सर्वेजनाः सुखिनो भवन्तु

THE MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

Vol. XVIII JANUARY 1952 No. 7

Indian Medical Association South Indian Provincial Branch

Post Box No. 530

Oppannakara Street, COIMBATORE

CIRCULAR NO. 4

COIMBATORE,
21—12—1951

Dear Doctor,

You are aware that as per resolution of the Council of the South Indian Provincial Branch of the I. M. A. held at Karaikudi on 9-9-1951, the Trichinopoly branch of the I. M. A. was authorised to continue the publication of the "Miscellany" as the official organ of the Provincial Branch and that the Managing Editor of the "Miscellany" should render accounts to the Provincial Council through the Trichinopoly branch and to pass on a share of the profits to the Provincial Association.

No doubt you are also aware that the "Miscellany" has so far been able hardly to maintain itself because of poor response from manufacturers of medical products. Only when the "Miscellany" is able to secure more number of advertisements, it will be possible to earn any profit out of the "Miscellany". Hence I would request you to impress upon the representatives of medical firms and to request all your members to do likewise, that the members of your association should patronise the products advertised in the "Miscellany". Such co-operative effort on behalf of all the office bearers of the Provincial Association, of all the Secretaries of the local and district branches under their jurisdiction of the South Indian Provincial branch, and all the members of our Association would help in improving both the standard of the publication and for increased profits from the "Miscellany".

Doctor P. A. S. Raghavan, the Managing Editor of the "Miscellany" is doing a grand work all by himself so long, and with the co-operation of every individual member of our association, we could expect him to do much better.

(Sd.) A. G. LEELAKRISHNAN,
Honorary Provincial Secretary.

(FOR CIRCULATION AMONGST MEMBERS ONLY)

THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
THE INDIAN MEDICAL ASSOCIATION

VOL. XVIII] JANUARY 1952 [NO. 7

COMMON NUTRITIONAL DISORDERS IN CHILDREN OBSERVED IN SOUTH INDIA

BY

P. S. VENKATACHALAM

Nutrition Research Laboratories, Indian Council of Medical Research, Coonoor, South India.

Before I describe the various nutritional disorders commonly met with in children, it is but proper that I should state briefly, how satisfactory nutrition in early years is of great significance in the life of the individual and what are the direct and indirect effects of malnutrition in early life.

Maintenance of satisfactory nutrition though important throughout the life of an individual is all the more essential during the first few years of life. Because of the astonishing rate at which the child makes additions to its body tissues, the question of diet and nutrition assume greatest importance in infancy and childhood. The young child reacts dramatically to even minor alterations in the quality or quantity of the diet.

If the mortality figures in our country are examined, we find that nearly half the total deaths are among children under ten years of age and of this, one-half takes place within the first year of life. I do not attribute this high mortality in children exclusively or solely to malnutrition or undernutrition, but there is no doubt this poor state of nutrition diminishes bodily resistance and makes them susceptible to infections. Unfortunately, our public health reports never mention anything about malnutrition as a cause of death, but record pneumonia or some such infection as the cause of infant and child mortality. This is apt to give an erroneous idea and obscure the fact that it was the poor nutritional state that was the indirect cause of death, the infectious disease being only a terminal event. Apart from being the direct or indirect cause of high mortality, malnutrition brings about a state of lowered health in those children but survive its ravages, and produces in them lasting changes which may be felt throughout life.

The title of the paper to be red before you now is "The Common Nutritional Disorders in children in South India". A introduction to the subject of malnutrition and disease was given by Dr. U. Krishna Rau, in his Presidential address yesterday and the importance of nutrition in the life of the individual was stressed. I only wish to add that this importance is raised tenfold in the case of growing infants and children.

I propose to discuss in the short time available to me some of the more common nutritional disorders occuring in infants and children in South India, as a result of primary dietary deficiencies. In text books of medicine and nutrition, one comes across classical descriptions of Scurvy and Rickets, which we seldom see in our daily practice. On the other hand, we meet with commonly, a clinical picture arising as a result of an all-round or multiple nutritional deficiency.

The commonest nutritional disorder in children in this part, is that attributable to vitamin A deficiency. Keratomalacia as a result of hypovitaminosis A is the commonest cause of preventible blindness in children in South India. Vitamin A is necessary for body growth and maintenance of healthy epithelium. The outstanding effects of deficiency of this vitamin are lack of growth in children and affections of eye leading to eventual blindness.

The ocular condition, which is considered more or less a specific sign of deficiency of this vitamin, is called Xerophthalmia. The initial lesion appears to be a dryness and wrinkling of the bulbar conjunctiva, and the earliest symptom is night blindness. The dryness is always found to be associated with a smoky discolouration of the conjunctiva. As the deficiency progresses whitish spots described as Bitot's Spots appear over the ocular conjunctiva. The Bitot's Spots are heaped up masses of dead keratinised epithelium. These spots are almost always seen lateral to the cornea and they are usually bilateral. In more acute deficiencies, especially in infants and younger children and in subjects with very badly balanced diet, the whole process rapidly spreads involving the cornea, which becomes soft, oedematous and infiltrated with leucocytes; this condition is described as Keratomalacia. Once the nutrition of the cornea is thus affected, organisms normally present in the eye, invade the membrane and destroy the cornea. A very high percentage of infants who develop Keratomalacia are subsequently blind. Keratomalacia occurs more frequently in young children. This more frequent occurrence of Keratomalacia in younger children and infants than in adults is due to the relatively increased requirements of Vitamin A in the former. It is also suggested that vulnerability of the cornea declines with age. Though there is no experimental proof of this statement, is supported by the general observation that Keratomalacia is rare in adults.

Keratomalacia is a medical emergency. The condition has to be treated immediately with massive doses of vitamin A to the tune of 1 to 2 lacs per day till the cornea clears up. If diarrhoea is a complication, it is preferable to give parenteral vitamin A. There is no point in administering fish liver oil in drops which contain very small amounts of the vitamin.

In chronic vitamin A deficiency, subjective manifestations like itching and burning of the eyes with photophobia may be present. In Nilgiris District, we find that intestinal infestation with Ascaris Lumbricoides is commonly associated with ocular vitamin A deficiency signs in children. We have gained the clinical impression that a heavy load of worms may actually aggravate the hypovitaminotic state. This relationship between the parasite and vitamin A nutrition has to be proved by further work.

I detail here only the ocular manifestations of vitamin A deficiency, since most of the children are brought to us only for these signs, In infants and children, changes are known to take place in the mucus membrane of the respiratory and digestive tracts also and patients may be brought to us for repeated attacks of respiratory catarrh or diarrhœa. Such cases are distincity benefited by the administration of vitamin A, besides specific

treatment for any superadded infection. It must be emphasised, however, that giving of large doses of the vitamin in infectious children with no evidence of vitamin A deficiency is unwarranted.

A condition of perifollicular keratosis of the skin in which the skin over some areas appears covered with horny erruptions, is another common disorder with a nutritional basis. The condition is called Phrynoderma. The incidence of phrynoderma is greatest between 5 and 15 years and is relatively infrequent in adults. It is interesting that in children in the younger group, the incidence is strikingly low. The skin in this condition generally appears dry, and hyperkeratotic papules around hair follicles appear over the proximal parts of the upper and lower extremities and the buttocks. Rarely, they may involve the trunk also. The condition was thought to be due to a deficiency of vitamin A, since continued administration of various fish liver oils cures the disorder. On the contrary, evidence has been accumulated to show that phrynoderma is a disorder due to deficiency of essential unsaturated fatty acids and the reported curative effect of cod liver oil was probably due to its unsaturated fatty acid content. It has been demonstrated that associated B_2 complex deficiency makes the condition resistant to fatty acid therapy, unless B_2 complex vitamins are also supplied. The rarity of the condition in children in the younger age group may be explained as due to incomplete development of pilosebacecous glands. If this condition is encountered, it is better to treat with one of the fish liver oils rather than with vitamin A concentrates.

Now I shall pass on to a discussion of another important nutritional disorder, the prevalence of which in this part of the country has been recognised. This is a condition variously described as Malignant Malnutrition, Kwashiorkar, Nutritional Oedema Syndrome, etc., and is a disease linked with poverty and undernutrition. Though a survey has not been carried out to determine its exact incidence in child population, yet its frequent occurrence can be surmised because of the coexisting poverty and ignorance and the relative rarity of good quality proteins in the dietary of our people.

This condition which we call in Coonoor as "Nutritional Oedema Syndrome" is characterised by massive oedema involving the entire body including the face and eyelids and gastro-intestinal upsets, in the form of diarrhoea. Occassionally, the skin and hair show pigmentation, but more often the skin shows a type of nutritional dermatosis, not unlike that of the adult pellagrous lesion. The syndrome is complete if the liver is enlarged and palpable. Preceeding the onset of the fullfledged syndrome, there is a history of retarded growth with occasional gastro enteritis. In a large majority of the cases, the diarrhoea is in the nature of steatorrhoea. Another noteworthy feature is the large incidence of heavy ascaris infestation in these patients. This fact is of considerable importance, since ascaris lumbricoides are known to disturb protein digestion and hence may aggravate the protein deficiency.

The dermatosis, which I mentioned above, differs from pellagrous dermatitis only in its distribution and its dynamic evolution. The crazy pavement dermatosis as it is described occurs over areas exposed to irritation and pressure like buttocks, back, groins and perineal region. The lesion, to start with, appears black, rapidly extends in area and at the same time fissuring of the skin occurs. This is followed by the skin being shed off in large flakes exposing pink areas underneath. If once the lesion is seen, one cannot forget the picture. They improve on administration of nicotinic acid proving their 'pellagrous' nature. The liver, whether enlarged, or otherwise,

shows on histological examination varying grades of fatty infiltration, which is reversible with treatment.

Anaemia of varying severity is also met with in these children. More often, the anaemia is of the dimorphic variety. The plasma proteins are lowered and the fall affects the albumin fraction to a greater extent than the globulin.

The age distribution of the condition is one to three years, though its occurrence between the fourth to sixth year is not uncommon. This extremely peculiar age incidence becomes significant especially if considered with its occurrence among the poorer section of the population, for only during this period, the protein requirements of children are very high. Actually the dietary history reveals a gross qualitative as well as quantitative lack of proteins in any form from the time of weaning. It is strange that infants do not as a rule suffer from this syndrome during breast feeding.

Treatment must be given with the full knowledge that the syndrome is mainly one of protein deficiency and hypoprotenemic oedema is its central feature. The essential factor in the treatment is the administration of as much protein in easily assimilable form in as short a time as possible. Dried skimmed milk in suitable doses in the form of reconstituted milk has given satisfactory results in our hands. Vitamin supplementation is only secondary in the treatment of the condition. Administration of only B Complex mixtures, with erroneous idea that the 'pellagrous' skin lesion constitutes the essential pathology, will bring about disastrous results. Apart from treatment with skimmed milk or other protein mixtures, it must be emphasised that adequate provision of good quality proteins must be made available once the signs and symptoms are relieved. Otherwise, a relapse of the condition is certain.

Another equally common clinical condition in infancy and childhood is that which in advanced stages is called marasmus. This is mainly due to poor intake of calories and occurs at any time during infancy and childhood and in both breast-fed as well as artificially-fed infants. Not infrequently, the marasmic state may be secondary to some infective process or diarrhoea, or other diseases which interfere with feeding. The condition progresses insidiously and the most important sign is the failure to gain weight. The picture presented by such children is classical. Unlike in Nutritional Oedema Syndrome the subjects look pinched up, with atrophic glueti, and wrinkled and baggy folds of skin over the extremities. The skin is dry, and inelastic, and there is very little subcutaneous tissue. Essentially, it is a picture of slow starvation. Rarely vitamin deficiency signs occur in this state. The condition has to be treated by attacking the underlying cause and gradually increasing the calcorie intake of the child.

Next, I shall briefly mention some common disorders due to B–Complex deficiency. Here, I shall not touch upon Infantile Beri-Beri or Infantile Pellagra, except to state that the former condition occurs commonly in the endemic beri-beri areas (Northern Circars), while the latter, though rarely reported, is often found superadded to Nutritional Oedema Syndrome. In spite of their absence in this part of India, one may encounter subclinical deficiency states, manifesting in the form of vague ill health. Then the condition leads to difficulty in diagnosis.

