of acute appendicitis "the first aim is to keep the inflamed parts absolutely at rest"... "but the bowel may be opened by enemas". "Emergency cases, operated upon without preparation, are no more liable to complications than others". As a routine, therefore, "... an aperient, and soap water enema are given before operation" (page 2), "and repeated after operation" (page 4). And so we need not be surprised that "gas distension of the abdomen is so common a postoperative complication as almost to be regarded as the rule" (page 9).

Even in "British Surgical Practice" (vol. 1: "After-care"), the traditional British ritual of purgation before and after operation is adhered to, although its rôle in causing painful colicky spasms is admitted.

In a well-known "Surgical Handicraft" it is written that "paralytic ileus" may be treated by the method of stimulation or by the method of rest. The latter method includes a turpentine or ox-bile enema, and then another turpentine enema. If these fail, a spinal anæsthetic and the passage of a rectal tube high into the colon through a sigmoidoscope are resorted to (as though the sigmoidoscope could get to (as though the sigmoidoscope could get through the obstructed ileocaecal region!). If this be rest. Heaven preserve us from

activity! Neither is far removed from the barbaric practices of the Zulu mother, who thrice daily inflicts upon her infant an enema administered through a hollow reed, convinced that if this were not done, the child's bowels would not open.

If anyone doubts that the evil spirits of primitive times still stalk the earth, and that their cult and ritual are still to be found in the shrines of modern medicine, I need only point to the unholy anticipation with which the *British Medical Journal* (1948) looked forward to the introduction into Britain of a new compound, D.F.P., discovered fittingly enough during research in chemical warfare, and which can be used to batter a way, with almost explosive effect, through the sick and ailing bowel. It can even sensitize the normal subject for weeks and produce a tumult of intestinal contractions.

### Teachers of Surgery

In order to secure a picture of present-day beliefs, I wrote to leading surgeons and teachers of surgery, in Great Britain, Europe, America and New Zealand. I asked them to describe their methods in regard to feeding, aperients and enemas after abdominal operations. I received fifty-three replies. Some of these were incomplete, probably because their authors had no method in the matter.

Sixteen used a good scheme of feeding, observing well the principles of "elective alimentary rest"; eleven, a fair scheme; and three advocated indulgence in a full diet from the first postoperative day.

Thirty opposed aperients; eight advocated their use on different postoperative days

Twenty-eight advocated, twelve opposed, enemas.

Sixteen advocated enemas and opposed aperients.

None advocated aperients and opposed enemas.

Six advocated a combination of enemas and aperients.

Ten opposed both enemas and aperients.

Some authors were vague; for example, they seldom advocated aperients unless indicated, or they deprecated the routine and excessive use of aperients, but gave no account of the circumstances in which they were to be used. Others were self-contradictory; for example, "we subscribe to the idea of alimentary rest as a general principle but prefer to individualize each case", in that, if the appendix were ruptured, D.F.P. was used, perhaps with pitressin or prostigmin, a low pressure enema of the irritant variety was given, and a Miller-Abbott and a rectal tube were left in place.

Many seemed a little shamefaced in confessing their use of the enema, and used euphemistic expressions, such as "small flatus enemas", "mild washings", "low enemas", "gentle low saline or soapy enemas in some cases", "occasional saline irrigations". It is difficult to see how really mild procedures which do not disturb the colon, could do any more than secure a few flecks of faeces from the rectum. Even if such futile procedures do no harm, it is difficult to see how they can do good. The author of a textbook explained in his letter (but not in his textbook) that the enemas which he advocated were "low pressure enemas". It is, of course, by the "low pressure enema" that the radiologist drives the barium to the caecum and through into the ileum. The high pressure enema is quickly resented, and expelled by the colon. One surgeon replied that his clinic had used enemas until five years ago, when they lost a patient because the enema "blew out" through the appendical stump. Many, like Wangenstein, have noted the extension of inflammation after an enema. One surgeon described himself as a "great believer" in postoperative alimentary rest, and referred me to an article which he had written in *The practitioner*. In this he shows an understanding of the intestinal tranquility which normally follows a laparotomy (although he

most ineptly names it "active ileus"); he respects it scrupulously, until almost the last moment; but then, when the least affected lower zone announces its recovery by the passage of a little flatus, discretion is thrown to the winds and the whole intestinal tract is thoroughly flogged, regardless of the stage of recovery of the middle zone. Very many surgeons fall into similar error, failing to realize that the bowel is not uniformly diseased, that it does not recover as a unit, and that its varying parts need varying lengths of time for recovery. Thus, if the upper zone can produce a borborygmus, or the lower zone a little puff of wind, it does not necessarily follow that the middle zone is in a fit state to withstand a battering by aperients and enemas, and to deliver a flow of intestinal contents with an energy far in excess of the normal.

Other surgeons divided their patients into two groups, one with, and the other without peritonitis. But this distinction is invalid. All the patients have peritonitis, even if it is not clinically obvious, ranging in an even gradation from the mildest to the most severe. This is more than a matter of terminology, because the two groups are submitted to contradictory plans of treatment. Some of these surgeons treat the severe cases by alimentary rest, and submit the milder ones to a rigor of activity, exceeding even that customary in normal health. Others commit the contradiction in the reverse fashion. The extreme contradictions in therapy contrast sharply with the even gradation in pathology.

Among the replies there was testimony to some unique methods and beliefs. One surgeon advocated the Miller-Abbott tube after practically every laparotomy. Another made free use of blood transfusion, but only direct transfusion, having "no use for the canned garbage dispensed by the blood bank". Another set great store by coca-

July, 1951]

### Mortality and After-Treatment

Among my fifty-three correspondents a few reported their mortality in acute appendicitis.

The best results were those of A. B. McGraw and his colleagues from the Henry Ford Hospital, presented in 1948 at the Annual Convention of the American Medical Association. There were no deaths during a five-year period (559 cases).

The next best were those of J. Shelton Horsley—0.84 per cent. in 594 cases (1938).

The third best were reported by Tor Hierton from the General Hospital, Örebro, Sweden—I per cent. in 2000 cases.

In each of these three clinics the principles of alimentary rest are not only "subscribed to", but carefully applied.

My own personal series has grown from the 346 cases reported in 1946 to nearly 400, with no deaths.

In all clinics reporting a higher mortality than 1 per cent. there were gross breachers of "elective alimentary rest". In some, the clinicians were dominated by the biochemical laboratory and by the ill-founded fears of a negative nitrogen balance, even in the average well-nourished patient. The surgeons in one great clinic explained that they were led to stir up the alimentary tract "earlier than nature desires it" so that they could get on with the oral, as well as with the parenteral, feeding! But if they were to give up their routine aperients and enemas, their D.F.P. and prostigmin four-hourly, they would then be able, in the first week, even in a severe case, to utilize the upper zone for feeding. Such a reduction in the violence of their after-treatment would reduce their mortality.

### "Paralytic Ileus": A Meaningless Term

The term "ileus" is derived from a Greek word meaning "to roll". It is not clear whether the intestine or the patient rolls. It is stated in "British Surgical Practice" (1947, vol. 1, "Acute Appendicitis") that there are two groups of patients

with "ileus", one suffering from peritonitis, the other from intestinal obstruction. In the first group, neither the intestine nor the patient rolls. The difficulty is worse when "ileus" is described as "paralytic", because, if paralytic, there can be no rolling. Even when there is absence of "rolling", peristalsis can usually be stimulated by drugs or by spinal anaesthesia, showing that there is no true paralysis.

As the derivation of the word is confusing, so also is its definition confused. Sometimes it is used to indicate the failure of the bowels to act within a certain time after operation (and different authors fix different times); sometimes to indicate intestinal distension; sometimes colicky pains; sometimes vomiting; and sometimes a combination of two or more of these symptoms.

With such confused derivation and definition, the term cannot be of value. As already mentioned, it is used in "British Surgical Practice" to include two different diseases, the symptoms and treatment of which not only differ but even contrast. Confusion becomes worse in the works of authors who find, not two, but fifteen or twenty diseases to group together as "ileus". One modern author speaks of "true ileus", "false ileus", "false inflammatory ileus", and so on. Another distinguishes "active ileus" from "paralytic ileus", using the term "active ileus" most ineptly for that period of intestinal tranquillity which normally follows a laparotomy. Disturbance of intestinal behaviour has so many causes, which differ so widely in mechanism and treatment, that only confusion results from the attempt to deal with them under one section. It is much better that intestinal distension should be dealt with under the various diseases which cause it—peritonitis, intestinal obstruction, typhoid fever, cardiac failure, hysteria.

A precise terminology is not merely a matter of literary purism. Plato records

the teaching of Socrates that "to use words in the improper sense is not only a bad thing in itself, but it also generates a bad habit in the soul". False terms create and perpetuate false ideas. The term "ileus" has for generations encouraged and covered up woolly thinking and vagueness and contradictions in treatment. When used by the voice of authority, false terms are particularly mischievous. The false words and false ideas lead to wrong action. Thus, not only do the minds of the speaker and listener suffer, but also the body of the patient. In peritonitis, and after abdominal operations, surgeons are too often found like "the generality of men" in the time of Socrates, "fumbling as it were in the dark, and making use of strange names, so as to demonstrate them as the very cause". If the bowels fail to act by the prescribed day, or if colicky intestinal contractions begin, or vomiting, or if the patient is distended, the condition is labelled "ileus". The label is mistaken for a diagnosis and the surgeon feels no further urge to understand, and so proceeds to treat without understanding. It naturally follows that "paralytic ileus" is treated with "anti-paralysants", just as dyspepsia would be treated by pepsin mixture. It is hard to understand why such irrational viewpoints can still persist, in face of the clear conceptions which are set out in figure 1, and which should by now be a part of the heritage of medicine. Perhaps the facts have been handicapped in their struggle for acceptance because they have no convenient word symbol. The basic fact is the cribbling of the middle zone. It is not adequately described as a "peritonitis" because the damage involves all layers of the bowel wall. The term "entero-colitis" is already in use to describe a condition which originates in the mucosa and is manifested by diarrhoea. "Ileitis" has already been claimed by Crohn. I suggest that we use the term "postoperative ileo-typhlitis". The advantages of such a

step would be far-reaching. If the condition were so recognized and so named, practitioners would not be led so easily to treat it by aperients, ancient and modern, by enemas and by injudicious feeding—and even by cæcostomy! The two grades of the condition are (1) "ileo-typhlitis with balanced exchange", and (2) "ileo-typhlitis with unbalanced exchange".

How easily the appropriate action follows when the terms are precise! Grade 1 is treated by "elective alimentary rest"; supplemented in Grade 2 by intestinal aspiration and intravenous fluids. There is no room here for the old expulsive superstitions.

\* \* \*

#### THE DIFFERENTIAL DIAGNOSIS OF TINNITUS—M. Spencer Harrison, M.D., M.R.C.P.Ed. F.R.C.S.Ed. Surgeon, Ear, Nose and Throat Department, Lincoln County Hospital.

Tinnitus may be defined as auditory sensation occurring in the absence of apparent auditory stimulation. This may arise, though rarely, from a source of mechanical vibration within the head, as, for example, an intracranial aneurysm. The resulting tinnitus has usually a pulsating character and can be heard by an observer by means of a stethoscope applied to the head. Still more rarely, clicking and snapping sounds may arise from spasmodic contractions of the intra-tympanic muscles or of the palatal muscles attached to the Eustachian tube, and these sounds, too, may have an intensity which renders them audible to an observer.

Much more common, and of greater importance, although less well understood, is the tinnitus, so-called neurogenic tinnitus, which arises from "spontaneous" nervous discharges occurring at various points on the course of the cochlear neurones between Corti's organ in the labyrinth and the

temporal lobes. The accurate diagnosis of neurogenic tinnitus depends upon a proper understanding of its pathological anatomy, and in the brief review which follows, the subject is discussed under a number of headings of this kind.

#### Reflex Tinnitus arising from Irritative Lesions of the Tympanum

Wax, although very common, rarely causes notable tinnitus.

Otitis media often causes tinnitus by virtue of the pressure changes which it induces in the tympanum by interference with the function of the Eustachian tube. The otitis is therefore typically of the catarrhal type with imperforate drumhead, and its diagnosis depends upon the recognition of the characteristic catarrhal changes in the drumhead and the onset of the tinnitus following a catarrhal infection.

Otosclerosis is almost invariably accompanied by tinnitus. The mechanism of the tinnitus is obscure, since the disease process, at any rate in its earlier stages, appears to be limited to the bony labyrinthine capsule, although Gray claims to have demonstrated degenerative changes in the cochlear nerve fibres themselves. This has not, however, been substantiated by other observers, and it seems more likely therefore that the tinnitus arises from some reflex irritation by the bony changes of the overlying tympanic plexus. The tinnitus is characteristically present from the earliest stages of the disease and the diagnosis of its cause depends upon the recognition of the typical otoscopic appearances, the character of the deafness, the family history and the other features which together make up the clinical picture.