Hyporiboflavinosis is rare in infants and children, compared to its incidence in adults. More commonly, the condition is found to complicate cases of Nutritional Oedema Syndrome. The lesions in children are confined to the oro-lingual mucus membrane and rarely involves other muco-cutaneous junctions. The commonest lesion is the angular stomatitis, where the angles of lips are pale, sodden and macerated. In advanced cases, fissures are seen to extend radially from the angles. The lesion is usually bilateral. Rarely, glossitis and cheilosis may also be present.

Infantile Scurvy and Rickets are rarely met with here. On the contrary, subclinical states of vitamin C and D deficiency are more common. Characteristically, vitamin C deficiency occurs at a time when the infant is switched over from breast milk to artificial diet, the common age incidence being six to twelve months. Even in severe vitamin C deficiency in infants, the classical signs and symptoms may be absent, the only indication of deficiency being a failure to gain weight, excessive irritability and peevishness. A diagnosis in such cases may be very difficult, except by the therapeutic method.

Rickets which is a nutritional problem in certain parts of North India is luckily rare here. Most of us would have seen cases with bony deformities in grown up children and adolescents. But how far rickets in early age is responsible for this is not known. Cases of active rickets are rarely observed. The reason for this, is probably because of the retarded growth rate due to presence of undernutrition in children, the vitamin D requirement is lowered and rickets does not develop. While mentioning rickets, reference must be made to tetany, which is much more common in children. Tetany occurs as a result of fall in blood calcium, and hence may occur independent of rickets, since the calcium level rarely goes down in blood in the latter condition. Tetany may complicate dehydration and alkalosis following on gastroenteritis.

Lastly, I shall say a few words about Nutritional Anaemia in infants and children. Severe forms of anaemia of nutritional origin are rare. Mild cases are frequent in infancy and are more common in artificially fed infants. The existence of anaemia indicates a very low standard of feeding, and invariably, the subject presents other features of general malnutrition.

I have tried to put before you in this short time a very vast subject and necessarily there will be lot of gaps. Purposely, I did not touch upon nutritional disorders as a result of conditioned deficiency, the most important of which is Coeliac disease and cystic disease of pancreas. My object has been to emphasise only the commonest nutritional disorders due to faulty diet; hence I have refrained from mentioning certain rare disorders with a nutritional basis.

[*Paper read at the 6th South Indian Medical Conference—Kozhikode Oct. 51*]

SOUTH INDIAN PROVINCIAL BRANCH

Resolutions passed at the open session of the 6th South Indian Provincial Medical Conference held at Kozhikode on 7-10-1951.

1. This conference places on record its deep sense of sorrow at the demise of the following members and conveys to the members of the bereaved family its sincere condolences:

i. Doctor P. Venkatagiri of Madras branch.
ii. Doctor M. S. Raghavendra Rao of Tanjore branch.
iii. Doctor P. S. Mannadiar of Nilgiris branch.

2. This conference is of opinion that Joint Provincial Conference of Andhra and South Indian Branches may be arranged, instead of separate conferences with great advantage to the members of our profession and requests the Executive of the South Indian Provincial Branch of the Indian Medical Association to take steps towards this end.

—Referred to the Joint Standing Committee.

3. This Conference requests the Executive of the South Indian Branch of the Indian Medical Association to depute a responsible and enthusiastic member of the Executive Committee to tour its area and in co-operation with the local branches to try and enrol all medical men as members of the Indian Medical Association and start new branches of the I.M.A., in places which justify the same.

—Referred to the Provincial Council.

4. This Conference requests the Government of Madras to recommend to the Central Delimination Committee and take such other steps as are necessary to include Lincentiates and diploma holders possessing registerable qualifications as defined in the Indian Medical Degrees Act VI clause 2 (7 of 1950) in the graduates constituency for the purpose of election to the Madras Legislative council, as has been done by the Bombay State Government.

5. This Conference is of opinion that in view of the useful work done by the Rural Medical Practitioners, the Government is requested

(i) to raise the subsidy from its present rate to Rs. 1,800/- per annum;
(ii) to remove the distinction between the Graduates and Licentiates in the service with regard to subsidy and other privileges.

The Conference authorises the President, the Secretary and three representatives of the Rural Medical Practitioners to be chosen by the President to wait in deputation on the Government and submit a memorandum putting forth the grievances.

6. This Conference requests the Government to make no distinction between Graduates and Licentiates in the matter of granting certificates of physical fitness to candidates appearing before the Public Services Commission for employment under Government service and for employment under local bodies.

7. This Conference reiterates the resolutions passed previously at Mangalore and Annamalainagar that the pay, privileges regarding leave, etc. and emoluments of Local Board Medical Officers should be raised to the level of those in Government service and requests the Government to implement these resolutions. It also requests the Government to receive a deputation.

8. This Conference is of opinion that all Medical men both in service and private practice should be classified as members of the 'Essential services' and for purposes of Rent Control Act.

9. This Conference is of opinion that the Madras Medical Council Act amending bill of 1951 which the Madras Government has introduced in the legislatures and which has now been referred to a Select Committee of both houses of legislature is a retrograde measure affecting the Medical profession vitally in many matters and requests the Government to withdraw the bill entirely.

10. This Conference is of opinion that the proposal of the Government to levy 'Sales Tax' on X-ray photos is not fair, as the taking of an X-ray is not a sale and it requests the Government to drop this levy.

11. This Conference places on record its deep appreciation of the excellent work done by the Malabar branch of the Indian Medical Association in organising the 6th South Indian Provincial Medical Conference at Kozhikode and in looking after the delegates and members of the Provincial Council and making the Conference a grand success.

12. This Conference places on record its appreciation of the help given by the authorities of the Ganapathi High School and thanks them for their cooperation.

13. This conference places on record its appreciation of the help given by all the Volunteers and Caterers during the conference.

ASSOCIATION NOTES

CHETTINAD BRANCH

President : Dr. S. Subramanyam
Vice-President : Dr. D. O. Sendel
Hony. Secretary : Dr. M. Srinivasulu
Jt. Secretary : Dr. V. Muthiah
Treasurer : Dr. A. Jabbar.

The first annual meeting of the Chettinad branch of the I. M. A. was held at Mr. M. C. T.'s bungalow, Kanadukathan on 25-11-'51 at 3 P.M. It was a pleasant and instructive day for all doctors present including a few doctors from Trichy, Madura, Tanjore and Pudukottai. Dr. S. Subramaniam presided. The following office bearers were elected unanimously for the year '51—'52.

President:
Dr. S. Subramaniam, M.B.B.S.

Vice-President:
Dr. D. O. Sendel, M.B., Ch.B., M.R.C.S.

Secretary:
Dr. M. Srinivasalu, M.B.B.S.

Joint Secretary:
Dr. V. Muthiah.

Treasurer:
Dr. A. Jabbar.

Committee members:
Dr. Mrs. Sukumaran, M.B.B.S.
Dr. A. Vaidyanadhan, M.B.B.S.

Auditors:
Dr. V. Veerappan, M.B.B.S.
Dr. Ponnambalam.

Representatives to the Provincial Council:
Dr. S. Subramaniam, M.B.B.S.
Dr. T. S. Setty, M.D.

Representative to the Central Council:
Dr. S. Subramaniam, M.B.B.S.

After Tea, the Secretary read the Annual Report which shows all round activity throughout the year which is essentially due to the keen interest and co-operation evinced by the members. The President Dr. S. Subramaniam then welcomed the guests of the evening. Then Major P. Govinda Rau, M.B.B.S., F.R.C.S. Madura gave an instructive and illuminating lecture on 'Recent advances in Urology.' He dealt in detail most of the common diseases of the Genito-urinary system met with in general practice, their differential diagnosis and treatment. A lively discussion followed in which several members took part.

Then Dr. N. R. Subramaniam, M.B.B.S, Tanjore spoke on 'Medical Emergencies in General Practice'. He dealt in detail most of the common medical emergencies, their differential diagnosis and treatment. This was followed by a discussion in which several members took part.

With a vote of thanks to the guests who responded to our invitation, to the lecturers of the evening and to all the members, the pleasant function terminated after Dinner.

Proceedings of the Annual General Body meeting of the Indian Medical Association (Madras Branch) held on 6-12-51 at the Madras Medical College, Madras.

Dr. D. V. Venkappa was in the Chair.

1. The Annual Report and the Statement of accounts were passed unanimously.

2. *Elections*:

The following Office Bearers were elected for the year 1951-52:

President: Dr. K. Narayanamurthy, M.D.

Vice-Presidents: Dr. K. Vasudeva Rau, M.D., F.R.C.P., T.D.D.
Dr. G. S. Katre, M.B.B.S.

Hony. Secretaries: Dr. K. L. Narayana Rau, M.B.B.S.
Dr. G. Ramachandramurthy, L.M.P.

Hony. Treasurer: Dr. R. Sankaran, L.M.P.

Executive Committee:

Dr. A. V. Avadhani, L.M.P.
Dr. M. R. Bail, M.B.B.S.
Maj. M. Chandrasekharan, M.B.B.S.
Maj. N. Gangadharan, L.M.S.
Dr. N. A. Iyengar, M.B.B.S.
„ P. Krishnaswamy, L.M.P.
„ K. C. Nambiar, F.R.C.S.
„ K. Rama Rao, L.M.P.
„ B. Ramamurthy, M.S., F.R.C.S.
„ G. Sriramulu, L.C.P.S.
„ K. V. Swamy, M.B.B.S.
„ D. V. Venkappa, L.M.P.

Central Council:

Dr. P. B. Anangarachari, L.M.P.
Maj. M. Chandrasekharan, M.B.B.S.
Dr. B. Ramamurthy, M.S., F.R.C.S.
Dr. A. M. Sivaraman, L.M.P.

Provincial Council:

Dr. P. B. Anangarachari, L.M.P.
Maj. N. Chandrasekharan, M.B.B.S.
Maj. N. Gangadharan, L.M.S.
Dr. C. Rama Rao, L.M.P.
Dr. K. Rama Rao, L.M.P.
Dr. G. Ramachandramoorthy, L.M.P.
Dr. B. Ramamoorthy, M.S., F.R.C.S.
Dr. R. Sankaran, L.M.P.
Lt. Col. T. S. Shastri, I.M.S. (Retd.)
Dr. A. M. Sivaraman, L.M.P.
Dr. D. V. Venkappa.

Resolutions: The following resolutions moved by Dr. R. Sankaran and duly seconded were passed.

(i) Resolved that when a General Body is called either for the nomination or for the election of the President and Vice-Presidents of the Provincial as well as the Central organisation of the I.M.A., 8 days clear notice shall be deemed in order.

(ii) Resolved that when the General Body meeting is called for the above purpose with 8 days clear notice by the Hon. Secretaries and when there is not the sufficient quorum as per rules of this branch then the Executive Committee shall on the same day or on any other day, exercise the powers of the General Body either for nomination or for final voting or for both as the case may be.

(iii) Dr. K. V. Swamy moved the following urgent resolution with the consent of the General Body, and was unanimously passed. "Resolved that this Madras branch be given the Provincial branch status and form itself into an independent unit."

Lt. Col. T. S. Sastry proposed a vote of thanks to the outgoing Office bearers. He narrated the services rendered by Dr. D. V. Venkappa as the President and Dr. A. M. Sivaraman as the Secretary during the past years and thanked them on behalf of the Association. He also thanked the other office bearers of the previous year for their work for the association.

CHANGE OF ADDRESS

Dr. Miss D. Balraj	from	Chettinad	to	Erskine Hospital, Madurai
„ V. V. Narayanamurthy	„	Tenkasi	„	Erskine Hospital, Madurai
„ T. M. Vajravelu	„	Jalakantapuram	„	Veloor, Salem District
„ M. K. Madhavan	„	Ambasamudram	„	Ponani, Malabar District
„ K. G. Janaki Bai	„	Trichy	„	Govt. Hd. Qrs. Hosp. Salem
„ S. Krishnamurthy	„	Valangiman	„	Karuppur
„ S. Parthasarathy	„	Paramakudy	„	Madurai
„ M. K. Madhavan	„	Ambasamudram	„	Ponani
„ K. L. Neelakantan	„	Palayamkottai	„	Paramakudy
„ M. P. Nayagam	„	Papanasam	„	Azeeznagar.