#### Lesions of the inner ear affecting Corti's organ

Labyrinthitis.—This is usually tympanogenic, i.e., the labyrinth is invaded by

direct spread of infection from the middle ear. Much less commonly it is meningogenic, i.e., the labyrinth is invaded by an infective process of the meninges by way of the cochlear aqueduct or the perineural spaces of the cochlear nerve. This complication is particularly common in meningococcal meningitis. The resulting tinnitus is characteristically accompanied by severe deafness and vertigo, and this, with the recognition of the primary infection, generally renders the diagnosis obvious.

Ménière's disease.—Intractable tinnitus is a characteristic feature of this disorder, the essential pathology of which consists of a disturbance in the circulation of the endolymph, with distension of the endolymphatic spaces and chronic degenerative changes in Corti's organ. The tinnitus is accompanied by deafness and a characteristic distortion of hearing. These features, taken in conjunction with the typical history of paroxysmal vertigo, with nausea and vomiting and alterations in the caloric test results, always make evident the cause of the tinnitus. A particular point of interest and importance is the occurrence in some cases of an exacerbation of the tinnitus with the onset of the vertigo.

Acoustic trauma.—If the ear is exposed to intense sounds, whether they be pure tones, noises or explosions, damage to Corti's organ results. In the case of noises and explosions the damage is generally maximal at the base of the cochlea where high tones are normally received. High-pitched tinnitus is usually the result. It is generally temporary. This applies also to the tinnitus which follows exposure to pure tones, although in this case the pitch of the tinnitus generally corresponds to that of the injurious tone.

Vascular lesions.—Vascular lesions, thrombotic or embolic, of the cochlear blood supply may occur in the course of serious

Sedatives are indicated; for some, of a hysterical temperament, elixir bromo-valerian (Gabail) is ideal; others tolerate phenobarbitone or a more potent barbiturate; a few are helped by the antihistamines in high dosage, although generally their effect is disappointing.

*Treatment of individual cases.*—Once the possibility of *venereal disease* has been eliminated, and *focal sepsis* excluded by every possible means, the local cause must be discovered and treated.

*Fungicides.*—Owing to the high incidence of fungus infection due to either ringworm or yeasts, especially in young women, it is often worth while beginning treatment with a fungicide which is also an antipruritic. Probably the best is a preparation of undecylenic acid which is best prescribed as "fungicidal ointment—Boots" (or "deciderm ointment—Duncan Flockhart"), 1 ounce (31 g.); K. Y. jelly to 2 ounces (62 g.). It was first used for the treatment of monilial vulvovaginitis by R. F. Kendall, but is just as effective in tinea infections. It has an antipruritic action in flexural infective eczema, psoriasis and neurodermatitis, rarely causes irritation, and is clean to use. Mycil ointment and pessaries are effective but more liable to produce contact dermatitis. Castellani's paint is a most useful antipruritic fungicide, can be diluted with water if too potent, but has the great disadvantage of staining clothing. This paint can be employed with advantage in most exudative states of the vulva, even contact dermatitis, but particularly in flexural infective eczema and psoriasis.

Crude tar, either as a paint or as a paste, is extremely useful but must be applied with caution and only when the skin is dry and scaly. It is indicated chiefly in circumscribed neurodermatitis, asthma-eczema, and in the healing stages of fungus infections, psoriasis and flexural infective eczema.

*Antihistamine creams*, such as anthisan and benadryl, are effective only in asthma-eczema and neurodermatitis, and may produce severe reactions if used on an inflamed skin. It will be found that much more relief can be obtained by using the simple bland applications such as calamine lotion, zinc ointment, or even white petroleum jelly.

*Radiotherapy* is an extremely potent weapon, but a dangerous one and the fact that a patient has pruritus vulvæ is no indication for X-ray treatment. It should be used carefully in conjunction with other treatment and only because of definite indications, e.g. neurodermatitis; the best results are obtained from fractional doses. Care should be taken not to exceed the maximum skin tolerance, and if there is any doubt, thorium-X should be used instead.

*Subcutaneous injection of anaesthetics*, such as proctocaine, is extremely efficacious in selected cases, and should be done by a gynaecologist in an operating theatre.

*Hormonal therapy* once so widely acclaimed as a wonderful treatment for pruritus, especially in menopausal women, has little value in the average case, either by mouth, injection, or local application. It is useful, however, in ointment form in some cases of kraurosis and lichen sclerosus et atrophicus.

*Hydrochloric acid*, supplemented by large dosage of vitamins, especially vitamin A, was first advocated as therapy for pruritus vulvæ by B. H. Swift, and T. N. A. Jeffcoate has recently stressed the importance of histamine-fast achlorhydria in obscure and intractable cases. Of 46 women, 34 were cured by the administration of dilute hydrochloric acid by mouth and iron preparations when required. The patients who respond to this treatment are generally post-menopausal women with yeast infections, circumscribed neurodermatitis, lichen planus and lichen sclerosus et atrophicus (sometimes), kraurosis, and occasionally leukoplakia.

*Psychotherapy* has occasionally to be invoked in severe and persistent cases, but generally is not required. Some doctors hold the view that the essential basis of all cases of pruritus vulvæ is psychogenic, but it is a great fault of our profession to consider as functional all symptoms for which we cannot find a cause, and the more cases of this trouble that one sees the more one realizes that a physical cause is almost invariably present, even though psychosomatic factors may seem predominant.

## ODDS & ENDS

World confederation of Physical Therapy in Copenhagen, Denmark 7—8 *Sept.*

Fifth World Congress of International Societies for the Welfare of Crippled Children 10—14 *Sept.*

International Congress of Anaesthesiology 20th *Sept.*

△

△

△

A doctor's attendance on a boy may mean anything. But, one interpretation which is unusual was obtained by overhearing the following altercation:—

"You are a coward, you don't want to fight."

"I am not a coward. I can lick you to pieces without a scratch on me."

"Then, why don't you try it?"

"My father will punish me."

"How will your father know when you won't get a scratch?"

"He will know when the doctor goes to your house."

△

△

△

Ram and Gope went up by the Mountain Railway to see Ooty for the first time. On the way they saw some attractive ~~plums~~ and hesitatingly bought two. Just when the train was about to enter a tunnel, Gope ate a bit of the fruit and when it was all dark he shouted "Ram, Ram, don't eat that fruit, it has made me blind."

△

△

△

Doctor: "There goes the only woman I ever loved."

Nurse: "Why don't you marry her?"

Doctor: "I can't afford to. She's my best patient."

△

△

△

"Well, what is the matter with your husband?"

"I think, doctor, he is worrying about money."

"Ah, I can relieve him of that."

△

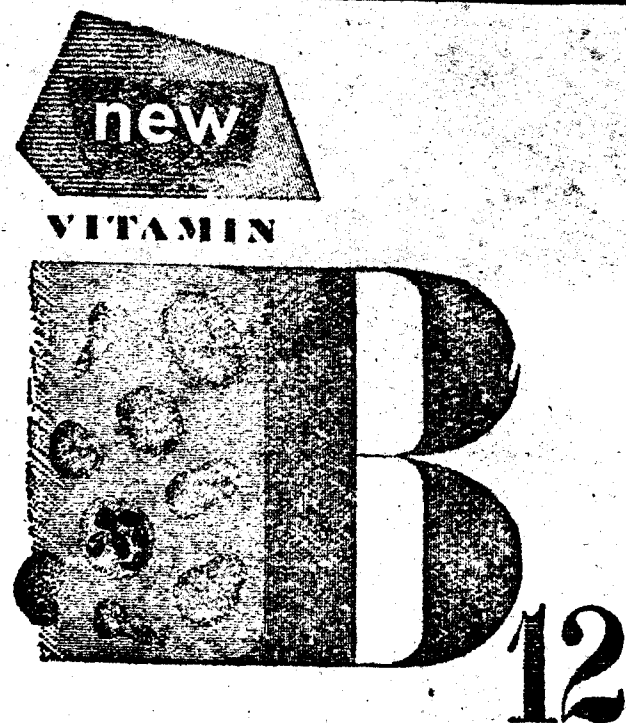
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The Compounder answering the phone call, told the lady the doctor was out.

"Will you tell him that I am having a carnival and that he must come and help?"

"Yes, madam, I will tell him as soon as he returns. In the meantime, rest in bed and apply hot fomentation for 5 minutes every hour."



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antianemic substance known."*

SMITH ET AL., J. N. B. A., 122-123, 1940

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सर्वजनाः सुखिनो भवन्तु

# THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH  
INDIAN MEDICAL ASSOCIATION

THE REGISTRAR OF

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Vol. XVIII

AUGUST 1951

No. 2

# THE SIXTH South Indian Provincial Medical Conference

KOZHICODE

|                                     |                                                                  |
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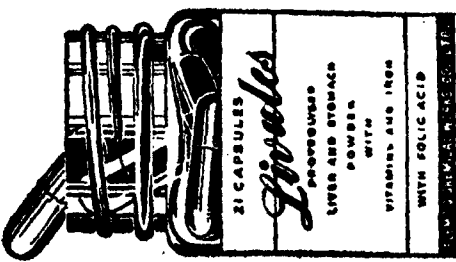
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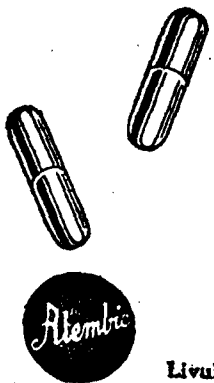
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# THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH  
THE INDIAN MEDICAL ASSOCIATION

VOL. XVIII]

AUGUST 1951

[No. 2

## STERILITY IN THE MALE

DR. P. GOVINDA RAO, F.R.C.S., Madura.

(continued from previous issue)

Barren marriages have almost always been blamed on the female partner. There is the case of one childless woman, who had two "D and C" operations, a tubal insufflation, a salpingogram, an endometrial biopsy, and a host of injections, tablets, and douches, extending over years, before some one thought of examining her husband, and his semen did not contain a single spermatozoa on repeated examination. This state of affairs is a very common one, especially in our country, where the male thinks, he could not possibly have any fault of his own. However, examination of the male is a much simpler affair, and if a marriage is unproductive after a reasonable period, it is best that the husband is examined first, and if active spermatozoa are found in the seminal fluid, then only the wife could be sent for complete investigation.

Sterility in the male denotes inability to produce and to transmit normal living spermatozoa. The condition is not necessarily associated with impotence, excepting that the impotent man is relatively sterile requiring the aid of artificial insemination. The responsibility of the male for barren marriages is variously estimated at from 25% to 50% (a recent investigation showed that

in 2/3 of the cases, it is the husband's fault) and as such one can realise the importance of examining the male partner.

Sterility may result from the lack or impairment of the spermatogenic function of the testes, from obstruction of the seminal passages, or from disease of the accessory sex glands.

Failure of the gonad function may be congenital, due to hypogonads, or bilateral cryptorchidism, or acquired. Acquired failure may result from castration, exposure to x-ray, injury, inflammation, endocrine disturbances, and nutritional disorders. Obstruction of the seminal passages results from injury, inflammation, or infection of the epididymis. Infection of the prostate and seminal vesicles is frequently injurious to the spermatozoa. Sterility also results, when there is pronounced deformity of the penis, either congenital, or acquired. In these latter cases, semen can often be collected for artificial insemination.

Diagnosis. A careful history and a complete physical examination are essential. Particular stress is laid on the physical examination of the genitalia for any evidence of abnormality, both developmental, and as a result

of disease. The most important single investigation however, is the examination of the seminal fluid. This must be done under specific conditions, as regards methods of collection, time factor, and frequency of intercourse. The use of the condom specimens is mentioned only in order that it may be condemned—the rubber is harmful to the spermatozoa, immobilising them quite rapidly, thus interfering with the motility count, which is one of the most important indices of their quality. The patient is instructed that the total amount of the semen ejaculated after masturbation (after a minimum period of abstinence of three or four days) be collected into a clean glass container, and be taken to the laboratory, the maximum delay being two hours between the time of production and the examination.

The following qualities of the fluid are considered:—

(i) Appearance—the normal seminal fluid has a whitish opalescent appearance. Occasionally where there has been a prolonged abstinence from sexual intercourse, it may have a yellowish tinge.

(ii) Volume—the normal volume is accepted as 2.5 to 5 c. c. 95% of this is from the secretions of the prostate and the seminal vesicles, (the total contribution from the testes, epididymides, and the ducti deferentes being about 5%) but this secretion is dependant upon the stimulation by the androgenic cells of the testis, and may be diminished where there is malfunctioning of the testis. There may be diminution also when there is obstruction in the passages, as in stricture or diverticulum of the urethra.

(iii) Viscosity—the seminal fluid when first ejaculated, is gelatinous within a period of 1/2 an hour, then liquifies and remains a rather tacky solution. Increased viscosity by itself, is considered to have no appreciable effect on the quality of the seminal fluid.

(iv) Motility—for normal fertility, the active motility should be at least over 50% and over. The percentage of motility has generally been made by counting both mobile and immobile spermatozoa in a number of restricted microscopical fields. This procedure is likely to give variable figures as it is difficult to count moving spermatozoa. The better method is to place a drop of diluted semen on a haemocytometer slide and immobile or sluggish spermatozoa are first counted, then all spermatozoa killed by brief application of heat, and counted again, and the difference between the two readings gives the number of fully active spermatozoa. This is a better method as it is easier and more accurate to count stationary spermatozoa.

Consistently low motility figures would brand the specimen as subfertile. Low motility figures may be due to an inherent defect in the spermatozoa, or malfunction of the prostate and the seminal vesicles so that the ingredients which ordinarily stimulate sperm activity are not properly regulated. Defective motility has also been considered as due to the presence of hydrogen peroxide caused by certain bacterial infections of the accessory glands, and massage, sulphonamides and when necessary endoscopic treatment may help to remedy the defect.

(v) Morphology—a smear of the seminal fluid may be stained by gram

stain and examined. It has been recommended that wet fixation methods alone should be used, as drying upsets the morphology. The normal spermatozoa has an oval head measuring from 4.5 to 5 m. The neck contains two knobs the posterior of which is attached to the axial filament running towards the tail. The tail is about 50 m in length. The common abnormal forms are the tapering forms, the round heads, the duplicate forms, giant and pinhead cells and the amorphous cells. In the normal fertile individual, the abnormal forms should be less than 30%. It is believed that pregnancy produced by a specimen showing an impaired morphology carries an increased risk of early abortion.

(vi) Count—Although semen specimens must be judged as a whole and not one or other of 'its' characteristics, still one can say that the count is the most important factor, especially so as it has been found that as the spermatozoa count falls, other defects in the semen increase almost in proportion. The count is carried out in the ordinary blood counting chamber, and the accepted lower limit of normal fertility is 40 million sperms per c. c.

It must be remembered, however, that the presence of even one spermatozoa in a man's ejaculate makes him a potential father. Pregnancies have been reported with repeated counts as low as one million and lower. These counts are not normal indications of fertility, but it shows the folly of telling a person suffering from oligozoospermia, that he is sterile. Even when not a single spermatozoa is found on examination—the condition of azoospermia—it is wiser to ask the patient to bring

another specimen some time later on as a case is recorded where the second time there were 30 million spermatozoa per c. c. The condition of azoospermia is found in about 10% of cases of subfertility sent for investigation, and these cases should be examined to see whether the condition is due to blockage of the epididymides, or vasa, or to failure of spermatogenesis. A biopsy of the testes is helpful in such cases. This procedure can be carried out under local anaesthesia and microscopical examination of the tissue removed reveals either normal seminiferous tubules with the occasional free spermatozoa in it, or there will be complete absence of germinal epithelium. In the former case, the azoospermic state is due to occlusion of the duct system, and vaso-epididymostomy may be tried; in the latter condition further treatment may be stopped.

Obstructive azoospermia is most often due to bilateral gonorrheal epididymitis, it may also be due to bilateral traumatic epididymitis, of tuberculosis of the prostate and epididymides. Seminiferous azoospermia or oligospermia where the basic fault is in the germinal epithelium, may be hereditary, due to malnutrition, fever of long standing, as also localised heat to the testes, bilateral cryptorchidism, mumps, tuberculosis, varicocele and irradiation. When Oligospermia or azoospermia is due to fever, one has to wait for about three months for full recovery. If operation is done before puberty in bilateral cryptorchidism, the prognosis is good. There is the story of a medical student (who was a bilateral cryptorchid) who heard Sir Astley Cooper declaring at a lecture, that bilateral cryptorchids were sterile;

he felt so depressed that he went and committed suicide. P. M. examination showed active spermatozoa in both the testes. Therefore the prognosis in cases of subfertility should be very guarded. A subfertile man married to a hyperfertile woman might produce a family, whereas two subfertile partners would not. Also a subfertile man has more chances of succeeding if he has intercourse at the time of ovulation of his wife. Riches reports a case of a man with azoospermia who had been working at a radon centre in a large hospital. A testicle biopsy had been done and showed absence of spermatozoa. The patient was told the outlook was poor but not hopeless, and 2 years later the man had a "bouncing boy" and so it is better to be careful not to tell anybody that their prospects are hopeless.

Treatment is determined by the cause of the sterility. Where it is obviously due to a deformity of the genitals, or to diseases of the accessory sex glands, treatment has already been suggested. In blockage of the passage as in gonorrheal or other condition of the duct or epididymides, vaso-epididymostomy may be carried out after making sure that the testes are really functioning. It must be remembered that interpretation of testicular biopsy is difficult. Also at operation, when incision is made in the epididymis, the escaping fluid should be examined for spermatozoa, and only after they are found should the anastomosis be carried out. In many cases where there are adequate testes, this procedure cannot be carried out because the site of blockage in the vas is above the point at which anastomosis with epididymis is possible. As such the operation is best suited to those

cases in which a gonorrheal infection has blocked off a portion of the epididymis, rather than those of congenital occlusion elsewhere in the genital tract. The most disappointing feature of the operation however, is, although potency may be obtained, still fecundity is rarely achieved due to the low sperm concentration in such patients. (It has been suggested that a number of these cases would have had poor semen specimens even in the absence of a history of gonorrhoea or bilateral obstruction.) Hence very often although the surgeon might consider the operation a partial success, to the patient it will be a total failure.

Most cases of oligozoospermia and azoospermia, are however due to faulty spermatogenesis itself, and the treatment of the condition is disappointing. Complete absence of a spermatozoa is with the exceptions mentioned before, a rather hopeless condition, and the patient may be advised (if he wants a child very badly) to adopt a child. In other cases thyroid extract has been given, chorionic gonadotrophins (the pituitary gonadotrophins have not been available in the Indian market) extolled to the skies, as of great benefit, and Vitamin E used in this condition as in many others, all with very disappointing results. There is one other product which had been declared contraindicated is sterility as it depressed spermatogenesis, testosterone—and in one case this drug converted a case of oligospermia to one of aspermia. However, its after effects seem to be beneficial and at present it is the drug of choice. It should be given in small doses—5 mgm. twice weekly, orally—when it is considered stimulating,

according to Millin, who has reported a number of successes with the treatment. Testosterone therapy is still in the trial stage and it is too early to draw definite conclusions. Irradiation of the pituitary gland is said to raise the sperm count temporarily, and may help in oligospermia. In addition general measures as rest and good food will always help a patient suffering from a sexual disorder.

Three common sexual disorders—impotence, spermatorrhea, and sterility—have been described in this paper, and it is hoped that it has been shown, that careful investigation and appropriate treatment will do a great deal to relieve the troubles of a group of patients who will not talk about their sufferings unless they are sure of patience and sympathy from their doctor.




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# ASSOCIATION NOTES

## COIMBATORE BRANCH

*President:* Dr. M. G. Nair  
*Vice-President:* Dr. I. Pichai Robert  
*Hony. Secretary:* Dr. K. V. Subramanyan, (Path.)  
*Assoc. ":* Dr. S. Balakrishnan  
*Hony. Treasurer:* Dr. T. V. Sivanandam.

The monthly meeting of the Coimbatore District Medical Association, Coimbatore was held on Saturday the 30th June 1951, at 6-30 P.M., in the Military Hospital, Coimbatore. Dr. M. G. Nair, the President presided. About ninety members were present.

President of the I. M. A. Dr. U. Krishna Rao, M.B.B.S., Thambu Chetty St., Madras.  
 Vice-Presidents " 1. Dr. Y. P. Vasudevan, M.B.B.S., B.S. Sc., Ranganathapuram, Coimbatore.  
 " " 2. Dr. Joseph Gnanadickam, Tiruchirapalli.  
 " " 3. Dr. P. Vadamalayan, M. S., Etc. Mathurai, (S. India).

With reference to the resolution moved by Dr. Y. P. Vasudevan regarding the proposal to construct a T. B. Hospital in Coimbatore Town for which necessary building sites may be given by the Government, it was resolved that a sub-committee consisting of the President, Hon. Secretary, the Dist. Medical Officer, Drs. Y. P. Vasudevan, N. Jagannathan, S.V. Subramaniam, Capt. Menon, C. J. Daniel, and B. S. Viswanathan, with powers to co-opt others from and outside the Association.

The next resolution moved by Dr. R. Lakshmana Rao, about the protest of the levy of sales tax on Radiologists was unanimously adopted by the General Body.

The President then introduced the lecturer of the day Dr. V. G. Govindan Nair, M.R.C.P., F.R.F.P.S., who gave an exhaustive lecture on "COMMON SKIN DISEASES" which was followed by a lively discussion. Owing to lack of time and the unavoidable absence of

After tea and light refreshments the General Body meeting began and the following members were nominated to the respective places noted against their names. (Ref.: I. M. A. Circular 34/50-51.)

Lt. Karpathia his paper on "Syndrome of protrusion of the intervertebral disc in the lumbar region" was cancelled.

The President then introduced Dr. Motahshaw of Messrs Lederle and Co., Ltd., who gave a short talk on 'AUREOMYCIN', which was followed by a film show on 'Aureomycin'.

Dr. S. Balakrishnan, M.B.B.S., D.L.O., the Associate Secretary proposed a vote of thanks. He first thanked the medical officers of the Defence Services and the staff of the Military Hospital, Coimbatore for their nice arrangement and the refreshments. He then thanked the lecturer of the day for his interesting talk. He also thanked Dr. Motahshaw and Messrs Lederle and Co., Ltd. for their nice film show. The final thanksgiving was to the members who assembled in large numbers in spite of their heavy work.

The meeting came to a close at 9-15 P.M.

August, 1951]

## ASSOCIATION NOTES

### MATHURAI BRANCH

*President:* Dr. M. N. Rajan  
*Vice-President:* Dr. T. S. Renga Iyengar  
*Hony. Secretary:* Dr. P. Krishna Menon  
*Hony. Treasurer:* Dr. A. S. Annamalai.

A meeting was held at 5 P.M. on Saturday the 4th August 1951 at the Government Erskine Hospital, Madurai.

The minutes of the last meeting were read out and passed.

Proposed by Dr. A. K. Rajagopalan and seconded by Dr. G. A. Naidu, Dr. U. Krishna Rau of Madras was nominated for the Presidentship of the South Indian Provincial Branch of the Indian Medical Association for 1951-52.

Dr. P. Vadamalayan of Madurai and Dr. Y. P. Vasudevan of Coimbatore were nominated for the Vice-Presidentships of the S. I. P. Branch of the Indian Medical Association, for 1951-52, being proposed by Dr. A. K. Rajagopalan and seconded by Dr. S. V. Joseph.

The following eleven members were unanimously declared elected as Delegates to the Sixth South Indian Provincial Conference of I.M.A. at Kozhikode.

1. Dr. M. N. Rajan
2. " K. Ramachandran
3. " P. Vadamalayan
4. " M. Venkatachalam Chetty
5. " V. Ramamurthy

6. Dr. K. A. Kalyanam
7. " K. G. Ramabadran
8. " A. S. Annamalai
9. " H. Shama Rau
10. " K. Balakrishnan
11. " K. Balasubramaniam

Dr. (Miss) Erickson M.B., Ch.B., Swedish Mission Hospital, Thirupathur, Ramnad Dt. gave a lecture on 'SOME CLINICAL ASPECTS ON STERILITY'. She detailed the numerous causes leading to the occurrence of a sterile marriage and pointed out the need for a systematic examination of the couple. Dr. Erickson, spoke at length on the endocrine deficiencies at work in the causation of sterility, and stressed the importance of an accurate diagnosis, and determining the particular gland that was at fault before launching hormonal therapy was essential. After discussing the treatment of the various conditions responsible for sterility the learned lecturer demonstrated a few films of Hystero-salpingography and the Tubal Insufflation apparatus. Dr. P. Govinda Rao and Dr. M. G. Varadarajan initiated a very useful discussion.

A vote of thanks was proposed. It was decided to hold the next monthly meeting at 6 P.M.

### TANJORE BRANCH

*President:* Dr. E. K. Menon  
*Vice-President:* Dr. T. M. Pillai  
*Secretary:* Dr. N. R. Subramanyam.

After tea given by Dr. T. M. Pillai on 29th April, 1951 at 4-30 P. M. in the Medical School buildings, R. M. Hospital, Tanjore, the members adjourned, for the regular meeting. 45 members attended.

The Vice President welcomed the new District Medical Officer, Dr. B. G. Shenoi who in turn replied expressing his pleasure and willingness to help the association in all its activities.

Members who have come from the neighbouring district of Trichinopoly were welcomed. Dr. Kalamegham, President of the Trichinopoly Branch intimated the members about the holding of the All India Medical Conference this year at Trichinopoly during December and requested one and all to give their co-operation.

Consequent on the transfer of Dr. Vaidyanathan, nominations for Presidentship was called for and Dr. E. K. Menon was unanimously elected as president. The minutes of the last meeting were read and adopted.

The newly elected president Dr. E. K. Menon, presiding requested Dr. M. S. Narayanan, L.M. & S. of Trichinopoly to give his talk on "Anæmias, Haematology and Therapeutics". The appearances of bone marrow and peripheral blood in normal and diseased conditions were discussed in detail. The value and use of drugs used in the treatment of anæmia were considered.