MADRAS BRANCH

ANNUAL REPORT FOR THE YEAR 1950—'51

The Executive Committee submits the following report for the year ending 30th September 1951.

Membership: The total number of members on the rolls at the beginning of the year was 256. 2 members died, 29 members resigned or membership ceased by default, and 15 members left Madras (either on transfer, or retirement or for studies in foreign countries) during the year. So the total decrease is 46. New members enrolled during the year was 38. So the strength of the Association at the end of the year is 248.

We regret to record the demise of Dr. G. R. Narayanaswamy and Dr. P. Venkatagiri and we offer our heartfelt condolences to the members of the bereaved families.

Meetings: There were 4 ordinary Executive Committee meetings, 2 urgent Executive Committee meetings, 7 Clinical meetings, 1 General body meeting and 2 other special meetings during the course of the year. The list of lectures for the clinical meetings is appended in the end.

During the year we had the pleasure of meeting and hearing the members of Dr. Hingorani's party. Dr. Hingorani, a practising Ophthalmological specialist in England brought a party of writers and doctors to tour India. The party was given a reception by the Association at the Madras Medical College on 21st October '50. Some of the members addressed the gathering.

The chief among the party were:

Dr. Affleck Greeves, B.A., M.B., M.S., F.R.C.S.,

Dr. George Black, M.B., B.S., F.R.C.S.,

Dr. D. Patric Trevor Roper, M.A., M.B. B. Chir. F.R.C.S., D.O.M.S.

Dr. (Mrs.) Dorothy, M.B., CH., D.O.M.S.

Tea Party: To felicitate Dr. K. Vasudeva Rau, a member of our Branch, on his appointment as the Director of Medical Services, Government of Madras, the Association got up a Tea Party on 28-6-'51. The function was well attended by the members and was a success.

OTHER ACTIVITIES:

1. Rent Control Order. In the new order of the Madras Government, medical men are not brought under the 'essential services'. So the Branch appointed a Sub-Committee consisting of Dr. D. V. Venkappa, Dr. U. Krishna Rau

Dr. K. C. Nambiar and Dr. A. M. Sivaraman to represent to the Government that doctors also must be included under the 'essential services' in the new Rent Control order. The President and the Committee interviewed the Minister in charge and also the various Officers of the Government. The Government has passed orders that the Service and honorary medical officers are declared 'essential services', but in case of the other doctors the Government will view each case on its merits when an appeal is made to them in any case of hardship, and this matter is still being pursued by our President with the Government to achieve our object.

2. The Head Office sent us a circular asking us to draw up a comprehensive list of surgical and other instruments and essential drugs for recommending to the India Government for free import and also for equitable distribution of the same. The Executive Committee appointed a Sub-Committee consisting of Dr. D. V. Venkappa, Dr. R. V. Rajam, Dr. C. Raghavachari, Dr. U. Krishna Rau, Dr. K. C. Nambiar, Dr. K. L. Narayana Rao, Dr. A. M. Sivaraman and Mr. Lalchand Dadha (co-opted). The Committee met in the Deans room of the Government General Hospital and drew up a list of essential drugs and instruments and this list was presented to the Working Committee by Dr. U. Krishna Rau at the Hyderabad meeting.

3. The Director of Public Health sent a Questionnaire on Hotel Sanitation and this was answered by a sub-Committee consisting of Drs. D. V. Venkappa, C. S. Krishnaswamy, Dr. M. R. Bail and A. M. Sivaraman. Dr. C. S. Krishnaswamy who has made a special study of this subject has helped us in giving a comprehensive reply to the questionnaire.

4. The Building Sub-Committee, consisting of Dr. D. V. Venkappa, Dr. U. Krishna Rau, Dr. P. Natesan, Dr. K. C. Nambiar, Dr. K. L. Narayan Rao and Dr. A. M. Sivaraman are pursuing the matter and are trying to find out a suitable place for a building for the Association. Dr. R. V. Rajam was good enough to take an initiative in this matter and the meeting was held at the Deans room to consider this matter. The President was authorised to interview the Officers of the Government and Madras Corporation for securing a suitable plot for the building.

Statement of Accounts was audited by Messers Brahmayya and Co. We thank the honorary Auditors for their work.

In conclusion the Executive Committee thanks the lecturers who gave lectures under the auspices of the Association, the Dean of the Madras Medical College for allowing the Association the use of the premises of the Madras Medical College for holding the meetings.

List of Clinical Meetings held during 1950-'51

No.	LECTURERS	SUBJECT	DATE
1.	Address by the Members of Dr. Hingorani's party		21—10—'50
2.	Dr. S. T. Achar, M.D.	Studies on the Effects of Protein Deficiency among Children in Madras	9—2—'51
3.	Dr. T. Guthe, Chief of the Venereal Diseases Section of the World Health Organisation	'Control of Venereal Diseases'	23—2—'51
	President:—Dr. R. V. Rajam, M.B., M.S., M.R.C.P., Dean, Govt. Genl. Hospl., Madras		
4.	Dr. K. S. Sanjivi, M.D.	'Tuberculosis Control in Madras'	21—3—'51
5.	Dr. K. R. Doraiswami, M.A.R.S. (USA.)	'Cancer Control in USA.'	28—3—'51
6.	Dr. M. Santhosham, M.B.B.S.	'Changing Ideas about Tuberculosis'	30—7—'51
7.	Dr. B. Ramamurthi, M.S., F.R.C.S.	'Are Brain Tumours Uncommon?'	10—8—'51

ANNOUNCEMENTS

Copy of Memorandum No. 22-23/51 PH. III dated the 20th Nov. 1951, from the Director General of Health Services, New Delhi.

It has been reported by the World Health Organisation that a number of misunderstandings have occurred concerning the date of issue, and hence, the duration of the period of validity, of International certificate of Inoculation and Vaccination, due to differences in national practice of recording the date. For example, 10 August 1951 may be written in the following manner: August 10th 1951,

It will considerably reduce the chances of such misunderstandings if in completing the International certificates of Inoculation or Vaccination the following method of recording the date is adopted. The day should be written in Arabic numerals and should appear first; the month should be written in Roman numerals and should appear second, the year should be written in Arabic numerals and should appear last. Written in this manner the date would appear as 10 VIII 1951.

It is therefore requested the medical practitioners in your state areas may be instructed through the Press and circular letters to adopt this method of recording the date of issue in the International Heath Certificates.

The action taken in the matter may please be communicated to this Directorate in due course.

SOUTH KANARA BRANCH

Proceedings of the Annual General Meeting of the South Kanara Branch of the Indian Medical Association, Mangalore, held on Saturday, the 17th November 1951 at 7 P.M. at its premises in the Jaya Laxmi Bank Buildings, Mangalore, SK.

Present:—Dr. A. F. Cœlho, M.B.B.S.—President & 35 other Members.

The meeting began with light refreshments.

The agenda of the business was next taken up.

1. Consideration of the Report (Sixth Annual) for the year ending 30-9-51.

Resolved that the Annual Report be adopted—Proposed by Dr. S. G. A. Raju and seconded by Dr. N. U. Pai—Passed Unanimously.

2. Consideration of the Audited Statement of accounts for the year ending 30-9-51.

Resolved that the Audited Statement of Accounts for the year ending 30-9-51 be adopted.—Proposed by Dr. N. U. Pai and seconded by Dr. S. G. A. Raju—Passed unanimously.

3. Consideration of the Budget for the year 1951-1952.

The Budget is approved.

4. Election of Office Bearers and Executive Committee members for the year 1951-1952.

(*a*) Dr. K. R. Kini spoke of the very satisfactory work done during the year under report and said that the office-bearers had been untiring in their efforts. He proposed that the President, Vice-President, the Hon. Secretary & Treasurer & the Hon. Joint Secretary of the last year be re-elected for the year 1951-52.

This was Seconded by Dr. N. U. Pai—Passed Unanimously.

(*b*) Resolved that the following members be elected for the Executive Committee for the year 1951-1952 :—

1. Dr. S. G. A. Raju.
2. Dr. M. S. Shastry.
3. Dr. J. Subba Rao.
4. Dr. K. B. Shetty.
5. Dr. (Kumari) T. M. Sunderi.
6. Dr. M. R. Shetty to represent I. F. Medical Officers.
7. Dr. M. R. Kamath to represent Independent Medical Practitioners from moffussil.
8. Dr. S. Gopalkrishna Rao to represent Rural Medical Practitioners.

Proposed by Dr. K. R. Kini and seconded by Dr. C. P. Kamath—Passed unanimously.

(*c*) Resolved that Dr. K. B. Shetty & one of the Honorary Secretaries be elected to the Central Council. Proposed by Dr. K. R. Kini and seconded by Dr. C. P. Kamath—Passed unanimously.

Resolved that Dr. K. R. Kini be also elected in case any one of the above cannot attend the Central Council meetings. Proposed by Dr. C. P. Kamath and seconded by Dr. N. U. Pai.

(*d*) Resolved that the following be elected to the Provincial Council.

1. Dr. K. R. Kini. 2. Dr. K. Nagappa Alva. 3. Dr. K. B. Shetty. 4. Dr. U. P. Mallya & 5. Dr. M. Umesha Rao—(Hon. Secretary—Ex-officio).

There were no suggestions to alter the bye-laws nor any Resolution by the members for consideration.

5. The Honorary Secretary then placed before the meeting the letter received from the Honorary Secretary, Madras Provincial Welfare Fund, S. K. Branch, regarding the sale of T. B. Seals and appealed to the members to purchase the seals.

6. The Honorary Secretary then placed before the meeting the letter received from the President of the Social Service league, St. Aloysius' College, Mangalore, S.K., requesting the help of the members of the Medical Association for starting free medical relief to the Harekal & Pavur Villages along with the Resolution passed by the Executive Committee of the Branch recommending the same to the members.

A discussion followed and it was resolved that the matter be considered again by the Executive Committee to formulate a regular scheme.

7. Resolved that the Services of the outgoing members of the Executive Committee, namely Dr. K. R. Kini, Dr. C. P. Kamath and Dr. E. K. P. Nambiar be placed on record—Proposed by the Hon. Secretary and seconded by the Hon. Jt. Secretray.—Passed Unanimously.

The President Dr. A. F. Cœlho then thanked the members on behalf of all the office bearers for having re-elected them for one more year and assured that they could continue their work with the same zeal and enthusiasm with which they worked last year and appealed to the members for their cooperation without which the Association could not show progress.

At this stage Hon. Sri A. B. Shetty, M.L.A., Minister for Agriculture arrived and was received by the President, Vice-President and the Hon. Secretaries and taken to the meeting hall. Sri A. R. Rajaratnam, District Collecter and Sri B. Manjayya Hegde, President, District Board were also present.

Dr. A. F. Cœlho, the President, then welcomed the Hon. Minister and spoke of his services to the State and his interest in our district and on behalf of the Association requested him to address the members of the Association.

Hon. Sri A. B. Shetty first thanked the members of the Association for having given his an opportunity to address them and also to meet many of his friends. He then referred to the schemes for the improvement of the District Head Quarters Hospital and other Hospitals in the District undertaken by the Government and also about the handsome contribution to Fr. Muller's Charitable Institutions at Kankanady by the Government. He also said that the Government in addition to its contribution towards the construction of the T. B. Sanatorium at Moodashedde in South Kanara District has also decided to bear the

annual recurring expenditure of about Rs. 60,000/- for the maintainence of the Sanatorium. He then went on to speak of the scheme of Antimalarial operations in the District as also of the Antifilarial scheme started in Mangalore and other places in the District. He then referred to the work started by the Government for the provision of protected water supply for Mangalore.

He then spoke about the necessity of more Medical Colleges for the training of more medical men and said that Dr. Madhava Pai's scheme of opening a Medical College at Udipi by private effort has aroused some interest and said that attempts along such lines would no doubt help the expansion of medical education.

The Minister then urged for more Honorary posts in the District and Taluk Hospitals with the idea of encouraging good physicians and surgeons and Specialists to settle down in moffussil stations in order to benefit the people in the surrounding rural areas where the services of such medical aid is wanting. He also wished that the refresher courses now given at the teaching institutions be extended to the District Centres so that more of our medical men might avail of the facilities offered.