The following resolution proposed by Dr. N. R. Thangavelu Pillai and seconded by Dr. P. Narayana Rao was passed unanimously.

"Resolved that this meeting of the Tanjore District Branch of Indian Medical Association requests the Government of Madras to reconsider their G.O. in M.S. No. 3385 Health dated 27th Sep., 1950 issued on the G.O. No. 1087 P.H. dated 8-4-1946 enforcing medical Officers and Subordinates in Local Fund and Rural Service to obtain casual leave on Sunday forenoon and all other Public Holidays if they want to absent themselves and to pass orders permitting Medical Officers in local board service to avail themselves of Sundays and all public Holidays on permission as in the

case of Government Medical and all other services".

The President in his concluding remarks thanked the lecturer for the exhaustive information given and Dr. T. M. Pillai for the tea.

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The monthly meeting of the Tanjore District Branch of Indian Medical Association was held on 24th June 1951 at 4-30 P.M. in the Medical School premises. Thirty members attended the meeting.

After tea provided by the association the meeting commenced with Dr. E. K. Menon the president in the chair. The minutes of the last meeting was read and adopted.

After reading out of the routine correspondence the following were nominated for the Presidentship and Vice-Presidentship of Indian Medical Association for 1951-52.

Lt. Col. Shastry -- President.

|                      |                    |
|----------------------|--------------------|
| Dr. P. A. S. Ragavan | } Vice Presidents. |
| " Venkappa           |                    |
| " Tirumurthi         |                    |

An interesting and useful lecture touching on the emergency conditions of the various systems in the body was given by Dr. K. I. Thommi, B.A., M.B.B.S., Asst. Surgeon, R. M. Hospital, Tanjore.

A lively discussion ensued afterwards in which many members took part. The President in his concluding remarks congratulated and thanked the lecturer for the exhaustive information provided.

The meeting terminated with a vote of thanks to the lecturer by the Secretary.

## TIRUNELVELI BRANCH

The monthly meeting of the Tirunelveli Branch of the Indian Medical Association was held at Papanasam (Inspection Bungalow) on Sunday the 25th February 1951.

The Inspection Bungalow at Papanasam is amidst picturesque surrounding on top of a hill with the Pambar Falls and the Agasthiar Peak in view.

The meeting began with the members coming in groups and in singles by about 8 A.M. After breakfast, the members went to the Hope lake for a boating excursion to Banatheertham where they had a bath.

At 11-00 A.M. the members numbering 32 gathered for the lecture. Owing to the unavoidable absence of the President, Dr. K. Madhava Menon, M.B.B.S., the Vice President, Dr. K. Rama Ayyar M.B.B.S. took the chair. After reading of the minutes of the previous meeting by the Secretary, Dr. R. Subramaniam T.D.D. gave a talk on "Artificial Pneumothorax." He said that with the introduction of streptomycin patients and practitioners were under the false impression that a drug has been found after all, that can cure Tuberculosis. That attitude has made them relegate the time tested and accepted methods of treatment with alarming results. Collapse therapy of which artificial pneumothorax is one form is the method of treatment and streptomycin is at best an adjuvant to it. He then dwelt on how artificial pneumothorax is induced and maintained, the complications and their management. There was a general discussion following the talk. The President winded up the meeting and the proceedings came to a close with the Secretary proposing the vote of thanks.

The Secretary thanked the staff of the Electricity Department for their kind co-operation and the fine arrangements they made for the boating and

Dr. Nayagam for the general arrangements.

The members adjourned to lunch after which the meeting terminated.

A second boating trip to Banatheertham was arranged at 3 P.M. for the benefit of those members who were late.

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The monthly meeting of the Tirunelveli Branch of the Indian Medical Association was held at Palayamkottai in the office of the District Medical Officer, on Saturday the 31st March 1951. Members numbering 42 were present.

After tea, by the President, the meeting began with the reading of the minutes of the previous meeting, by the Secretary.

Then Dr. T. Alwar, D.M.&S., read an interesting paper on "Idiopathic Hypopiesis". He dwelt at length on the history of blood circulation from the days of Hippocrates through the days of Galen and Harvey upto the present day. He spoke on the various factors that control the blood pressure and influence it—the normal variation in blood pressure—The methods of estimating it and the pathological conditions in which it is lowered. He proceeded on to the condition of Idiopathic Hypopiesis which he maintained was a physiological normality and discussed the incidence of it in relation to sex and age, the symptomatology, the differential diagnosis and prognosis of the condition which makes a man not too ill and yet not quite well.

There was a general discussion after the lecture in which several members took part.

After the concluding remarks by the President, the Secretary thanked Dr. T. Alwar D.M.&S. for his interesting

paper, the President for the Tea and the members for their active participation. Then the meeting came to a close.

\* \*

The monthly meeting of the Tirunelveli Branch of the Indian Medical Association was held at S. A. V. High School, Tuticorin on Saturday the 28th April 1951. Members numbering 31 were present. The Tuticorin Medical Association were the hosts for the evening.

After tea, owing to the indisposition of the President, the Vice-President, took the chair. Condolence resolutions on the death of Dr. D. Nallathambi Pillai and Dr. Mrs. E. Bernard Carr were moved from the chair and passed all the members standing in silence for a minute.

Then the resignation of Dr. K. Madhava Menon, M.B., B.S., from the Presidentship of the Association was placed before the house and accepted with regret.

The Secretary read the minutes of the previous meeting and then Dr. V. Kuruvilla M.B., B.S., delivered a lecture on "Acute Abdomen". A careful history taking and methodical elucidation of physical signs in an essential pre-requisite in the management of a case of Acute abdomen, where even with all facilities the diagnosis may still be uncertain. He dealt at length on the various conditions; inflammatory, obstructive and traumatic that produce an acute abdominal catastrophies and their management—operative, pre-operative and post-operative of such cases, and the various pitfalls to be avoided.

There was a lively discussion following the lecture in which several members took part.

The President then wound up the proceedings by remarking that the abdomen in an acute case is like a

closed box and has to be opened to see the mischief inside. The dictum when in doubt open and see is nowhere more true than in an acute abdominal emergency.

The Secretary then proposed the vote of thanks and thanked the Tuticorin Medical Association for the excellent arrangements they had made.

After a short recess the members adjourned for dinner, after which the meeting came to a close.

\* \*

The monthly meeting of the Tirunelveli Branch of the Indian Medical Association was held at Palayamkottai in the office of the District Medical Officer on Saturday the 26th May 1951 when members numbering 37 were present.

The meeting began with tea by Dr. R. Subramanian. The election of the President then took place and Dr. K. Rama Ayyar was unanimously elected President.

After reading on the minutes of the previous meeting by the Secretary, the subject of holding a conjoint conference of the Medical Associations of the Southern Districts was taken up for discussion and a committee consisting of the following members—the President, the Secretary, Dr. K. Madhava Menon, Dr. L. Mahadevan and Dr. V. S. Ramachandran was constituted to make the necessary arrangements.

Dr. K. Rama Ayyar delivered a lecture on "Diseases of the Testis." Starting with the anatomy and embryology of the testis, he spoke of the congenital conditions which affect the testis—the undescended and the ectopic testis. Traumatic orchitis and inflammatory conditions of the testis both acute and chronic, specific and non specific were dealt with. Neoplastic swellings of the testis were discussed. There was a discussion following the

lecture in which several members took part. The meeting then terminated with a vote of thanks by the Secretary.

\* \*

The monthly meeting of the Tirunelveli Branch of the Indian Medical Association was held at Palayamkottai in the office of the District Medical Officer on Saturday the 30th of June 1951 when members numbering forty were present.

The meeting began with tea provided by Dr. P. V. Venkatachalam. Then the election of the Vice-President took place. Dr. P. R. Acharya of Tuticorin was proposed by Dr. A. R. Tampi and seconded by Dr. P. S. Kalyanasundaram and he was unanimously elected as Vice-President.

After the reading of the minutes of the previous meeting by the Secretary, details regarding the arrangement for holding the conjoint conference of the Medical Associations of the Southern Districts was taken up for discussion and it was unanimously agreed that all the members of our association must pay the subscription of Rupees Ten for the Conference.

Then Dr. G. Subramanian, M.B., B.S., Honorary Assistant Medical Officer,

Government Head Quarters Hospital, Palayamkottai delivered an interesting lecture on "Recent Advances in Therapeutics". Medical Therapeutics had made rapid strides during the last few years that an up-to-date knowledge of the present discoveries in the field of curative medicine is quite essential in keeping up with the time. Many newer antibiotics of proved value and of definite potentialities have come with the result that penicillin is remembered almost as a thing of the past Streptomycin and with it an array of newer products—auromycin, neomycin and viomycin, the newer chemotherapeutic agents, the newer antimalarials and a host of other products adorn the firmament of modern therapeutics.

The lecturer then dwelt at length on the advanced made in the treatment of such common diseases as typhoid fever, malaria, amœbiasis and venereal diseases. He wound up by saying that the present century has contributed much more in the field of therapeutics than all the previous centuries put together.

There was some discussion in which several members took part after which the meeting terminated with a vote of thanks by the Secretary.

#### TIRUCHY BRANCH

President: Dr. R. Kalamegham

Vice-President: Dr. T. V. Srinivasan

Secretary: Dr. C. R. Chari

Jt. Secy. & Treasurer: Dr. T. V. Sundaram.

A monthly meeting of the Association was held on Saturday the 19th May 1951 in the premises of the Govt. Hd. Qrs. Hospital, Puthur, Tiruchirappalli with Dr. R. Kalamegham the President in the chair. After Tea kindly provided by Drs. Enok and Balammal the President informed the members about the

All India Medical Conference to be held in Dec. 1951 in Tiruchy and read the names of the various office-bearers of the Reception Committee and it was approved by the members unanimously.

Then he introduced Dr. D. S. Iyer, M.S., F.R.C.S. of Madras to the members

and requested him to give his talk. The lecturer gave a very interesting lecture on Emergencies in Surgical Practice which was very much appreciated by the members. After the usual discussion by the members and with a

vote of thanks by the Secretary to the lecturer, the hosts of the evening and to the Superintendent of the Govt. Hd. Qrs. Hospital for allowing the hospital premises for the meeting the meeting terminated at 9 p.m.



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**RESTFUL SLEEP**

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NEUROSIS  
EPILEPSY  
MIGRAINE

**LUPOT**  
*Cipla* BOMBAY-8.

---

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symptoms rapidly disappeared and the urine became sugar-free.

Early in January 1934, I was again consulted, and I found that the urine contained more sugar than at any previous examination, a brick-red reduction being obtained with Benedict's solution, but no acetone bodies were present. The patient had not been careful about her diet, and was only taking 5 units of insulin twice a day. The blood pressure had risen to 190/100 mm. Hg, the brachial arteries were thickened, and the blood sugar at noon was 180 mg. per 100 ml.

In May 1934, the first symptom of peripheral gangrene appeared, and in an unusual site, at the tip of the middle finger of the right hand. Five days before I was consulted a small incision had been made into the tip of the finger, with gas anaesthesia, under the mistaken impression that the lesion was a whitlow. The patient now looked very ill, the temperature was raised, the middle finger was swollen all the way up, the tip of the finger was blue and cold, and the hand was discoloured. I arranged for immediate admission to hospital, when X-ray examination of the finger showed loss of soft tissue at the finger tip, with necrosis of the terminal phalanx, but no sequestrum was seen. I kept the hand and fingers at rest on a palmar splint and applied "antiphlogistine" every twelve hours to the finger. It appeared at first very probable that amputation of the finger would be required, and after a day or so a portion of the nail was removed under gas anaesthesia. The glycosuria was easily controlled by increasing the insulin to 24 units in the morning, and 10 units in the evening, and a diet was given containing carbohydrate 53 g., protein 89 g., fats 96 g., with a calorie value of 1,433. Healing took place rapidly, with loss of a portion of the pulp of the finger tip, and the patient was able to leave hospital after four weeks. It was curious that she was very liable to hypoglycaemic

attacks about 3 p.m., despite the fact that no insulin was given before lunch, but they were easily controlled by eating 2 or 3 lumps of sugar.

I again saw the patient in 1936. The finger had remained perfectly healed, the urine was free from sugar, and the insulin dosage was now 36 units a day. The blood pressure had risen to 200/104 mm. Hg.

I was able to follow up this case until death occurred at the age of seventy-eight from heart failure. During this time the patient was troubled at intervals with diarrhoea. Barium meal examinations showed no abnormality, and the diarrhoea was not of the nocturnal type which is sometimes met with in diabetes mellitus. It seemed probable that it was associated with the severe constipation and excessive use of purgatives.

*Comment.*—Insulin is always required in cases of diabetes with threatened gangrene. I have seen such cases in hospital when the house physician has ordered no insulin because the glycosuria has been controlled by dieting. This is a mistake. In all cases of threatened diabetic gangrene I now give injections of penicillin, with a view to combating secondary infection. I still find that "antiphlogistine" is a satisfactory local application. The amount of pain experienced in the affected extremity depends largely upon the circulation. When endarteritis or arterial calcification is present, pain is likely to be severe. The probability of saving the extremity also depends to a great extent upon the adequacy of the arterial blood supply. If there is arterial circulatory deficiency, as shown by dependent rubor, when the foot is hung down over the side of the bed, efforts should be made to improve the circulation by the use of vasodilators and other methods described later in the cases illustrating arterial obstruction.

**Thromboangiitis Obliterans**

In 1940 a man, aged fifty-one years, was admitted to hospital under my care on account of symptoms of intermittent claudication. After walking for 100 to 200 yards he complained of his legs "seizing up" with pain in the calves, but after standing still for a minute or two he could walk for another 100 yards, and so on. For two years he had not been able to play a full round of golf, but by resting on a shooting stick he was able to manage a few holes. The right leg was first affected and the early symptoms of discomfort had been noticed in the calf about twenty years ago. He had found lately that he could walk farther on grass than on pavements or roads.

Before coming into hospital two physicians, two orthopaedic surgeons, a physiotherapist, a neurosurgeon and two osteopaths had been consulted. Various treatments had been tried without any relief, and these included short wave therapy, mud packs, dry and wet massage, colonic irrigation, wax baths, radiant heat, ultraviolet, light, and intermittent venous occlusion with a Pavaex apparatus. He was accustomed to take "parsley tea" with the intension of "keeping his bladder clean". The neurosurgeon had advised a sympathectomy, but this operation had not been performed.

The patient smoked 30 cigarettes a day, drank beer and spirits, and had noticed that white wine intensified the pain in his legs. The legs and feet were always cold at night, but there were no rest pains. I found the feet cold and bluish-red, and there was a dark area, almost black, on the tip of the middle toe of the right foot. I could not feel pulsation in the dorsalis pedis or posterior tibial artery on the right side, nor in the posterior tibial artery of the left foot. On hanging the legs down there was dependent rubor over both feet and ankles, more marked on the right side,

and blanching of both feet on elevation. Pain could be induced in both calves if the patient flexed and extended his ankles while lying down. The pubic hairs were scanty, the legs almost hairless, and the genitalia small. X-ray examination showed no calcification in the arterial walls of the thighs or legs.

In all cases of threatened gangrene due to Buerger's disease certain investigations should be carried out. The blood Wassermann reaction should be determined, and a search made for a septic focus. The teeth, or jaws if the teeth have been extracted, should be X-rayed, together with the cranial sinuses. The tonsils should be examined for infection. A bacteriological examination should be made of the urine and, in the male, of the prostatic secretion obtained after massage.

In this case no evidence of infection was obtained, and the blood count and sedimentation rate of the red cells were normal. The dependent rubor and blanching of the feet on elevation indicated arterial obstruction. The degree of organic, as compared with spasmodic, obstruction in the vessels can be determined by taking the skin temperature of the toes, feet, ankles and legs before and after a spinal anaesthetic, or before and after warming the naked patient for one hour in a room at a temperature of 78° F. (25.5° C.). In this case the temperature of the toes of the left foot rose 10° C., but a rise of only 4° C. was obtained on the right foot, indicating that the obstruction on the left side was almost entirely spasmodic, whereas that on the right side was largely organic. These conclusions are only approximate and too much reliance must not be placed on them.

No drugs were required in this case to induce sleep, as there were no rest pains. Smoking was forbidden. Intermittent venous occlusion treatment was applied to each leg for half an hour daily, using an apparatus working from a tap in the

The subject of *cramp* falls to some extent within this class. There is no doubt that some persons suffer more extensively from this complication of bathing than others, and it is to be supposed therefore that it is they who are unduly sensitive. The condition of *cramp* is somewhat obscure and there can be little doubt that it is composite in origin. Some cramps are ordinary vascular spasms resulting from a sudden exposure to a lower temperature and, like the intermittent claudication of arterial disease, lead to intense pain, spasm, and loss of function of the striated muscle of the skeletal system upon which we rely for our safety when out of our depth in the water. Another rare type of "cramp", as the term is used by the public, is the vasovagal or syncopal attack which results from immersion in water when the stomach is overloaded after a meal and the physiological arrangements for adjusting the vascular bed, so dependent upon the splanchnic area, are therefore largely in abeyance. Such a state may lead to fainting and unconsciousness, no less dangerous in its results than muscular dysfunction.

#### River Bathing

Naturally, many of the conditions which I have already mentioned apply equally to bathing in any situation, but there are certain special features applicable to river bathing with which I now propose to deal.

In the river there is less likelihood of overcrowding. In the broader tolerance which obtains to-day it is permissible to change one's clothes behind a suitable bush or in such seclusion as nature offers, rather than in a formal building. In consequence, the dangers from contact with other human beings and their clothing are less likely to occur. On the other hand, the danger from infected water is greater, for there may be contamination from sewage effluent and the like. Usually the rate of flow and the high degree of dilution of any such contamination is a sufficient safeguard, but in

popular resorts, where large numbers of people congregate on public holidays, and in the proximity of large towns, the danger cannot be entirely disregarded, but nevertheless, this should not be overrated.

In river bathing there is an added danger from broken glass and other discarded utensils which are thrown into the water by ill-mannered and thoughtless persons. As with bathing in pools, the greatest risk will be infections of the ear and accessory nasal sinuses.

Parliament and the press have recently given some publicity to bathing in the River Thames. The differences of opinion expressed should be viewed in the light of the fact that the suitability of a river for bathing will vary, not only from place to place, but from time to time, depending upon many variable factors: the amount of pollution, the volume and the temperature of the water, and the amount of recent sunshine. Pollution is usually measured bacteriologically, i.e., by a *B.coli* count, and although the presence of these organisms in a sample of river water indicates contamination with animal or human excreta, it does not necessarily mean that the water is dangerous for bathers. The chance of pathogenic organisms being present in sufficient numbers to cause trouble is probably still remote except when high counts are obtained, and especially when a dangerous disease spread via the excreta is epidemic.

The cost of purifying river water for bathing, without interfering with the other amenities, seems prohibitive even in a branch stream.

#### Sea Bathing

Overcrowding, even though it may appear to be present in some of our larger watering places, is nevertheless unimportant because of the vast volume of the sea and the consequent infinite dilution of any contaminant which may find its way there. Moreover, brine in itself is a good

disinfectant and bacteria can only look forward to a short life when immersed in it. However, as the nasal and aural complications previously mentioned are due mainly to the mechanical action of the water, they may and do commonly occur after sea bathing. It is only in a confined harbour or in close proximity to a ship discharging its effluent into the water, that any risk of infection from the sea need be considered.

Naturally, in organized bathing stations where the use of cabins or tents is practised, and where clothing and towels are available for hire, the same hazards due to these articles apply as in swimming pools.

With regard to the sea water itself, salt is curative to some of the dermatoses, but aggravates others. A minor objection to sea bathing is that the swallowing of large quantities of salt may induce severe vomiting, but this is only likely to occur in young children or others very unskilled.

#### Some Rare Complications

Among the rare complications of bathing must be mentioned canicola fever and *Spirochaetosis icterohaemorrhagica*. These diseases are only likely to be contracted by those who bathe in such places as stagnant farmyard ponds and the like, which may be infected with the urine and faeces of infected animals. In any event, such pools have neither flow of water, volume of water nor disinfection to dilute or destroy any organisms that may have been introduced into them. It is therefore of some importance that parents should be instructed in the dangers of this pastime and its avoidance be strongly urged.

The danger of drowning is remote in pools and in places where large crowds are present, but this is very real in lonely spots and where tides and currents constitute a special risk.

#### Summary and Conclusion

Bathing is a popular, agreeable and desirable pastime; more especially is this

the case when it is done out of doors. It encourages healthy activity, enjoins the habit of cleanliness, and fosters a competitive and team spirit. Its hazards are few and many of them are rare. They are quite outweighed by the abundant and manifest benefits of this form of exercise. With a little elementary attention to hygienic principles, with care and with a minimum of knowledge, most of the hazards can be avoided.

It is appropriate that we should encourage in those responsible for organizing bathing a proper knowledge of these hazards and the means of their avoidance. I consider that only in a major epidemic of a dangerous disease, or when there is evidence of gross contamination of the water, should public bathing be forbidden. The wise and proper precaution to adopt is to regulate the pools and other public bathing places, to see that those who have their charge are properly instructed in the risks involved and the means of their avoidance, to encourage the public in the use of consideration and good manners, and to ensure that children are properly taught the art of swimming and diving.

\*\*\*

#### TREATMENT OF ACNE PITS BY SANDPAPER ABRASION.

The use of sandpaper abrasion in the treatment of pits resulting from acne is recorded by W. G. McEvitt (*Journal of the American Medical Association*, March 4, 1950, 142, 647). The patient is hospitalized, intratracheal anaesthesia is administered, and abrasion with sandpaper is carried to the point of profuse capillary bleeding. Haemorrhage is controlled by pressure, and then petroleum gauze, followed by a pressure dressing, is applied to the skin. The dressing is removed in ten days, by which time in most cases the treated area has healed and dried. In some cases, in which the skin is extremely reactive or the

abrasion has been unusually deep, healing may not have occurred; in this event the face is washed with soap and water, and a light dressing of penicillin ointment applied, which results in healing within a few days. In those cases in which pitting is diffuse, and mounds and tunnels are present, excision is first carried out, followed after a rest period of three to six months by sanding. The patients are re-examined after periods of three to six months and further abrasion carried out as indicated, the cycle being repeated until maximum improvement is achieved. In conclusion the author states: "... the results obtained with these methods have been gratifying. No case has come to my attention in which some degree of improvement has not been achieved, and, in most instances, the improvement has been considerable".

\* \*

### AUREOMYCIN IN WHOOPING —COUGH.

Satisfactory results from the use of aureomycin in the treatment of whooping-cough are reported by Chang, Shih-Man and his colleagues (*Journal of Pediatrics*, April 1950, 36, 443.) The initial dosage was 100 mg. of crystalline aureomycin hydrochloride per kg. body weight daily for five days. Subsequently this was changed to 60 mg. per kg. body weight daily for ten days. The daily amount was given in four equal doses during feeds. If vomiting occurred less than an hour after a dose, the same dose was repeated. Twenty-two children received aureomycin, only five of whom were over three years of age. The control group, to whom aureomycin was not given, consisted of the same number of children, and was comparable also in other respects; e.g., number previously

immunized, and duration of cough before admission to hospital. The frequency and intensity of the paroxysmal cough began to decrease after the second or third day of treatment. Of the ten patients who received aureomycin for only five days, three relapsed when treatment was stopped. Of the twelve patients who were treated for ten days, two had an increase of cough for several days after apparent improvement. The average duration of cough in hospital was 21.7 days for those who received aureomycin, and 30.3 days for the controls. Nasopharyngeal cultures for *H. pertussis* became negative on the third day of treatment among those who received aureomycin, and remained negative in all except three of the patients who were given aureomycin for only five days. The only side-effects noted were loose bowel movements and mild vomiting in six patients.

**A DEODORANT CREAM**—According to J. S. Peel (*Pharmaceutical Journal of New Zealand*, January 1950, 22, 18), the following is a "well-tried" and "effective" deodorant cream:—

|                         |         |
|-------------------------|---------|
| Diglycol stearate ..... | 20.0    |
| Hexamine.....           | 5.0     |
| Water .....             | to 75.0 |

The rationale of the use of hexamine for this purpose is that in contact with acid perspiration it is broken down and liberates formaldehyde. In this way it neutralizes the acid secretion and releases formaldehyde which is both astringent and bactericidal, according to the flow of the sweat. As soon as this is neutralized, the decomposition of hexamine ceases: "Thus, it is never in excess, whilst at the same time it exerts an astringent, neutralizing, deodorizing, and bactericidal effect".

## ODDS & ENDS

The spinal column is a long bunch of bones. The head sits on top and you sit on the bottom.

Manager (angrily) "How can you insure a man 90 years old?"

New agent: "I was going through the statistics and I saw very few people of that age die in a year."

The chief constable of a small town was also an expert veterinary doctor. One night there was a call for him on the phone and his wife answered it and enquired:

"Do you want my husband as a Vet. or as a policeman?"

"Both, madam," came the reply. "We can't make our dog to open his mouth and there is a burglar in it."

An aggressive looking woman consulted her lawyer regarding an injury to her thumb in an accident.

"Why do you want, 25 thousand rupees damages for this small thing?"

"Well, that was the thumb I was keeping my husband under."

She was 72 years of age and very ill in hospital. A few days later, thanks to a fundamentally sound constitution and modern chemo-therapy, she had considerably recovered. As I was about to pass on to the next bed she recalled me "Doctor" she inquired hesitatingly "do you think I shall get better?" "Of course" I replied reassuringly "you're well on the road to recovery already." "That's good, doctor, I do so much want to get back to my work." I was unable to disguise my surprise as I inquired what her work might be. "Well," she admitted shyly, "I look after an old lady."