He advised the members of the medical profession to keep themselves abreast of the times by reading new books and current journals, visit modern hospitals and seek opportunities to come in contact with the best men of the profession.

Hon. Sri Shetty then stressed the importance of Social Medicine and the need for greater attention to psychological factors in present day medicine, and also said that emotional troubles play a great part in the production of actual physical disorders. He referred to the science of nutrition which has established itself as one of the major branches of preventive medicine. He also emphasised the importance of environmental hygiene and social background and the study of the same in which the disease had developed. He said that the greatest single factor for building up resistance against disease was the improvement of the dietetic condition of the people.

In the end, Hon. Sri Shetty said that the Health & Medical Services in India had to grapple with the problems created by ignorance, poverty and squalor and said that adminstrative measures of great magnitude would be required to improve the environmental sanitation, increase food production and raise the level of public health in this country and appealed to the members to work in the best interest of the public.

Dr. A. F. Cœlho, the President, in his concluding remarks thanked the Minister for taking keen interest in the welfare of the country as a whole and our district in partrcular and also assured him of the willing cooperation of the members of our association in all matters relating to medical and public health problems of the country. He also thanked the District Collector and the District Board President for gracing the occasion and all members for making the function a success and also all those who have helped the association.

The members then moved to the Mohini Vilas where Dinner was served. The members dispersed after a very pleasant evening.

TIRUCHY BRANCH

President: Dr. R. Kalamegham
Vice-President: Dr. L. S. Ramachandra Iyer
Secretary: Dr. A. Dharmarajan
Treasurer: Dr. T. V. Sundaram

The 22nd Annual Meeting of the association was held on Sunday the 18th November 1951 at 10-30 A.M. in the premises of the Bishop Heber High School, Teppakulam, Tiruchirapalli. About 100 members including the press representatives were present. Dr. R. Kalamegham the President was in the Chair. Dr. C. R. Chari, the Secretary presented the annual report and Dr. T. V. Sundaram, the Treasurer presented the audited statement of accounts for the year and both were unanimously adopted after being duly proposed and seconded. The President then suggested that the convention of electing the President and the Vice-President unanimously on the floor of the house may be followed and it was accepted.

Proposed by Dr. T. N. Subramanyam and seconded by Dr. T. V. Srinivasan Dr. R. Kalamegham was re-elected as President unanimously and proposed by Dr. T. V. Srinivasan and seconded by Dr. P. A. S. Raghavan, Dr. L. S. Ramachandra Iyer was elected as Vice-President unanimously. The following office-bearers were elected for the year.

Secretary: Dr. A. Dharmarajan.

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

Committee members:
Dr. P. A. S. Raghavan.
„ C. R. Chari.
„ P. V. Sundaram.
„ V. Enok.
„ S. Venkatesan.

Provincial Council:
Dr. T. S. Balasubramanya Iyer.
„ C. R. Chari.
„ P. V. Sundaram.
„ V. Iravatham.
„ R. Ganesan.

Central Council:
Dr. T. S. Balasubramanya Iyer.
„ V. Iravatham.

After a breakfast provided by the Chemists and Druggists of Tiruchirapalli, the annual gathering commenced with Dr. R. Kalamegham, the re-elected President in the Chair.

The President introduced Dr. Y. P. Vasudevan, Retired Municipal Health Officer, Coimbatore to the members and requested him to give his address. Dr. Y. P. Vasudevan in his address outlined a practical scheme for the prevention of tuberculosis in India. He said that every case should be isolated and attention should be paid to the proper nutrition of the vulnerable section of the population. He added that in addition to about 40,000 beds which were needed in sanatoria, there should be 60,000 beds in isolation centres, with minimum requirements of food, clothing and equipment for treatment. The immediate objectives of such isolation centres should be to provide accommodation, however little, to every tuberculosis patient, who sought admission. He suggested that the vacant site of about 25 acres to the south of the Rajaji Sanatorium, was best suited for the isolation shelters to the many tuberculosis patients who had neither facilities in their homes nor the money to pay for food or treatment. Temporary buildings, cottages or huts could be put up on the spot which could be rented out annually to private medical practitioners to house and treat their private cases. The speaker then gave details as to how this Centre could work and the basis underlying the scheme. He appealed to the members of the association to take up the scheme and work it.

The following resolution was passed. "This association endorses the scheme of Dr. Y. P. Vasudevan in general for Tuberculosis relief in Tiruchy and appoints a sub committee consisting of Drs. R. Kalamegham, P. A. S. Raghavan, T. V. Srinivasan, N. C. Subramanyam, T. M. Krishnamoorthy, K. G. Menon and Dr. A. Dharmarajan to go into the details and report to the General Body of the association as early as possible."

The President referred to the services rendered by Dr. B. Jayaram as the Superintendent of the Rajaji Tuberculosis Sanatorium in maintaining it at a high level and also making it popular.

Then Dr. R. Subramanyam, Retired Director of Public Health was introduced to the members by the President. In his address Dr. R. Subramanyam stated that preventive medicine should be given its due place in the curriculum of medical studies. According to the Bhore Committee's report, it was recommended that the Government could start rural public health centres catering to all aspects of public health. Though the Madras Government started five such centres they did not succeed in all aspects. The one great difficulty, he added, was the lack of proper medical personnel to man these institutions. Referring to the long and costly course of medical education, the speaker said that the medical man should be fairly compensated for his arduous work and he should be given an attractive remuneration.

Then the members adjourned to lunch at 1 p.m. provided by Messrs, Pharmaceutical and Research Laboratories, Madras.

The after-noon session commenced at 2 p.m. when Dr. N. Vaidyanathan, M.D. gave a lecture on "Coronary Insufficiency" after which Major K. N. Rao, M.D., F.C.C.P., F.I.C.S. and Dr. D. Damodar Das, M.B.B.S., T.D.D. gave lectures on "Recent Trends in control and treatment of Tuberculosis."

Then the members were entertained with Tea provided by Messrs. Sarabhai Chemicals, Baroda.

The evening session commenced at 5 p.m. when Dr. C. Raghavachary, M.S. F.R.C.S. and Dr. V. S. Subramanyam, M.B.B.S. M.Sc., F.A.C.S., gave lectures on "Diseases of Rectum and Anal Canal in General Practice" and "Diseases of Larynx" respectively.

All the lectures were very much appreciated by the members and in the interesting and useful discussion that followed each lecture many members took part.

The members were supplied cool drinks at intervals.

At 7 p.m. the films on Modern Sanatorium and Surgical treatment of Pulmonary Tuberculosis, Nutritional Dystrophy among children in Madras, the working of the Pasteur Institute of Southern India, a film on topical interest were shown by Dr. D. Damodar Das, M.B.B.S., T.D.D., Madras and the films on Larynx by Dr. V. S. Subramanyam, M.B.B.S., M.Sc. F.A.C.S. Extra Pleural Pneumothorax by Major K. N. Rao, M.D., F.C.C.P., F.I.C.P. and on Anemia by Messrs. Sarabhai Chemicals, Baroda were shown to the members. All the films were very much appreciated by the members. The facilities for projection of films were afforded by Mr. J. Sadagopan of Tiruchy.

The Secretary proposed a vote of thanks to all the lecturers for having kindly addressed the association, to the firms who stood as hosts for the meeting, and to the authorities of the Bishop Heber High School, for kindly placing the hall for the meeting.

After a dinner provided by Messrs. W. T. Suren & Co. Ltd., Bombay to the members at 8-30 p.m. the grand function came to a close at 9 p.m.

TIRUNELVELI BRANCH

President: Dr. K. Rama Ayyar
Secretary: Dr. R. Gopalan

The monthly meeting of the Tirunelveli Branch of the Indian Medical Association was held at Palayamkottai at the office of the District Medical Officer on Friday, 12th October 1951 when 45 members were present. It was marked by the distinguished presence of Dr. P. Arunachalam, M.D., M.R.C.P. (Lon.) T.D.D., (Wales) D.M.R.E. Deputy Director of Medical Services, Madras.

The meeting began with tea provided by the association after which the Secretary read the minutes of the previous meeting.

After a brief introduction by the President, Dr. K. Rama Ayyar, the lecturer of the day, Dr. P. Arunachalam gave a talk on "The Doctor's Bag". He gave in detail the drugs and appliances which must find a place in the Doctor's bag for treatment of medical emergencies. The lecturer then answered questions from the members pertaining to the subject.

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

TIRUCHY BRANCH

President: Dr. R. Kalamegham
Vice-President: Dr. L. S. Ramachandra Iyer
Secretary: Dr. A. Dharmarajan
Treasurer: Dr. T. V. Sundaram

The 23rd Inaugural meeting of the association was held on Monday the 10th December 1951 in the premises of the Govt. Head Qrs. Hospital, Puthur, Tiruchy under the Presidency of Dr. R. Kalamegham. About 50 members were present. After Tea kindly provided by the President, the President brought to the notice of the members the following two circulars received from the Central Office.

1. Regarding the forthcoming All India Medical Conference to be held in Ahmedabad.
2. Regarding the two posts offered in Canada for residents in Tuberculosis.

Then he introduced Dr. P. Arunachalam, MD, MRCP, DMR, TDD, Director of Medical Services, Madras to the members and requested him to give his talk.

The lecturer gave an interesting talk on Rheumatic Fever which was very much appreciated by the members.

After the usual discussion, the Secretary proposed a vote of thanks to the lecturer, the host of the evening and the Superintendent Govt. Head Quarters Hospital for allowing the premises for the meeting. The meeting came to a close at 8 p.m.

INDIAN MEDICAL ASSOCIATION

SOUTH INDIAN PROVINCIAL BRANCH

CIRCULAR NO. 3

COIMBATORE,
20—12—1951.

To

ALL MEMBERS OF SOUTH INDIAN PROVINCIAL BRANCH

Given below is a copy of the circular received from the Central Office regarding availability of large number of residencies for young doctors in U. S. A. and Canada. Intending applicants are requested to forward their applications through their respective local branches on or before 30th January 1952 to this office for necessary screening and selection.

(Sd.) A. G. LEELAKRISHNAN,
Honorary Provincial Secretary.

Copy of No. 751/51-52/ PGTA dated 8th December, 1951 from the Central Office, Indian Medical Association, Delhi to the Honorary Secretaries, All Provincial Branches and Local Branches of the Indian Medical Association.

DEAR SIRS,

From letters received from U. S. A. and Canada, it appears that a fairly large numer of Residencies—Junior and Senior—may be available for young Indian doctors in Hospitals in U. S. A. and Canada in the near future. The Residencies will commence usually from 1st July, 1952. The Specialities in which Residencies may be available are as follows:

		DURATION
1.	Pathology & Bacteriology	one, two or three years.
2.	Orthopedic Surgery	,,
3.	Ear, Nose & Throat	,,
4.	General Surgery	,,
5.	Neurology	,,
6.	Neurology and Psychiatry	,,
7.	Psychiatry	,,
8.	Pediatrics (Children diseases)	,,
9.	Dermatology	,,
10.	Anæsthesiology	,,
11.	Radiology	,,
12.	Internal Medicine	,,
13.	Obstetric & Gynæcology	,,
14.	Tuberculosis	,,

Selected candidates may be kept longer than one year if they prove satisfactory. These candidates will be given free board and lodging and a small stipend each month for incidental expenses. These candidates will have

to live and board along with other Residents in the hospital premises. As such, vegetarians or persons not willing to take the usual American type of food or unused to Western type of living, need not apply.

Qualifications: Only young doctors with at least one year's experience of House Surgeon, House Physician etc. need apply, stating the speciality chosen. Selected candidates will have to bear the cost of passage to destination and back and be in a position to meet other incidental expenses.

Applications should reach the Provincial Secretaries of the Indian Medical Association (through the Secretary of the Local Branch) before the 30th of January (30—1—1952).

Applicants must give full details of their qualifications and experience, date of birth etc., and mention whether married or single, and enclose 3 copies of passport size photographs, and not more than 3 testimonials—including one from the Dean of the Medical College. Applications must be type-written and submitted *in triplicate*. In the case of selected candidates, their applications in triplicate should be sent to the Central Office by the Provincial Branches.