The doctor whose medical skill far exceeded the clarity of his handwriting sent an invitation to a patient to spend an evening with him, adding that there would be music, cards and so on. The friend failed to turn up and sent no explanation. When they met the following day, the doctor asked whether he had received the note. "Yes, thank you," replied the other. "I took it to the chemist and had it made up, and I feel much better already."

"I have no faith of your modern science of medicine. Do you think you can cure me?"

"Oh, don't worry. The mule has no faith in veterinary science, but still, the Vet. is able to cure him of any illness he may have."

"How is Krishna getting on in the hospital?"

"Fairly well, but I don't know whether he will be out soon."

"Why? Did the doctory say so?"

"No, I saw his nurse."

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| Niacinamide . . . . .              | 20.0 mg.    |
| Ascorbic Acid . . . . .            | 45.0 mg.    |
| Pantothenic Acid . . . . .         | 1 mg.       |

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# THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH  
INDIAN MEDICAL ASSOCIATION

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SEPTEMBER 1951

No. 3



THE **SIXTH**  
**South Indian Provincial Medical**  
**KOZHICODE**

The Sixth South Indian Provincial Medical Conference will be held at Kozhicode (Calicut) on 5th, 6th & 7th October, 1951.

Sir A. L. Mudaliar, M.D., F.R.C.O.G., Vice-Chancellor, Madras University will inaugurate the Conference.

Dr. K. Vasudeva Rao, M.D., M.R.C.P., T.D.D., Director of Medical Services will open the Scientific Session.

Dr. K. S. Viswanathan, Director of Public Health is expected to preside over the sessions.

Papers will be read by—

- Dr. Betts of Vellore
- Dr. Moller of Madanapalle
- Dr. Anna Vareed of Coimbatore
- Dr. K. Ramurthy of General Hospital, Madras
- Dr. K. R. Doraiswamy, Radiologist, Madras
- Dr. C. Raman, Dist. Med. Officer, Malabar
- Dr. P. S. Venkatachalam, Nutrition Institute, Coonoor and others.

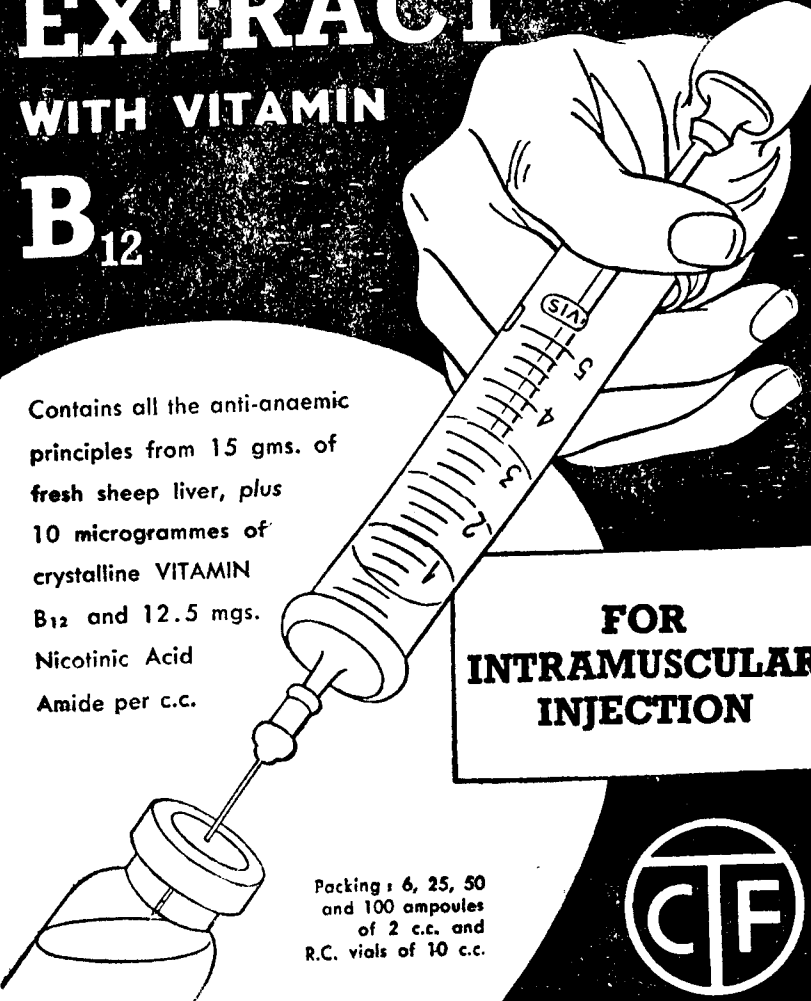
Dr. U. Krishna Rau who has been unanimously re-elected as President will preside over the open sessions.

Entertainments like **Kathakali**, **Ottam Thullal** and **Kolkali** are also have been arranged.

*All medical men are cordially invited to attend.*

**Dr. C. V. NARAYANA IYER,**  
*Hony. Secretary.*

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# THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH  
THE INDIAN MEDICAL ASSOCIATION

VOL. XVIII]

SEPTEMBER 1951

[No. 3

## RICE PROBLEM IN NUTRITION

BY

DR. R. SAMBASIVAN, M.B.B.S., TIRUCHY.

We have to consider this in relation to India's population. The latest published figure for India's population is roughly 35 crores. The present rate of annual increase in the population is 36 lacs. This works out to a monthly increase of 3 lacs. In other words 10,000 children are being added to our population every day. A writer has drawn attention to the serious fact that 6 children are born every minute in our country. Even allowing for the high rate of infantile mortality in our country this problem of the net increase in our population day after day, month after month, and year after year, is facing us grimly. Neither the present Government nor our public bodies nor our individual leaders, statesmen, thinkers, and writers seem to have faced this problem and worked out any solution.

This population problem has to be met in relation to our food production. Forecasting experts are frightening us that our population about 5 years hence would reach the stupendous figure of 50 crores.

Is there a corresponding increase either in food production or in food imports? The answer is NO. Then what is the advice given by our Government? They say "Cut down rice and take to tubers and groundnut". We shall test this advice in the background of certain biological facts.

Half the world population live and thrive and reproduce on rice as the staple diet. Again, 1/3 of the Indian population live on rice. How does it happen that this particular cereal is the staple diet for half the number of people of the globe?

The answer to this question is covered by two factors:—

1. Geographical factor i. e. Rice is the staple diet in those areas and countries where paddy is cultivated and grown for centuries. Naturally, it is the staple diet for the large groups of population living in those paddy areas and countries.

2. Biological selectivity factor—In explaining this factor we will first

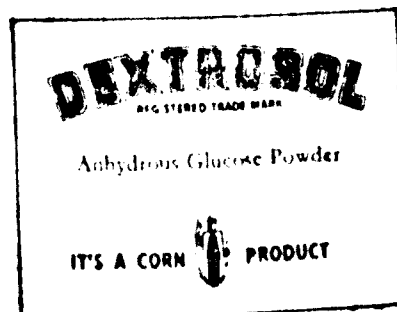
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economist consider the protein status of rice. The biological value of rice-protein can be easily judged from the index figures of the following table:—

|                      |         |
|----------------------|---------|
| Human flesh          | ... 100 |
| Meat and Beef        | ... 98  |
| Egg                  | ... 94  |
| Ragi                 | ... 89  |
| Yeast                | ... 86  |
| Milk                 | ... 85  |
| Rice                 | ... 80  |
| Red Gram (Toor Dhol) | ... 75  |
| Wheat                | ... 67  |
| Black gram           | ... 64  |
| Groundnut            | ... 58  |
| Green gram           | ... 51  |

These values are determined in relation to the Amino-Acid make-up in these food stuffs. The biological protein values in the above food stuffs are assessed thus: The more closely the Amino-acid make-up of a food protein resembles that of the body tissues, the greater its biological value; the more digestible and completely absorbable a food protein is, the greater its biological value. In this way the above table indicates clearly the following fact: Barring the animal proteins (meat, egg and milk) the cereal ragi contains protein of the highest biological value; but ragi is not grown universally in all parts of the globe. Next to ragi, Rice-protein shows the highest biological value and rice is grown on about 200 million acres in the whole world and India cultivates rice on about 50 million acres. Further, it has to be noted from the above table that rice-protein occupies the nearest status to the animal proteins, barring ragi.

When we are advised by political to cut down rice they are carried away by two factors, namely the Vitamin B-content and the starch content of rice. They say "you have Vitamin-B in groundnut and you have starch in Tubers (Tapioca, Sweet Potato etc.) This kind of advice completely ignores the vital importance of protein factor in our diet.

But then they say "you have proteins in pulses and millets". Against this advice Dr. Ackroyd says "more important than the total protein content of a diet is the proportion of protein of high biological value that diet includes." Proteins contained in various foods differ in their Amino Acid constitution. Amino-Acids are the bricks with which human tissue is built and replaced. As stated above, the more closely the Amino-Acid make-up of a protein resembles that of the tissues the greater its biological value. Dr. Ackroyd says further "Another factor to be considered in assessing the biological value of any food protein is the digestibility of the food stuff."

Then, pulses and millets are much shorter in supply than rice from the point of view of over-all agricultural production. Further is it practicable to substitute rice, bulk for bulk, by millets and pulses for large sections of the population? So, we come back to the finding again that rice stands as a staple cereal diet for centuries by mere biological selectivity. This is so because rice protein is of a high biological value next only to egg, milk and ragi.

Already there is short supply and high prices for "protective" foods

namely milk and milk products, egg, meat, fish, vegetables and fruits. So the population is already largely deprived of these "protective" foods containing first class proteins, vitamins, and minerals. Now on the top of this we are advised to cut down rice and its protein.

Let us now analyse the result of practising this advice. Dr. Ackroyd's figures for a balanced diet for a South Indian read thus:

|                  |                                              |                        |
|------------------|----------------------------------------------|------------------------|
| Rice             | ... 10 ozs. (equivalent to 20 grams protein) | Totalling 58           |
| Milk             | ... 8 ozs. ( " to 8 " " )                    | grams protein          |
| Millets & Pulses | ... 8 ozs. ( " to 30 " " )                   | tein per head per day. |

Dr. Ackroyd himself admits that anything below 65 grams of daily protein is a poor physiological standard. To put it in another way, this 58 grams protein in the above "balanced" diet is a mere 'subsistence' standard, i.e. for a man at rest all the 24 hours without work of any kind.

After a bare survival in life with the above 58 grams protein available in the above table, we find milk, millets, and pulses are simply not consumed in most families because of poverty, or unavailability, or habit, or indifference and ignorance.

So we see that even the 'survival' or 'subsistence' standard of protein is not reached with Dr. Ackroyd's 10 ozs. of rice and our Government have reduced even in this 10 ozs. because we have sweet potato, ground-nut and tapioca.

Now what is the protein status of sweet potato, groundnut, and tapioca? Suppose we cut down rice to 5 ozs. per head per day and substitute instead 2-1/2 ozs. of sweet potato; 2-1/2 ozs. of groundnut and 2-1/2 ozs. of tapioca; the diet table will read as follows:—

|                              |                    |
|------------------------------|--------------------|
| 5 ozs. of rice               | = 10 grams protein |
| 2-1/2 ozs. of sweet potato   | = 1 " "            |
| 2-1/2 ozs. of groundnut      | = 20 " "           |
| 2-1/2 ozs. of tapioca        | = 0.25 " "         |
| add to this, 8 ozs. of milk  | = 8 " "            |
| 8 ozs. of millets and pulses | = 30 " "           |

The total protein works out into 69 grams which is Dr. Ackroyd's physiological standard. The mathematics of this table seems quite correct and fine. But we have to judge the protein value of this table by two standards as already mentioned, namely Amino Acid make up and digestibility. We find the protein from sweet potato and tapioca is too negligible in quantity

to merit our attention. The protein from groundnut is certainly of real value from all known records. The Amino Acid make-up in groundnut protein contains all the 10 essential Amino Acids minus Iso-Leucine. But then the standard of digestibility for groundnut is so low that it is not a fit stuff as a staple diet in the daily table. This indigestibility of ground-

nut is due to its 40% oil content. To overcome this they talk of de-fatting groundnut. What does this defatting mean? It means, in practice, removal of the oil from the groundnut and recommending the groundnut-oil cake for human consumption. Well, this looks odd enough from the practical point of view. We have yet to test this groundnut-oil cake as a staple diet on large groups of the population

over a period of several months before we can judge the results thereof and decide the desirability of substituting groundnut for rice even partially as a staple diet.

With increasing population, decreasing production, costly imports, and very difficult and delayed and irregular transport and distribution, we are thus getting into a blind alley.

(To be continued.)



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September, 1951]

## ASSOCIATION NOTES

### SOUTH INDIAN PROVINCIAL BRANCH

Minutes of the Meeting of the Council of the South Indian Provincial Branch of the Indian Medical Association held at the Travellers' Bungalow, Chingleput, at 11 A.M. on 30-6-1951.