Secretaries of Provincial Branches are requested to form Selection Committees for the purpose of interviewing and screening of candidates, so that their recommendations can reach the Central Office by the *31st January, 1952*. Not more than three persons in each category should be recommended by each Provincial Branch. The Provincial Committees should satisfy themselves about the health and financial position of the candidates. On receipt of recommendations from the Provincial Branches, the Central Committee will proceed to make the final selections and may interview the candidates who must be prepared to travel for this purpose at their own expense. This may take place at AHMEDABAD at the time of All India Medical Conference between 13th and 19th February, 1952, or at Delhi soon afterwards.

After final selection by the Central Committee, the names chosen will be forwarded to the authorities of the various Hospitals concerned for approval and appointment. It is hoped that final intimation will be available by the end of March 1952 and the selected candidates will have to leave India towards the end of May, 1952.

It is requested that branches—Provincial & Local—will give this matter quick publicity amongst their members.

Copies of this Circular are being sent to all Medical Colleges.

Yours faithfully,

(Sd.) S. C. SEN,
Honorary General Secretary,
Indian Medical Association.

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

DIAGNOSIS OF EARLY CARCINOMA OF THE CERVIX BY SPONGE BIOPSY—*The Clinical Journal—Feb. 1950.*—Successful treatment of malignant disease in any site depends upon early diagnosis.

In such conditions as gastric and bronchogenic carcinoma, although the diagnosis is made when the patient complains of his first symptom, the disease has often already progressed beyond the stage where radical cure is possible. For successful treatment in such cases the detection of the disease will have to be made before the onset of clinical complaints. S. A. Gladstone[1] points out that the cervix uteri, because of its ready accessibility, provides an ideal site for the detection of early carcinoma, prior to the onset of symptoms or signs, and he reports two such cases diagnosed by the method of sponge biopsy.

This method depends on the absorption of fluid cells and tissue particles from the surface of an ulcer or mucous membrane rubbed by an absorbing sponge of suitable structure and chemical composition. The sponge and absorbed contents are fixed information, embedded in paraffin, sectioned by microtome and stained. The stained sections are then examined for tumer cells.

A flat square of sponge (which must be of such composition as to withstand the solvent action of alcohol, chloroform, acetone or other chemicals used in tissue preparations) is clamped along one margin by a surgical sponge forceps, and the dry diagnostic sponge is rubbed gently over the suspected area. The flat sponge may be used for rubbing of the surface of the cervix uteri or for lesions of the skin, mouth, or rectum. By slight modification the method can be used through a sigmoidoscope or bronchoscope.

The first of the two cases reported by Gladstone was a 40-year-old married woman who complained of backache of 2 years' duration. Physical examination was negative, apart from slight obesity, and pelvic examination was normal apart from the presence of a left-sided Bartholin cyst and a retroverted uterus. The cervix appeared normal on visual inspection through a bivalve speculum. Sponge biospy was performed by rubbing a flat sponge over the cervix, and fragments of cancer tissue were detected in the sponge inserted into the cervical canal. A diagnosis of epidermoid carcinoma of the cervical canal was made, and total hysterectomy and bilateral oöphorectomy performed.

The second case was that of a 48-year-old woman whose vague complaints were thought to be of menopausal origin, and who was referred to a gynæcologist for endocrine therapy.

During the pelvic examination a sponge biopsy was performed and the histological diagnosis was of epidermoid carcinoma of the cervix. This examination was followed by a curettage which confirmed the previous finding, and later hysterectomy and bilateral oöphorectomy was carried out.

In both cases the cervix looked normal on clinical visual inspection, and the diagnosis of epidermoid carcinoma would not have been made at the initial time of examination had it not been for the use of the sponge biopsy technique as described above.

[1] *New Eng. Journ. Med.*, 1949, 240, 26, 1040.

Printed at St. Joseph's Industrial School Press, Trichinopoly—1952

28th All India Medical Conference

of

Indian Medical Association

AHMEDABAD

The above Conference will be held in Ahmedabad on the 17th, 18th and 19th February 1952 along with the Golden Jubilee celebration of the Ahmedabad Medical Society.

During the Conference there is a possibility of the meeting of the Commonwealth Medical Conference being held in our country for the first time.

Doctors attending the conference can avail themselves of Railway concession which will be single fare for the double journey. The concession forms are available from the local branch secretaries and they must be filled and forwarded to the Railway Divisional or District Traffic Superintendent, who will then issue order which will have to be presented to the Station Master for obtaining the railway ticket at concession rate.

The Working Committee will meet on the 13th and 14th Feb. 1952 and the Central Council on the 15th and 16th Feb. 1952.

P. A. S. Raghavan,
Managing Editor.

Registered No. M. 4839

ODDS & ENDS

"Doctor, what will you advise me to do if I want to live long?"

"Do you smoke or drink or play with women?"

"No, I don't do any of these things."

"Then, why do you want to live long?"

△♡△

The mile runner was down with fever and after the nurse took out the thermometer, he enquired what the temperature was and was informed it was 101°. His next querry was "What is world's record."

△♡△

A wise man said "I regularly get myself examined by the doctor once a month, pay him decently, get the prescription made up by the chemist and then throw away the medicine in the gutter. When asked why, he said, "I want the doctor to live, the chemist to live and I also want to live."

△♡△

Prospective donor: I can't give blood to-day. I am heavily drunk. 90% of my blood will be alcohol.

Nurse: It does not matter. We will be able to use it for sterilizing our instruments.

△♡△

Papa: the hair tonic is doing more good to your head than your hair.

"Why do you say that."

"Because your scalp is growing taller than your hair."

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

Vol. XVIII FEBRUARY 1952 No. 8

Indian Medical Association South Indian Provincial Branch

Post Box No. 530

Oppannakara Street, COIMBATORE

CIRCULAR NO. 4

COIMBATORE,
21—12—1951

Dear Doctor,

You are aware that as per resolution of the Council of the South Indian Provincial Branch of the I. M. A. held at Karaikudi on 9-9-1951, the Trichinopoly branch of the I. M. A. was authorised to continue the publication of the "Miscellany" as the official organ of the Provincial Branch and that the Managing Editor of the "Miscellany" should render accounts to the Provincial Council through the Trichinopoly branch and to pass on a share of the profits to the Provincial Association.

No doubt you are also aware that the "Miscellany" has so far been able hardly to maintain itself because of poor response from manufacturers of medical products. Only when the "Miscellany" is able to secure more number of advertisements, it will be possible to earn any profit out of the "Miscellany". Hence I would request you to impress upon the representatives of medical firms and to request all your members to do likewise, that the members of your association should patronise the products advertised in the "Miscellany". Such co-operative effort on behalf of all the office bearers of the Provincial Association, of all the Secretaries of the local and district branches under their jurisdiction of the South Indian Provincial branch, and all the members of our Association would help in improving both the standard of the publication and for increased profits from the "Miscellany".

Doctor P. A. S. Raghavan, the Managing Editor of the "Miscellany" is doing a grand work all by himself so long, and with the co-operation of every individual member of our association, we could expect him to do much better.

(Sd.) A. G. LEELAKRISHNAN,
Honorary Provincial Secretary.

(FOR CIRCULATION AMONGST MEMBERS ONLY)

THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
THE INDIAN MEDICAL ASSOCIATION

VOL. XVIII] FEBRUARY 1952 [NO. 8

COMMON PATHOLOGICAL LESIONS OF THE CERVIX UTERI AND THEIR CLINICAL SIGNIFICANCE

BY

DOCTOR MRS. ANNA VAREED, F.R.C.S., M.B.B.S., L.M.D.R.C.O.G., F.R.F.P.S.,
COIMBATORE

Mr. President, Ladies & Gentlemen,

I consider it a great privelege to be here today. I am pleased and flattered by the invitation though it was with some reluctance that I made up my mind to accept this responsibility. It then took me considerable time and thought to decide on a suitable subject for the occasion. At last I have chosen this *viz.* Common pathological lesions of the Uterine cervix and their clinical significance. This may sound a bit uninteresting to most of you, I presume, but from the point of view of the women's well-being, general health and comfort, her cervix uteri holds a very important place. Every doctor, especially women doctor, even though she may not be a specialist in Gynaecology, should possess a clear idea of the normal and pathological appearances and feel of the cervix. One should at least spot out if there is any deviation from the normal and promptly direct such to the proper place and person for further investigation and treatment. In the investigation of cases of sterility, dysmenorrhoes, dyspareunia, repeated spontaneous abortions, chronic pyelitis, rheumatic complaints, lower abdominal pain, pelvic congestion, hyperaemia inflammation and cellulitis, low back pain, contraception, vaginal discharges, pruritis vulva, in short, in all. gynaecological and vague general complaints, a study of her cervix uteri should be an essential part of our examination.

A digital and bimanual examination of the cervix and uterus by a gloved finger, followed by inspection with a bivalve-speculum, will reveal a lot of information, even though the woman may not make any specific complaints pertaining to her cervix.

The anatomy of the uterine cervix needs no special description in an article like this. I may just mention that the cervix which is an inch long, is divided for purposes of description into 2 parts: the lower part projecting into the vagina is called the portio vaginalis, while the part above the cervicovaginal attachment is called the supravaginal cervix. In a rullipara the portio vaginalis is shaped like an inverted cone and the external OS forms a small circular or transverse aperture at its apex. But after child birth the portio is modified in shape and size, and the external OS becomes wider and more patulous or the cervix may present lacerations or tears, or its lips may even be everted.

The vaginal mucosa is reflected over the outer surface of the portio and is firmly attached to the cervical tissue. The epithelial covering of this part of the cervix is therefore the same as that of the vagina *viz.* squamous. At the external OS it changes abruptly into the cubical epithelium which lines the cervical canal. This bit of histology is very important to remember and explains the occurrence of erosions. In front the cervix is united to the bladder by a layer of loose cellular tissue while at the sides it is in contract with the lateral masses of pelvic cellular tissue. Hence the ease with which pelvic cellulitis and parametritis follows injury and infections of the cervix.

In situ the body of the uterus is inclined forwards from the cervix, so that the axis of the organ forms a curve open widely in front, forming an abtuse angle of 160°. In the erect posture the external OS is at the level of the ischial spines. Distension of bladder and rectum can affect the positions of the uterus, and various postures and muscular efforts, increasing or decreasing intraabdominal pressure can also affect the position of the cervix and uterus. The cervix can be drawn down almost to the vulva, more so in multipara. The study of the cervix, its position, secretion, patency of its canal etc. are more important to the gynaecologist investigating cases of sterility, than the study of the uterus itself.

The fibro-muscular tissues of thy cervix and vagina are so intimatele blended together that separation of the vagina from the cervix is possible only by cutting. This union is the principle support of the uterus, the rest being by means of ligaments which carry blood vessels, lymphaties and nerves—acting more like a mesentery.

Affections of the cervix uteri may be classified under the following heads:

1. Malformations and Hypoplasia.
2. Abnormalities of endocervical secretions.
3. Displacements of the cervix.
4. Injuries.
5. Infections — and inflammatory precesses.
6. New growths-simple and malignant.

(*1*) *Malformation and Hypoplasia :—* Developmental abberations like double uteri, cervix or vagina or absence of any of these organs and other congential defects are real disorders of development—occuring during the embryological state and hence strictly speaking do not come under pathological lesions. Defects of development are very often multiple and may effect other parts of the generative system, as well as other systems. Hypoplesia of the uterus and cervix and atresia of the cervical canal need special mention. Severe forms of atresia cervix may give rise to haematometra and haematosalpinx *i.e.*, collection of menstrual blood within, giving rise to pain and distension of lower abdomen. Immediate attempts must be made to relieve the condition by giving exit to the blood. If it cannot be dealt with from below, abdominal operation is called for and if there is no possibility of canalising the cervix, the uterus may have to be removed with conservation of the overies.

Pin hole OS with conical cervix is a condition commonly met with. The portio vaginalis is much smaller and more conical than normal and often there is an exaggeration of the anteflexion of the uterine body—which is undersized. Dysmenorrhoea, sterility and oligomenorrhoea are often associated with this condition. The abnormally small OS is spoken of as "pin hole OS" though it is definitely much larger than a pinprick. It may be too narrow to admit the uterine sound. In some cases the sound as well as dilators easily pass the external OS, but

refuse to pass the internal OS. Hypoplastic conditions of the uterous are usually associated with acute anteflexion and stenosed OS. An exaggerated condition of anteflexion sometimes produces what is called a cochleate or small flexed uterus.