Dr. U. Krishna Rau, the President conducted the proceedings of the meeting.

The following members of the Council were present:—

|                      |                      |             |
|----------------------|----------------------|-------------|
| Dr. U. Krishna Rau,  | President,           | Madras      |
| „ Y. P. Vasudevan,   | Vice-President,      | Coimbatore  |
| „ P. S. Srinivasan,  | do.                  | Chingleput  |
| „ A. K. Rajagopalan, | Secretary,           | Madura      |
| „ D. V. Venkappa,    | Hony. Jt. Secretary, | Madras      |
| „ P. V. Sundaram,    | Hony. Treasurer,     | Thiruchi    |
| „ R. Varadarajan     |                      | Chingleput  |
| „ A. Sundararaja Rao |                      | Chingleput  |
| „ S. Subramaniam     |                      | Chettinad   |
| „ B. S. Viswanathan  |                      | Coimbatore  |
| „ T. V. Sivanandam   |                      | do.         |
| „ M. R. Bail         |                      | Madras      |
| „ V. Samuel          |                      | do.         |
| „ R. Sankaran        |                      | do.         |
| „ D. Damodar Das     |                      | do.         |
| „ G. R. Murthy       |                      | do.         |
| „ C. Rama Rau        |                      | do.         |
| „ A. M. Sivaraman    |                      | do.         |
| „ K. Rama Rau        |                      | do.         |
| „ G. A. Naidu        |                      | Madura      |
| „ P. Krishna Menon   |                      | do.         |
| „ P. Gopal           |                      | do.         |
| „ A. B. Das          |                      | Malabar     |
| „ P. A. S. Raghavan  |                      | Thiruchi    |
| „ C. R. Chary        |                      | do.         |
| „ R. Ganesan         |                      | do.         |
| „ C. B. Ethirajulu   | co-opted.            | Chingleput. |

The President, as per Rule 7(B) of the Rules of the South Indian Provincial Branch co-opted Dr. C. B. Ethirajulu of the Chingleput branch for that meeting of the Provincial Council.

The following condolence resolution on the death of Dr. P. Venkatagiri of the Madras branch and Dr. M. S. Raghavendra Rao of the Tanjore branch was moved from the Chair.

"This meeting of the Provincial Council places on record its deep sense of sorrow at the demise of Dr. P. Venkatagiri of Madras and Dr. M. S. Raghavendra Rao of Tanjore and authorises the President to convey to the members of the bereaved families its sincere condolences."

(The resolution was passed unanimously all standing)

The Minutes of the previous meeting held at 'Dasaprakash', Ootacamund which had been circulated to the members of the Council previously was adopted.

### 3. Business Arising out of the Last Meeting.

#### (a) Condolence Resolution of the death of Major M. G. Naidu.

The President informed the house that the condolence passed at the last meeting was communicated to the members of the bereaved family.

#### (b) Hakim and Vaidya Scheme:

The resolution of the Working Committee of the Indian Medical Association was read at the meeting.

The members of the Provincial Council, however, were of the opinion that the Indian Medical Association should have nothing to do with the Village Vaidya Scheme. The President promised to convey this view to the Working Committee of the Indian Medical Association at its next meeting at Hyderabad.

#### (c) Editing of the I. M. A. Journal in the South:

The President informed the house that he could not convene a meeting of the Committee. He requested that this matter may be adjourned to the next meeting before which time he promised to call for a meeting of the Committee.

#### (d) Simpson's Medical Centre:

The Sub Committee appointed at the last meeting submitted the following recommendations:—

"This Sub Committee is of the opinion that Medical Officers attached to industrial concerns should be in full charge of all matters connected with

the health of the workers. The certificate granted to the workers shall be binding on the workers as well as on the management. All matters of dispute should be referred to a tribunal consisting of

- (i) A Government Medical Officer, i.e. a Senior Physician of any of the Government Hospitals in Madras City or the District Medical Officer in the mofussil.
- (ii) A representative of the local branch of the Indian Medical Association to be elected by the respective branch, and
- (iii) A medical man nominated by the concerned Labour Union.

This Tribunal will decide all appeals properly and duly made. The tribunal should have the power of co-opting one expert where necessary.

Each member of the Tribunal should be paid a sitting fee of Rs. 20/- for considering and deciding one appeal.

A properly and duly filed appeal will be an appeal filed on behalf of any member of a Labour Organisation sent through the Labour Union with an advance deposit of Rs. 60/-. The deposit is refundable if the appeal is decided to be bonafide by the Tribunal. Otherwise it will be forfeited. This deposit is meant to prevent frivolous appeals being made. If approved the Government may be requested to frame the necessary rules for this purpose.

The Medical Officer concerned should be consulted before any judgment is given by the tribunal. In no case should cases be judged by non medical personnel.

The Sub Committee is of the opinion that the Medical Officers in industrial concerns should move freely with the workers and give necessary advice on health matters. The medical Officers should so behave as to make the workers feel that the Medical Officer is their friend, philosopher and guide.

The Provincial Council accepted the recommendations of the Sub Committee and authorised the President to forward it to the proper authorities.

#### (e) Insurance Scheme for medical Men:

Adjourned to the next meeting.

#### (f) Editing 'The Miscellany':

In reply to the query of the Provincial Council, the Managing Committee of the Trichy branch informed the Provincial Council through a resolution passed on 18-5-51 that the 'Miscellany' is run by the Trichy branch only on behalf of the Provincial Branch as per resolution dated 4-5-1947 passed

at Perundurai and as such the handing over of the 'Miscellany' to the Provincial branch did not arise.

Dr. Sivanandam, on behalf of the Coimbatore branch proposed to take over the Miscellany to Coimbatore. The subject, however, was adjourned to the next meeting and the provincial Council appointed a Committee consisting of

- (i) The President,
- (ii) Two representatives to be elected by the Coimbatore branch of the I. M. A.,
- (iii) Two representatives of the Trichy branch to meet at Trichy before the next Provincial Council meeting and to examine the whole question and submit its report to the next Provincial Council.

(g) **Formation of the working committee for the South Indian Provincial Branch.**

The matter was referred to a Sub Committee consisting of:

- (i) Dr. U. Krishna Rau, of Madras,
- (ii) Dr. A. K. Rajagopalan, of Madras, (Convener)
- (iii) Dr. P. A. S. Raghavan, of Trichy,
- (iv) Dr. D. V. Venkappa, of Madras,
- (v) Dr. Leelakrishnan, of Coimbatore,
- (vi) Dr. M. N. Rajan, of Madras,
- and (vii) Dr. S. Subramanian, of Karaikudi.

The Report of this Sub Committee will be circulated by Dr. A. K. Rajagopalan (Convener) to all the branches whose opinion will be obtained and placed before the next meeting of the Provincial Council.

(h) **Status, Pay and Prospects of Medical Personnel:**  
(I. M. A. Circulars Nos. 16 & 32)

The reply received from the Southern Railways was placed before the Provincial Council. It was decided to send this with further particulars to the Centre.

(i) **Financial Assistance to refugee Doctors from W. Pakistan:**  
(I. M. A. Circulars Nos. 20 & 33)

The Secretary reported to the House that there was no such doctor within the jurisdiction of the South Indian Provincial Branch who had applied for assistance. This was recorded.

(j) **Arrears of C. F. C.**

The President and other members representing the Provincial Branch in the Working Committee promised to look into the matter with the Secretary and Treasurer of the I. M. A. at the next Working Committee meeting and come to a decision.

The Provincial Council authorised Sri Lakshminaraya, the clerk of the Secretary to accompany the President with all the relevant files. The President promised to report at the next meeting.

(k) **Venue of the next All India Medical Conference:**

The house was given to understand by Dr. P. A. S. Raghavan that it was not possible to hold the next All-India Medical Conference at Trichy during December 1951 as the General Elections would be held at the same time as the All India Conference. The Provincial Council decided to pass this information on to the Secretary of the Indian Medical Association.

4. Resolution of the Tanjore and Trichy Branches regarding the G.O. No. 1887 of 8-4-46 enforcing Medical Officers and Subordinates in Govt., Local Fund and Rural Medical Services to obtain Casual Leave on Sundays while going outside with formal permission.

It was brought to the notice of the Council by Dr. P. A. S. Raghavan that the Govt. had already withdrawn this order and hence no further discussion on this subject took place.

5. Resolution of the South Arcot and South Kanara branches regarding Dr. Ambedkar's remarks about Medical Certificates:

Since this was an All-India question the Secretary was authorised to forward the same to the Centre for necessary action.

6. Letters from the South Kanara and Ramnad Branches re. G. O. prohibiting District Medical Officers from accepting the office of President of the local branch of the I. M. A.

It was decided not to take any action in the matter.

7. Letter from Mrs. Lakshmi Narasu, wife of the late Dr. M. S. Raghavendra Rau.

It was resolved to send the amount of Rs. 4/- from the South Indian Provincial Branch to the wife of the late Dr. M. S. Raghavendra Rau being the refund of the C. F. C. for the second half of 1950-51 as the doctor died during the first half after paying the full c.f.c.

## 8. Indian Medical Association Circulars :

- (i) Re. calling for Application for Senior Lecturships in Malaya.  
It was reported that no application was received. Recorded
- (ii) Free supply of International Code of Medical Ethics to members of the I. M. A. who have paid the c.f.c.

It was reported that the Journal Department had sent the necessary number of copies to each local branch and that the branches would be distributing the same to the members.

## 9. The next Provincial Conference :

Resolved to accept the invitation of the Calicut branch of the I.M.A. to hold the next (sixth) South Indian Provincial Conference at Calicut. It was decided to hold the Conference at Calicut on the 14th, 15th & 16th of October 1951. The Council thanked the Malabar branch for this kind invitation sent through its representative Dr. A. B. Dass.

## 10. The next meeting of the Council of the South Indian Provincial Branch of the I. M. A.

It was decided to accept the invitation of the Chettinad branch to hold the next meeting of the Provincial Council in Karaikudi during the first week of September.

The Secretary was authorised to call for nominations for the Offices of one President and two Vice Presidents for the next year. The Secretary was asked to inform the branches to send all their nominations and voting papers before the next meeting of the Provincial Council in September.

With a Vote of Thanks to the Chingleput branch of the I. M. A. and to Dr. R. Varadarajan the Secretary for the kind hospitality shown and the excellent arrangements made at Chingleput, the meeting terminated.

A. K. RAJAGOPALAN,  
Secretary.

U. KRISHNA RAU,  
President.

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the contributions of modern biochemistry in the field of urology especially in cases of water retention and salt retention in the tissues. There was lively discussion in which several members took part. The meeting terminated with a vote of thanks by Dr. K. V. Subramaniam, M.B.B.S., (Path.), Secretary, Coimbatore District Medical Association.

The next day at 10 A.M., the members again gathered to hear Dr. R. Kesavan Nair, M.B.B.S., F.R.C.S., (Eng.), Superintendent General Hospital, Trivandrum read his delightful and lively paper on "Adenoma of the Thyroid". Dr. P. Vadamalayan, M.B.B.S., Honorary Surgeon, Erskine Hospital, Mathurai, took the chair.

Dr. R. Kesavan Nair based his paper on a survey of 50 cases of adenomata of the Thyroid which he has operated during the past 4 years. Adenoma of the Thyroid is a nontoxic, non-malignant condition of the Thyroid in considering which such conditions as foetal adenomata and the enlargement of the thyroid associated with puberty have to be excluded. He then dealt at length on the anatomy of the Thyroid, the pathology of the disease, the signs and symptoms and the complications of haemorrhage which is very rare, of toxicity which is bound to occur some day or other and of potential malignancy which necessitate operative interference. He then dealt at length on the operative treatment of the condition stressing on such details as choice of Anaesthesia amount of thyroid to be removed and the difficulties in dealing with substernal adenomata and also the care to be taken in ensuring adequate hæmostasis

and in preserving the parathyroids and the recurrent laryngeal nerves. There was discussion following the lecture in which several members took part and in answering certain questions raised by members, Dr. R. Kesavan Nair stressed that operation is the only rational method of treatment of an adenoma of the thyroid though it is not in the nature of an emergency. This is in view of the potential dangers of toxicity and of malignancy. In the choice of anaesthesia, local is the best and least dangerous but it is time consuming and laborious and where a skilled anaesthetist with modern equipment is available, general anaesthesia with an endotracheal tube takes away a heavy load from the surgeon's shoulders and makes him fully concentrate on the operative field.

Dr. P. Krishna Menon, Secretary, Mathurai Medical Association proposed the vote of thanks and the meeting came to a close.

Immediately following the lecture, there was a general forum which was presided by Dr. U. Krishna Rao, President, South Indian Provincial Branch of the I.M.A. in which resolutions by members were taken up for discussion and adoption.