A stenosed cervical canal is very often not the only cause of painful and scanty menstruation and dilatation of the cervix for dysmenorrhoea and sterility is becoming less popular in western countries whereas D & C i.e. dilatation and curettage are the two most abused and misused operative procedures in these parts. Any gynaecological complaint including sterility has become an indication for a D & C!! In such cases there is no need to curette, unless there are specific indications for same. Curettage is essentially a diagnostic procedure, and should never be lightly undertaken. It is criminal to curette in the presence of frank spesis or without proper preparation, as it may even lead to fatal septicaemia. Many a woman can blame a carelessly conducted or unnecessary curettage for all her pelvic troubles and chronic ill health. To take out a strip of endometrium for biopsy to decide about ovulatuion the narrow Randall's curette can be used without any dilatation.

Hypertrophic elongation of the cervix. Congenital and acquired varieties of this condition are met with. The congenital variety is found in nullipara and is often a cause of sterility and dyspareunia. The portio vaginalis is usually 1/2″ long, elongates till it reaches the vulva in some cases. The acquired elongation is frequently present in cases of procidentia, usually affecting the supravaginal portion but sometimes it affects the vaginal portion also. In both, congenital, and acquired varieties, the elongation is not due to stretching but it is a definite new formation of tissue and is therefore hypertrophic. The cervix when seen at the vulva may be mistaken for prolapse. But on bimanual examination though the cervix is felt and seen at the vulva, the fundus of the uterus will be felt at its normal level —whereas it is displaced downwards in prolapse. *Treatment* Ambutation of the cervix.

Dilatation of the cervix is carried out as a routine preliminary step in all operations on the cervix.

Endo-Cervical Secretions and their abnormolity. The endocervical mucus, under normal healthly conditions, provides a medium in which spermatozoa easily live and flourish but it also shelters them from the hostile vaginal moisture. When the endocervical secretions are altered by disease, they likewise cause the speedy death of the spermatozoa. One of the prerequisites of absolute fertility is that the endocervical secretions be favourable to the spermatozoa. Abnormalities of the endocervical secretion due to infection are a major factor in the causation of infertility. The secretion of muscus during ovulation period has to be thin, watery, nonviscous and alkaline in reaction, allowing spermatozoa to quickly travel up. In a thick, viscid type of secretion, the spermatozoa get entangled like flies on fly-paper. Numerous sterility cases have conceived when the cervicitis present in them was cured and the endocervical secretion became healthy. Therefore in sterility studies a healthy state of the cervix and cervical secretion is as important as the patency of the fallopian tubes and the presence of live, healty spermatozoa in the semen. Routine aspiration and examination of post-coital cervical mucus at ovulation time, so-called Smith-Huhner test, is nowadays the final evalution of infertile cases.

Vaginal acidity is unimportant, so long as delivery-reception of sperm functions normally and sperms are promptly carried into the cervix. Normal post-coital findings in the endocervix allow us to make certain

conclusions. Faults of delivery-reception are ruled out and hostility of endocervical secretions is proved to be non-existent.

Displacements of the cervix uteri. Hitherto we have been used to talking about displacements of the body of the uterus, but from the time I started taking interest in sterility studies, I have been giving great importance to the position of the cervix uteri. It is always a more rational plan to correct the fundamental faults of delivery-reception of the spermatozoa and in the woman these faults comprise chiefly malpositions of the cervix.

Anteflexion of the cervix. One must not lose sight of the fact that cervical anteflexion as already mentioned, is usually a stigma of pelvic hypoplasia, the other features of which should receive attention. Sometimes surgery is required to rectify this displacement by lengthening the anterior cervical attachments. A transverse incision is made in the anterior vaginal wall going through the entire thickness of tissue till the peritoneum is reached. The anterior surface of the cervix is freed for the rest of the tissue, the cervix is thrown back and the horizonal wound is now closed vertically. The cervix thus goes backwards, the body of the uterus falling forwards, maintaining the normal anteflexion of the body of the uterus, with the cervix in its normal position.

Cervical elongation. Whether developmental or hypertrophic already mentioned may prevent direct insemination, gaculation in such cases taking place above and behind the cervix. Sims was the first to notice the coincidence of this deformity with sterility. He says "If the cervix protrudes one half inch into the vagina sterility is probable, if one inch it is almost positive to follow, if more than one inch, it must cause sterility". In cases of primary developmental elongation the sterility is due only in part to the local anatomy, a more weighty factor is the genital hypoplasia of which the cervical morphology is an obvious evidence.

Anterversion of the cervix caused by Retroversion of the uterus with little or no flexion, operates just like anteflexion by carrying the OS externum forwards so that it comes to lie in contact with the anterior wall of the vagina. Displacement of this type i.e. Retroversion of the uterus often a sequela of previous child bearing, is encountered in many cases of secondary sterility and conception soon follows correction of same by means of a pessary or by operation.

Descent of the cervix, part of the general status of uterine prolapse should usually be treated by palliative measures as long as further childbearing is desired. The entire vaginal vault sags downwards carrying with it the bladder, the uterus and very often the rectum also. Most of these women complain mostly about their bladder, as the cystocele causes irritability of the bladder, frequency of micturition or impaired urinary control called stress-incontinence. Good results are often obtained by supporting the uterus with a rubber ring pessary of the "dough-nut" type—but this is only a temporary measure and most cases will require surgical repair of the entire pathology viz. anterior colpoplasty and correction of the cystocele, posterior colpo-plasty, amputation of the cervix and a perineorrhaphy—the combined procedure is usually called the Manchester operation after Fothergill.

Injuries to the cervix uteri. The majority of injuries to the uterine cervix are the direct result of factors incidental to pregnancy, labour and abortion. Laceration of the cervix is so common in labour that signs of this injury are regarded as an indication of previous childbearing. Similar tears can also result for surgical trauma unskillfully applied, such as during instrumental dilatation of the cervix or during extraction of large submucous fibroids Pituitary infection during labour unkillfully and unscrupulously given often cause bad tears of the cervix. Obstetric tears are usually of moderate degree. If not deep, they do not give rise to severe postpartum haemorrhage. They are often not noticed nor repaired at the time of labour. Later they produce visible scarring, the left side being more commonly torn than the right, due to the predominance of vertex I positions. A post-natal examination of the parturient woman after the 6th week following confinement should be insisted on in every case. If, during labour, the tear extends upwards, it may even involve large blood vessels at the base of the broad bigament and sometimes uncontrollable or even fatal haemorrhage result.

Deep bilateral tears split up the cervix into 2 halves. Infection sets in followed by fibrosis and thickening of the cervical tissue. Each lip of the cervix becomes everted and rolled outwards producing a condition called Ectropion. Chronic inflammation of the pelvic cellular tissue from spread of infection quickly follows, the women suffers from pain, discomfort and impairment of her general health. In no time she becomes a chronic invalid with all sorts of vague and intractable complaints.

These tears impair the retentive capacity of the uterus during subsequent pregnancies if she conceives and they are a very important cause of repeated spontaneous abortions. The low grade infection sets up a chronic unhealthy state of the uterine cavity causing death and expulsion of the ovum—or the tear causes an incompetence of the cervix and the ovum sags down and is eventualy aborted. Incompetance of the internalos of cervix has been mentioned in the 1950 year book of Obs. and Gynae.: as an often-overlooked but common cause of habitual abortion. Rapid labours with resultant tearing of the cervix, or forceps labour through an incompletely dilated cervix—or when the shoulders are forcibly pulled through an unsuspected contraction ring, all these factors cause a certain amount of incompetance of the cervix—just as overdilatation and overzealous curettage can cause the same injury to the anterior wall of the internal OS. The degree of incompetance may vary so that habitual abertion may not occur if the patient is kept supine until term to prevent herniation of the dependent bag of waters through the partially opened, incompetent OS—Diagnosis of the condition is easy. Expose the cervix by a bivalve speculum in a good light—The defect can be felt by the educated finger also.

Treatment Prophylaxis is very important. Proper conduct of labour in all its stages, and if any tear has taken place, it has to be repaired forthwith—Routine post-natal examination of every parturient woman in the 6th week should be insisted on—If a tear has occurred repair operation after 3-4 months should be advised—When the conditlon is met with during a gynæcological examination, the only treatment is by surgical repair—In a few selected cases where the cervix is so badly damaged and when there is associated uterine disease and when no more childbirth is desired, the entire uterus with the cervix may be removed by abdominal or vaginal hysterectomy.

I like to mention one case in this connection. A young woman Mrs. N. aged 26 consulted me with signs of an inevitable abortion which was her 11th abortion following a forceps delivery, nearly 7 years previously — All her abortions were spontaneous, between the 2nd and 3rd months of pregnancy in spite of her taking bottles of Vitamin E and several injections of lutocyclin etc. I told her that I could not save that pregnancy either as she had come too late. She aborted the same day,

it was a complete abortion. I said that I would like to see her for a thorough examination after a month—She came for the examination. She had very extensive bilateral tears of the cervix. Operation was advised after 3 months but before I could operate on her she again conceived. I told her that I was very very pessimistic about saving that pregnancy also but I kept her in bed throughout her pregnancy with the foot of the bed raised, with a vulcanite ring pessary fitted inside, which was periodically cleansed and re-inserted—and believe it or not, she carried that pregnancy to term with no mishap or threatenings even, had a very normal delivery which I attended, she got a very healthy child but she has not yet turned up for the repair operation, though it is nearly a year since she gave birth.

Infections and inflammatory conditions of the cervix uteri. Acute infection of the cervix is generally the result of direct spread and occurs along with acute infection of the lower genital tract, especially gonorrhœal and streptococcal infections. Infection of the cervix occurs in 90% of cases of gonorrhœa. Acute cervicitis can also supervene upon infected lacerations of the cervix such as usually result from faulty obsterics or during surgical procedures like dilatation, or extraction of fibroids. When a cervix is intact, its vaginal surface is protected by squanous epithelium but when lacerated the columnar epithelium of the cervical canal is exposed—the glands secrete tenaceous mucus with inspisated pus—later there is only a clear mucoid discharge.

In acute gonorrhœal cervicitis the woman seldom makes any reference to her cervix. She complains of dysuria, pruritis, a feeling of weight and a profuse purulent discharge per vaginum. Back ache may be complained of, but in the majority of cases the only complaint is about the discharge—which is frank pus to begin with.

Nowadays I very rarely see cases of acute gonorrhoea—thanks to the good services rendered by penicillin and sulpha drugs or even other antibiotics but in insufficient dosage in most cases. But, alas, it is my misfortune to daily come across any number of cases of chronic gonorrhoeal endocervicitis with all its usual pathetic sequelae. The discharge in chronic cases is not much to speak of, it may even be quite clear but can still be infectious. To take a smear the cervix must be well exposed by a bivalve speculum the area wiped with sterile swabs of cotton wool and the smear taken from the epithelial lining of the endocervix and not from the pus-like discharge which may show only pus cells.

Our public has still to be taught that gonorrhoea, is indeed a very very serious disease and not a minor or trifling accident. Men doctors, please warn your menpatients that very serious and lasting results often follow this disease in married life. Gonorrhoea is directly or indirectly responsible for very many cases of both male and female infertility—In women, apart from the cervicitis and hostile cervical secretion, it does produce pelvic inflammation resulting especially in tubal damage and occlusion. In men it likewise leads to sterility by chronic inflammation and obstruction and occlusion in the male genital tract, so much so, control of gonorrhoea becomes an important item of preventive medicine especially in sterility studies.

The uncured man infecting his wife is responsible for 50-75% of Gonorrhoea in the female. At present we have nothing to prevent a man with communicable Gonorrhoea or syphilis from marrying and infecting his bride. Many a time this outrage has been perpetrated with full knowledge on the husband's part of what he was doing. So it is up to the medical attendant to give sufficient information and

warning to the victims of these diseases. Women doctors while treating women patients should so advice the husbands of their patients that they also take proper treatment, so that there is no re-infection. I always guarantee a re-infection in the woman if both husband and wife do not take proper treatment at the same time and both get completely cured. once and for all.

Very great importance has been given in these parts to the curative value of the vaginal douche for all cervical conditions. Next to the abuse of D. & C. already pointed out, comes the abuse and misuse of the vaginal douche. Doctors, midwives and nurses are too eager to give vaginal douches to all cases who have any gynaecological complaint viz. Leucorrhoea, menorrhagia, metrorrhagia or any other symptom. Even normal puerperal cases are sometimes not exempted. Other than the mechanical cleansing of the vagina a douche does little good and is definitely unnecessary in most cases, but it can do great harm in acute cases. Apart from gentle swabbing of the vagina, vigorous local treatment including douching should be avoided in all acute conditions, as it may cause extension of the trouble to the upper genital tract; same holds good in acute puerperal infections of the cervix also.

Chronic cervicitis and endocervicits. In chronic gonorrhoeal infection next to the urethra, the cervix is the most common seat of infection. Cervicitis is present in 90% of the acute and 95% of chronic cases. In many cases as I mentioned already, the infection starts as an acute endocervicitis going on to chronic endocervicitis. Suppurating points of infected Nabothian follicles may be seen in some cases. The vaginal mucous membrane being squamous escapes in most cases except at the Bantholin glands where the infection lingers. Secondary organisms invade the affected area in the cervix and a chronic low grade, infected surface comes to stay for ever.

Tuberculosis and syphilis can cause a severe ulcerative type of cervicitis, which may even be mistaken for early carcinoma. Biopsy and W. R. or/and Kahn will clinch the diagnosis; I speak very dogmatically about both syphilis and tuberculosis causing ulceration of the cervix because I have seen instances of both affections among my patients.

A lady about 30 years old was brought to me, because of a blood-stained discharge p.v. She complained of pain all over the body, had difficulty in passing urine, sorethroat and general malaise. Her temp. was 100°. On examination there was pus seen coming from the urethra and the cervix was swollen, and inflamed filling up the entire vagina, and perspeculum a red angry-looking ulcer was seen, about 2″×2″ around the OS, readily bleeding on touch. I sent her blood for Kahn, it was .... She was started on antisyphilitic treatment, 10×6 lacs penicillin followed by 8 weekly injections of Bismuth. In the meantime I sent a note to her husband (said to be an educated person) along with her blood report, advising him to see his blood also and to take treatment any where he liked till his blood become negative. The husband left for Madras on business the next day so the wife told me and was away for 2 months, but about three months later he sent me his Kahn report which was negative and also sent word that he had been taking injections. The wife, of course, got all right, she now has a perfectly healthy cervix covered over by healthy vaginal mucous membrane. To this day, I have never met the husband. I think he was too shy to show himself!

(To be continued)

ASSOCIATION NOTES

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 24th November 1951 at 6 p.m. in the Association premises. About 68 members attended. Owing to the unavoidable absence of the President, the Vice-President, Dr. Y. P. Vasudevan was proposed to the Chair.

After tea and refreshments the Secretary read the minutes of monthly meeting held in September and the Managing Committee meeting held in October, which were adopted. New members were introduced. On behalf of the Association, the Secretary congratulated the following for being elected to the respective posts, in the I.M.A.:—

1. Dr. T. S. Tirumurthi, President, I.M.A.
2. „ Y. P. Vasudevan, Vice-President, South Indian Provincial branch of the I.M.A.
3. „ A. G. Leelakrishnan, Hony. Prov. Secy., S.I.P. branch of the I.M.A.
4. „ T. V. Sivanandam, Member, Central working Committee.

Secretary read letters from Dr. P. A. Natesan and 28th A.I.M. Conference. I.M.A. circular 3/51-52 and the letter from the President, Red Cross Society, Coimbatore Branch, was read. Dr. T. V. Sivanandam moved the following resolution which was unanimously adopted:—

"This Association notes with regret the orders of the Government in their memo. No. 42407/L/51-3 Health dated 18-10-51, stating that the Central Jail Cemetery site asked for by the Red Cross Society for construction of the tuberculosis hospital at Coimbatore, is not available and the Red Cross Society may select some other suitable site for their purpose.

As there is no other alternative site within the Coimbatore Municipal limits for the purpose and as the Jail Cemetery site, which is not much in use at present, is the only site ideally suited for locating tuberculosis hospital, this Association resolves to request the Government to reconsider their orders and sanction the alienation of the site at an early date."

In the symposium on "Recent Advances" Dr. C. V. Ramaraj talked about recent advances in Surgery, Dr. N. Subramaniam, in medicine, Dr. (Mrs.) Anna Vareed, on Gynaecology, Dr. P. R. Subbian on Peodatrics, Dr. S. Balakrishnan, on E.N.T. diseases, Dr. L. Munuswamy on Veneriology, and Dr. M. K. Ramasubramaniam on Anaesthesia. Each speaker took about 10 minutes including the discussion.

Owing to lack of time, consideration of Dr. Santhanam's resolution was postponed to the next meeting.

After the President's concluding remarks and vote of thanks to the host Major R. Sudhakara Rao and various members who took part in the day's proceedings, the meeting terminated at 8-30 p.m.

* * * *

The monthly meeting of the Coimbatore District Medical Association was held on Saturday the 22nd. December 1951, at 6 p.m., in the Association premises. Dr. M. G. Nair the President presided. About 70 members attended.

After tea and light refreshments the minutes of the previous monthly meeting was read and adopted. In the minutes of the Managing Committee meeting the following points were amended and the rest of the minutes were adopted.

1. Majority voted for the Association Annual to be held here itself on Saturday the 19th. January 1952.

2. Regarding the request from the Registered Practitioners of Indian Medicine to use the Asscciation, library, reading room, journals and periodicals, and to be allowed to be present during the Scientific meetings after some discussion on the subject. Consideration of this item was postponed to the next monthly meeting.

I.M.A., circular No. 758 regarding applicatlons for a large number of Residencies in the Hospitals in U.S., for young doctors, a notice from the Executive Officer, Peelamedu Panchayat Board, calling applications for the post of a Hon. Medical Officer in the Panchayat Board Dispensary, Peelamedu, a letter form Dr. I. G. K. Menon, Pasteur Institute, Coonoor for sera from cases of Tropical Eosinophilia were read.

A letter and the following resolution by Dr. C. N. Santhanam and 29 others were read. There was some discussion on the subject. Dr. S. Dorairaj of Hardypet proposed a few suggestions. Finally the resolution was put to vote and majority voted for the resolution: Viz. WE RESOLVE THAT, TILL SUCH TIME AS THE CENTRE GIVES A DIRECT AND FINAL REPLY TO OUR ORIGINAL UNANIMOUS RESOLUTION, OR TILL SUCH TIME AS WE FIND WAYS AND MEANS FOR IMPROVING THE FINANCES OF OUR ASSOCIATION, THE ORIGINAL RESOLUTION TO DISAFFILIATE SHOULD STAND AS IT IS. 22 voted for and 4 against the resolution and the resolution was carried.

The President introduced the Lecturer Dr. P. Kalyanaikutty, B.Sc., M.D., M.R.C.O.G., (Lond.), D.C.H., (Lond.), who read a short and interesting paper on "EARLY DIAGNOSIS AND TREATMENT OF CANCER OF THE CERVIX." There was a discussion in which some members took part.

The president in his concluding remarks stressed the early detection of the cancerous lesions and treatment as was pointed out by the lecturer. He said that this aspect should be stressed. He thanked the learned lecturer of the day for having come all the way from Trichur. He next thanked the host of the day Dr. U. A. Menon, for the tea and refreshments and the members who took part in the day's proceedings.

The meeting terminated at 8-30 p.m.

CHETTINAD BRANCH

President: Dr. S. Subramaniam
Vice-President: „ D. O. Sendel
Secretary: „ M. Srinivasalu
Joint Secretary: „ V. Muthiah
Treasurer: „ A. Jabbar

The monthly meeting of the Chettinad branch of I.M.A. was held at the Swedish Mission Hospital, Tirupatur on 15th Dec. '51 at 4-30 P.M. The hospital staff were 'At Home' to the members and guests. Dr. S. Subramaniam presided.

Dr. D. O. Sendel, M.B., Ch.B., M.R.C.S. Vice-President of the Association and the chief medical officer of the hospital gave a very interesting talk on 'Experiments in Therapy'. The speaker dealt with in detail how gastric letage with Pot. permanganate lotion greatly benefits cases of chronic gastritis. He demonstrated this with case records of cases treated in the hospital including gastric analysis done before and after gastric latage. Then he described briefly the technique of partial gastrectomy as done in the hospital. Next he referred to cases of Lumbago and Myalgia where injections of a local anaesthetic (Pantocaine or Novocaine) combined with a drug to produce local vasodilatation (Priscol) greatly relieves the pain that is so excruciating. He then dealt with Non-specific protain therapy in corneal ulcers, Iritis, Iridocyclitis, Rypopion etc. and was of the view that injections of boiled milk in doses of 5 cc. daily for 10 or 12 days gave good results. He then referred to cases of uterine inertia during labour and said how a single injection of cal. gluconate 10%-10 cc. (preferably Sandoz) acts like a charm in initiating strong uterine contractions and the delivery is compleated in a very short time.

There was a lively discussion in which several members took part. With a vote of thanks by the secretary to Dr. Sendel for the very instructive talk and to the hospital staff for the 'Tea' the meeting terminated.

CHINGLEPUT BRANCH

Proceedings of the Annual Meeting of the General Body of the Chingleput District Branch of the Indian Medical Association held on Saturday the 24th November '51 at 2-30 P. M. at the Municipal Council Hall, Chingleput. In the absence of the President and Vice-President, Dr. A. S. Johnson, M.B. B.S., M.R.C.P., Superintendent, Government Hospital, lecturer of the day, was voted to the Chair to conduct the proceedings at the out.

A. Read minutes of the Previous Meeting "Adopted."

B. The Statement of accounts from 1-10-50 to 30-9-51 presented by the Secretary were approved and passed. At this stage, Vice-President came and took his seat.

C. Read letter of Dr. C. B. Ethirajulu M.B. B.S., resigning the presidentship of the association from 11-10-51 vide G. O. "Recorded."

The Association places on record the indefatigable services rendered and enthusiasm evinced by Dr. C. B. Ethirajulu during his term of presidentship.

D. Election of Office-bearers for the Year 1951-52. The following Office-bearers were elected unanimously.

(a) President: Dr. P. S. Srinivasan, L M.P., Kancheepuram, (b) Vice-President: Dr. A. Sundararaja Rao, L.M.P. Chingleput, (c) Secretary and Treasurer: Dr. R. Varadarajan, L.M.P., L.P.H. Chingleput, (d) Members of the Executive Committee: 1. Dr. K. Vittal Doss Pai, M.B. B.S., Pallavaram. 2. Dr. P. K. Varugheese, L.M. and S. Tambaram. Dr. V. L. Raja, M B.B.S., Chingleput. 4. Dr. T. K. Thayumanava Mudaliar, L.M.P., Kancheepuram. (e) Election of representative to the Central Council as per rule 15-1. B. (a) of the Indian Medical Association. Dr. P. S. Sreenivasan, L M.P. Kancheepuram (President). (f) Election of representatives to the Provincial Committee. 1. Secretary, 2. Dr. P. S. Ananthanarayanan L.M P., Kancheepuram, 3. Dr. D. Rajamanickkam, L.M.P., Kancheepuram.

After Tea, Dr. A. S. Johnson, B.A, M.B. B.S., M.R.C.P., Superintendent, Government Mental Hospital, Madras, gave an illuminating and instructive lecture "Place of Mind in the Origin and Treatment of Disease."

With a vote of thanks by the President to the learned lecturer, the meeting came to a close.

MATHURAI BRANCH

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

The monthly meeting for November was held at 5-30 p.m. on the 24th at the Erskine Hospital, Madurai. Dr. M. N. Rajan occupied the chair. The minutes of the previous meeting were read and adopted. Dr. R. Kalamegham, B.A., M.B.B.S., President, Trichy Branch of the Indian Medical Association gave an interesting talk on CONSTIPATION. He referred to the popular and pseudo-scientific beliefs relating to CONSTIPATION and its supposed illeffects and emphazised the fact that PURGATIVES HAVE NO PLACE EITHER IN MEDICINE OR SURGERY.