Dr. T. S. Tirumurti of Madras brought forth a resolution in absentia that referring the G.O. of the Madras Government No. 1758/51-1, Public (General) Department dated 7th July 1951 regarding Lease and Rent Control Act 1949—service of members of the Indian Medical Association—declaration as essential—this joint conference of the medical associations of the Southern Districts whilst feeling thank-

ful to the Government for stating that it is open to them to approach Government as and when they require protection from eviction and the Government will then consider the question on the merits of each case resolves to appeal to the Government for further consideration of the desirability, necessity and importance of treating the members of the profession as belonging to the essential services thereby preventing the Government from being troubled by individual representations and also saving the members of the profession from making such representations.

Dr. Venkappa, President, Madras Branch of the I.M.A., seconded the resolution and the resolution was adopted unanimously.

Then another resolution by Dr. T. S. Tirumurthi was put forth:—

Resolved to request the Government to make provision in the choice of students for admission to medical colleges, preference should be given to sons and daughters of medical men, who by virtue of their having established nursing homes, laboratories, X-Rays Institutes and such other equipments at great cost for rendering medical relief to the public, would lend over their heritage and experience to their duly qualified sons and daughters affording greater scope for rendering medical relief on a larger scale. The resolution was ably seconded by Dr. Venkappa. Dr. Leelakrishnan of Coimbatore opposed the resolution on the ground that it was creating vested interest in the land where there are already many. Dr. Krishnamoorthy of Coimbatore supported Dr. Leela-

krishnan by saying that the adoption of such a resolution will prevent doctors from going to the villages as most of the nursing homes, X-Ray clinics and laboratories are in large cities.

Then Dr. R. Kesava Nair supported the resolution. It was not from a selfish point of view alone but in the larger interests of the country that this resolution has to be adopted nem con because the son of a medical man has a better and a more congenial heritage to fall back upon than anybody. The passing of the resolution must go hand in hand with the education of those in power, of the necessity and value of such a resolution.

The resolution was then put to vote and was carried out by a vast majority.

Then Dr. S. Chandrasekharan moved a resolution to the effect that the meeting requests doctors to contest elections and get elected into the legislature in large numbers. The President ruled this resolution as out of order in view of the definite ruling of the I.M.A., that the association will not put up candidates for election to the legislature nor support such candidates.

Dr. Venkappa brought forth a resolution on behalf of the medical officers employed in the local boards that this conference resolves that the medical officers employed in the Municipalities and local boards may be placed on a par with Government servants as regards their pay etc., and that they may be provincialised. The resolution was seconded by Dr. A. L. Ramaswamy Sarma of Vilathikulam. The President requested Dr. Venkappa to withdraw the

resolution in view of the fact that the Indian Medical Association has already passed a similar resolution with slight modification and the Government are considering it and before they come to any definite conclusion, this resolution is rather premature and may prejudice the Government. The resolution was then withdrawn. The Secretary then proposed vote of thanks.

At 4-45 P.M., the members again gathered to hear Dr. B. Ramamurthi, M.S. (Mad.) F.R.C.S. (Edin.), Neur. Surgeon General Hospital, Madras talk on the "Diagnosis of Intracranial Lesions in general practice". Earlier at 4 P.M., the members were entertained to Tea by Messrs. South Indian Manufacturing Co., Mathurai.

Dr. K. S. Krishnan, Honorary Surgeon, Erskine Hospital Mathurai presided over the evening session.

The lecturer said that intracranial lesions are of common occurrence and it is their early diagnosis that is quite necessary for effective treatment. The classical signs of headache, papilloedema and vomiting are tell-tale of an intracranial tumour but they are only late symptoms and to look for them will only be to brook delay when the case is past operative interference. The earliest signs are in

the eye and a good ophthalmoscope is as much an useful adjunct to a general practitioner as the stethoscope. Peripheral haziness in the fundus is the earliest sign to look for in a case of suspected intracranial tumour. Perimetry by a simple method which can be done at the bed side also helps in diagnosing the lesion.

There was discussion following the lecture in which several members took part. The President then wound up the proceedings and the meeting came to a close with a vote of thanks proposed by Dr. R. Kesava Nair, Secretary Travancore-Cochin Medical association.

There was a music party by Kumari Rajam of Tenkasi.

Then at 8 P.M., all the members were entertained to a sumptuous banquet by Messrs. Albert David and Co., Calcutta. The toast was proposed by Dr. K. Madhava Menon, District Medical Officer, Tirunelveli. Dr. U. Krishna Rao replied on behalf of the guests and Sri Radhakrishna Iyer on behalf of the non-Medical men present. The Secretary then thanked the various associations and their Secretaries that took part in the conference, the various distinguished guests, the lecturers, the various companies that stood as hosts and to many others who contributed to the success of the Conference.

#### COIMBATORE BRANCH

*President :* Dr. M. G. Nair  
*Vice-President :* Dr. I. Pichai Robert  
*Hony. Secretary :* Dr. K. V. Subramanyam (Path.)  
*Assoc. " :* Dr. S. Balakrishnan  
*Hony. Treasurer :* Dr. T. V. Sivanandam.

The monthly meeting of the Coimbatore District Medical Association was held on Saturday the 25th, August 1951, in the association premises, at 6

P.M. Dr. M. G. Nair, the President presided. Seventy-eight members including a good number from the moffusil attended.

After tea and light refreshments the minutes of the previous monthly meeting (June '51), the Tuberculosis Sub-Committee meeting, and the Managing Committee meeting were read by the Secretary and unanimously adopted by the General Body.

Letter from the Deputy Commissioner, Commercial Taxes, R. S. Puram was read.

The president introduced the speaker of the day, Dr. D. Damodar Das, M.B. B.S., T.D.D. (M) of Madras who read an interesting paper on 'The general practitioner and his tuberculosis patient.' The paper was followed by a film show in which the following films were shown:—

1. Nutritional dystrophy among children in Madras.
2. Treatment of tuberculosis and a modern Sanatorium.

3. The working of Pasteur Institute, South India.

Dr. A. G. Leelakrishnan congratulated Dr. Damodhar Das for his excellent and useful hobby and also suggested to him to show these films to all other associations.

The President in his concluding remarks thanked Dr. Das for having taken the trouble of coming over to Coimbatore and addressing the association and for the instructive film shows.

He then thanked the host of the day Dr. K. S. Vedachalam, for the nice tea and refreshments. He thanked Mr. S. V. Krishnamurthi for the projection of the films and Messrs C. S. & W. Mills for the loan of the furniture.

The meeting came to a close at 8-30 P.M.

#### TANJORE BRANCH

*President:* Dr. E. K. Menon

*Vice-President:* Dr. T. M. Pillai

*Secretary:* Dr. N. R. Subramanyam

The monthly meeting of the association was held on 29th July 1951 at 4-30 P.M., in the Medical School buildings R. M. Hospital, Tanjore. 41 members attend the meeting. Dr. E. K. Menon, presided over the meeting.

The members were entertained with tea before the commencement of the meeting by Dr. S. Viswanathan, Koradacheri.

Nominations for the offices of the South Indian Provincial Branch of I.M.A. for 1951-52 for one President and two Vice-Presidents were called for.

Dr. U. Krishna Rao was nominated for President and Drs. Y. P. Vasudevan and P. S. Sreenivasan for Vice-Presidents.

Information was given to the members regarding Vith South Indian Provincial conference to be held at Calicut on 14th, 15th and 16th Sept., 1951 at Ganapat High School and delegates for the same.

A talk on "Recent Advances in therapeutics" was given by Dr. N. R. Subramanyam, Hon. Physician, Govt. Head Quarters Hospital, Tanjore

touching on the recent advances in therapeutics, their pharmacology, correct indications and their uses.

The President in his concluding remarks stressed the necessity to know about the advances in therapeutics before putting them into use.

With a vote of thanks proposed by the Secretary for Dr. S. Viswanathan for the tea provided, the meeting came to a close.

### TIRUCHY BRANCH

*President:* Dr. R. Kalamegham  
*Vice-President:* Dr. T. V. Srinivasan  
*Hon'y. Secretary:* Dr. C. R. Chari  
*Hon'y. Treasurer:* Dr. T. V. Sundaram.

A monthly meeting of the association was held on Saturday the 18th August 1951 in the premises of the Govt. Head Quarters Hospital, Puthur, Tiruchy with Dr. R. Kalamegham in the Chair. About 60 members attended.

After Tea kindly provided by Capt. C. M. S. Rajan and Capt. C. M. C. Sekhar, the President informed the members that Dr. U. Krishna Rau has been re-elected unanimously as the President for the South Indian Provincial Branch for this year also, and the Managing Committee of the association has nominated Dr. Y. P. Vasudevan of Coimbatore and Dr. P. S. Srinivasan of Conjeevaram as Vice-Presidents for this year and it was approved by the members.

Then the President introduced Dr. P. Rathnaswamy, B.A. M.D. of Madras to the members and requested him to give his talk on Modern Concepts in Medical Treatment. The lecture was very much appreciated by the members.

After the usual discussion, the Secretary proposed a vote of thanks to the lecturer, the hosts of the evening and to the Superintendent, Govt. Head Qrs. Hospital for allowing the premises to hold the meeting, the meeting terminated at 9 p.m.

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A film show was held on Saturday the 1st Sept. 1951 in the premises of the Govt. Head Qrs. Hospital, Puthur, Tiruchy.

Dr. R. Kalamegham, the President, informed the members that one President and 3 Vice-Presidents should be elected for the I.M.A. Central for the coming year and read the proposed names sent by the Centre. Dr. T. S. Tirumurthy of Madras, as President and Dr. D. V. Venkappa of Madras, Dr. P. N. Ramasubramaniyan of Madura and Dr. P. Kutumbiah of Vellore as Vice-Presidents were selected.

After Tea given by Dr. A. Shankar Rao, the film show on "Anaesthesia" kindly lent by Messrs. Imperial Chemical Industries Ltd, Madras was shown and it was very much appreciated by the members.

A vote of thanks was given by the Secretary to the host, to Messrs. Imperial Chemical Industries Ltd., Madras, to Mr. J. Sadagopan of Messrs. J. S. Radio Co. Trichy for the excellent projection and to the Superintendent, Govt. Head Quarters Hospital, Tiruchy for allowing the premises for the film show, the gathering dispersed at 9 p.m.

## ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

### FOREIGN BODIES OF THE EYE—

*J.A.M.A., Jan. 50—Alston Callahan, M.D.*

Small foreign bodies on the external surface of the eye, especially on the cornea, may escape notice unless a magnifying loupe is worn by the examiner and the illumination focused to a point with a strong convex lens. The use of these simple aids, or preferably the slit-lamp microscope, will allow detection of particles of extremely small size. Moreover, the focused beam of the slit-lamp parallelgram allows observation of the corneal depth which the foreign body has reached.

*Location of Foreign Bodies in a Series of 192 Consecutive Industrial Patients*

|                          | Number | Percentage |
|--------------------------|--------|------------|
| 1. Cornea .....          | 148    | 77         |
| 2. Conjunctiva.....      | 12     | 6          |
| 3. Upper cul-de-sac..... | 19     | 9          |
| 4. Lower cul-de-sac..... | 11     | 6          |
| 5. Intraocularly .....   | 2      | 1          |
|                          | 192    | 100        |

The cornea is by far the most frequent site of location of foreign bodies as shown in an analysis of a series of 192 consecutive cases from an industrial plant which were observed personally.

Foreign bodies are probably more frequent in the lower cul-de-sac than in the upper, but in the former location they may be removed by the lacrimal fluid or by the patient's own efforts. The upper cul-de-sac requires more scrutiny than does the lower, for it extends several millimeters above the tarsus in the upper lid, and simple eversion of the upper lid does not expose it. When a foreign body is suspected but remains undetected, one should evert the tarsus and then stretch the cul-de-sac forward and convexly with a Walker or Fox lid everter. The fold behind the lacrimal caruncle is another recess which may conceal a foreign body.

Intraocular foreign bodies must always be suspected in blast injuries, or when the patient has been near the application of striking, grinding or cutting force applied to metal. A few cases of "uveitis" have been traced by Haik to unrecognised intraocular foreign bodies.

### Examination

When the presence of an extraocular or intraocular foreign body is possible, the following examination must be made:

1. The vision should be measured as soon as possible. This is of prognostic value whether the foreign body is corneal or intraocular in location.

A reduction of vision is the rule when a foreign body enters the eye, but it is by no means a unique experience to see a mildly inflamed eye with 20/20 vision in which a small steel foreign body has been present two or three weeks. Intraocular foreign bodies may cause little or no pain at the time of impact; frequently there is noted only a slight stinging sensation in the eye, accompanied sometimes by a "sick feeling" in the stomach. This is in considerable contrast to the patient who has a severe pain from a cinder in the cornea or from a superficial corneal abrasion.

Intraocular hemorrhages make the examination difficult and the prognosis uncertain. It is important to try to determine the extent and exact location of these hemorrhages. They may be from the retinal or uveal circulation and may occur in the anterior chamber, vitreous, retina or uveal tract. Hemorrhages into the anterior chamber should be evaluated if secondary glaucoma develops and continues, but in my experience this has been rare unless

Read in a Symposium on Ocular Injuries before the Section on Ophthalmology at the Ninety-Eighth Annual Session of the American Medical Association, Atlantic City, N. J., June 8, 1949.