Dr. Kalemegham dwelt at length on the preliminaries to an operation in surgical constipations, which he said, were absolutely the same as intestinal obstructions whatever the cause. The general practitioner faced with surgical constipations was asked to institute gastro duodenal aspiration, to start an I. V. saline and glucose, and a dose of atropine. A plain X-ray of the abdomen with the patient standing, the socalled scout film is taken where facilities exist to study the patterns of gas and fluid levels. This helps to determine small bowel or large bowel obstructions as the case may be. Gastro duodenal aspiration helps in small bowel obstructions only.

A single enema at the end of 48 hrs. is tried which does not bring out faeces or flatus and the case is inmediately handed over to the surgeon. A very interesting discussion followed to which the learned lecturer suitably answered. The meeting terminated after a vote of thanks.

Proceedings of Combined Monthly and Extraordinary General Meeting held on 12th Jan. 1952.

The above meeting was held at 5-30 p. m. at the Govt. Erskine Hospital, Madurai. Dr. M. N. Rajan occupied the Chair.

At the outset a motion of condolence at the demise of Dr. Varadarajan of Madras was moved from the Chair and passed all members standing for a minute. The Secretary was requested to convey the sentiments of the House to the bereaved family.

The minutes of the last monthly meeting was read out and adopted. Circulars No. 3,51-52 and No. 751,51-52 of Central Office of I. M. A. were discussed with great interest. The following were unanimously elected as delegates from Madurai Branch to the 28th Annual Conference of I. M. A. at Ahmedabad. 1. Dr. K. G. Ramabadran. 2. Dr. A. K. Rajagopalan. 3. Dr. S. Kanthimathinathan. 4. Dr. P. A. Y. Narayanan. It was decided to send two more delegates if any were prepared to go to the Conference.

Dr. S. V. Joseph, Asst. Dt. Medical Officer, Madurai, was then called upon to read his paper on PSYCHO—SOMATIC MEDICINE. He traced the origin, development and present status of psycho-somatic medicine and discussed the features of some important minor mental maladies. The lecturer explained the symptoms and differential diagnosis of the anxiety neuroses and hysteria and its varied manifestations. The increasing incidence of 'stress diseases' according to the speaker, was due to the mounting tension and stress incidental to modern civilized life. The meeting terminated after a vote of thanks by the Secretary.

MALABAR BRANCH

President: Dr. C. K. Menon
Vice-Presidents: Dr. C. V. Narayana Iyer, Dr. A. Narayanaswami
Secretaries: Dr. C. P. Parasuraman, Dr. A. B. Das
Treasurer: Dr. M. K. Koya.

A Special Meeting of the Malabar Branch of the I.M.A. was held on Wednesday 19th December 1951 at 5 P.M at the Government Headquarters Hospital, Beach Road, Kozhikode. In the absence of the President, the Vice-President, Dr. C. V. Narayana Iyer presided.

This meeting was arranged to hear the address of Dr. P. Arunachalam, M.D., M.R.C.P., T.D.D., D.M.R., Director of Medical Services, when he was on his visit to Kozhikode. The Chairman welcomed the distinguished guest on arrival and introduced him to the members present. Then the members were treated to nice Tea Party.

After the introductory remarks, the District Medical Officer, Dr. C. Raman demonstrated four interesting clinical cases and these were followed by lively discussions wherein the distinguished guest and all the members took part. After the cases, Dr. P. Arunachalam addressed the members on "HYPERTENSION" and the Role of the General Practitioner towards the Hypertensive patient. The lecture was very elucidative and entertaining, after which

the lecturer was asked a lot of questions by many members for which he answered suitably.

Dr. C. R. Parasuraman proposed a vote of thanks.

45 members were present for the meeting.

***

A meeting of the Malabar Branch of the Indian Medical Association was held at 5 P.M. on Saturday the 26th January 1952 at the West Coast X-Ray Institute, Travellers' Bungalow Road, Kozhikode. Dr. C. K. Menon presided. 27 members were present.

The members were treated to nice refreshments, the host being Dr. P. Balram, L.M.P., L.G.O.

After the President's introductory remarks, the Secretary read the minutes of the last meeting held on (29-12-1951).

Dr. K. Seetharaman, B.Sc., M.B.B.S., then read a paper on "*Acute Respiratory Emergencies.*" Following the paper, there was a nice discussion wherein all the members took part.

After a vote of thanks by the Secretary, Dr. C. R. Parasuraman, the meeting ended.

NILGIRIS BRANCH

Proceedings of the Annual Meeting of the Nilgiris District Branch of the Indian Medical Association.

On Sunday 4th November 1951, the annual meeting of the Association was held at the Lawly Institute, Ootacamund with Lt. Col. J. C. Bharucha in the chair. Dr. A. Balasubramanian, Secretary, presented the Annual Report for the year 1950–51. The report was adopted and the accounts passed. The following office bearers were elected :—

President: Lt. Col. J. C. Bharucha
Vice-Presidents: Dr. S. R. Pandit & Dr. C. Gopalan
Hony. Secretary: „ P. V. Kurian
Joint Secretary: „ K. P. S. Nambiar
Committee Members: Col. A. J. D'Souza; Dr. I. G. K. Menon; „ (Mrs.) C. C. Herbert; „ N. S. Menon; „ V. N. Viswanathan & Capt. V. Govind

A subcommittee was appointed to go into the question of securing a 16 mm. sound projector for the Association meetings.

About thirty members of the Coimbatore Branch of the I. M. A. and forty members of the Nilgiri Branch were entertained to lunch at the Lawley Institute.

After lunch the clinical meeting commenced under the chairmanship of Lt. Col. J. C. Bharucha who welcomed the members of the Coimbatore Association. Dr. M. P. Pai of Coimbatore gave a practical talk on the "PLACE OF SURGERY IN THE TREATMENT OF TUBERCULOSIS". Antibiotics have enabled surgeons to undertake more extensive surgical procedures for the treatment of tuberculosis. In abdominal tuberculosis, parenteral streptomycin with oral P. A. S. was giving excellent results. The speaker dealt with the indications for lobectomy, pneumonectomy and thoracoplasty. Even in very ill patients thoracoplasty can now be done with the aid of polythine balls. In addition to streptomycin and P.A.S., he said that immobilisation of the neck with a cotton wool collar was found beneficial in tuberculosis of the glands of the neck. He answered several questions, raised by doctors present at the meeting.

Dr. Thiruvengadam, Assistant District Medical Officer, Coimbatore, gave the case histories of seven patients on whom he had operated for abdominal tuberculosis. It was noted that majority of his patients were women.

Dr. N. Jeganathan of Coimbatore demonstrated serial diagrams of several of his patients who are treated with artificial pneumothorax and streptomycin.

Referring briefly to the history of influenza and its epidemiology, Dr. I. G. K. Menon related his recent experiences in research on Influenza. He spoke about the various types of viruses isolated at Coonoor, the part played by secondary organisms and the different methods used in research.

The meeting closed with vote of thanks by the Secretary and Tea.

RAMANATHAPURAM BRANCH

Minutes of the Annual Meeting held on 2—12—51.

The members were entertained to tea by the association and a photograph taken.

Dr. M. G. Jones, president of the association presided.

Dr. S. Sundaresan read the annual report of the association and the audited account for the year 1950–51 with a balance of Rs. 648—11—0.

The following Office Bearers were elected unanimously for the year 1951–52.

President:
Dr. M. G. Jones, St. Martins Hospital, Ramanathapuram.

Vice-President:
Dr. R. Venkatachari, Virudhunagar.

Hony. Secretary & Treasurer:
Dr. T. Muthusamy, Virudhunagar.

Provincial Council:
Hony. Secretary (Ex-Officio)
1. Dr. S. N. Ganapathi, Virudhunagar
2. „ Sundararajan, Rajapalayam.

Central Council:
1. Dr. Janakiram, Keelasevalpatti.
2. „ T. S. Kalkura, Aruppukottai.

Committee Members:
1. Dr. S. Sundaresan, Kamuthi.
2. „ S. Meenakshisundaram, Ramanathapuram.
3. „ Mary Verghese, Virudhunagar.

The members of the association expressed gratitude to Dr. Sundaresan who had served as secretary of the association for nearly eight years.

Dr. P. Govinda Rao, M.S.F.R.C.S., Madura gave a very interesting talk on recent advance in Urology with skiagrams and instruments. There was a general discussion on the subject. Later Dr. S. Rajan demonstrated a case of head injury.

The secretary proposed a vote of thanks to the President, the Lecturer and the members present. The meeting terminated after dinner.

TANJORE BRANCH

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

On Sunday the 23rd September 1951 at 4-30 P.M. the monthly meeting of the Indian Medical Association, Tanjore District Branch was held. 30 members attended the meeting.

Dr. P. A. K. Nair, D.M. & S., T.D.D., G.H. Hospital, Tanjore was 'At home' to the members.

After tea, the members adjourned for the regular meeting with Dr. E. K. Menon, President of the Association in the chair.

From among the list of members nominated for the post of President and Vice Presidents I.M.A. for 1951-52 the following were elected unanimously.

Dr. T. S. Tirumurthi for Presidentship

Vice-Presidents:
Dr. V. Govindan Nairu (Kunhamkulam)
„ P. N. Ramasubramaniam (Madura)
„ Kutumbiah (Vellore)

The minutes of the last meeting was read and adopted. After the routine correspondence Dr. T. S. Shetty M.D., Chettinad, the principal speaker of the evening was introduced to the

audience and was requested to give his talk on 'Certain Ear, Nose and Throat conditions met with in general practice' which was very much appreciated by the audience.

There was a lively discussion after the end of the lecture in which many members took part.

The President in his concluding remarks thanked the lecturer for the valuable lecture delivered which will be very useful to the general practitioners. A vote of thanks was proposed by the Secretary to the lecturer of the evening for the instructive lecture delivered and to Dr. P. A. K. Nair for the fine tea provided.

TIRUCHY BRANCH

President: Dr. R. Kalamegham
Vice-President: Dr. L. S. Ramachandra Iyer
Secretary: Dr. A. Dharmarajan
Treasurer: Dr. T. V. Sundaram

A monthly meeting of the association was held on Wednesday the 9th Jan. 1952 in the premises of Aerodrome, Tiruchy under the Presidency of Dr. R. Kalamegham. About 50 members were present. After Tea kindly provided by Dr. Vepa Ramurthy, Air Port Health Officer, the President introduced Dr. C. V. Ramchandani, Asst. Director-General of Health Services, Govt. of India to the members, and requested him to give his talk on W. H. O.

The lecturer explained the details regarding the origin and functioning of the World Health Organisation and how it had been carrying out the objective of extending help to all under-developed countries. He also said the idea of starting such an organisation was mooted in 1945 and it had gradually developed into a world organisation with a central Directorate at Geneva and six regional directorates in various parts of the world. Each member nation paid a subscription according to its means. He said that W.H.O. had been rendering financial and technical assistance on the basis of first things first. So far as India was concerned, the W. H. O. had sent out malarial experts at our request to demonstrate the cheapest and latest methods of malaria control. A joint scheme would soon be worked by the Govt. of India in collaboration with W. H. O. and the F. A. O. The Point Four programme, the Colombo plan, and the International Children's benefit Fund could all be best utilised by India by presenting comprehensive schemes of amelioration.

Dr. P. A. S. Raghavan announced that the Commonwealth Medical Conference would meet in India for the first time in February at Ahmedabad and if the members happen to come to Tiruchy, the Tiruchy Branch should call for a meeting and stand as host for them and it was approved unanimously.

After the usual discussion, the Secretary proposed a vote of thanks to the lecturer, and to the host, the meeting came to a close at 7 p.m.

TIRUNELVELI BRANCH

President: Dr. K. Rama Ayyar
Vice-President: Dr. P. R. Acharya
Secretary & Treasurer: Dr. R. Gopalan.

The twenty third annual gathering of the members of the Tirunelveli Branch of the Indian Medical Association was held at the Centenary Hall Palayamkottai on the 17th November 1951 at 5 p.m. Members numbering fifty including guests were present.

The day's proceedings started with the commencement of the business meeting at 5 p.m. under the Presidentship of Dr. K. Rama Ayyar, M.B B.S.

The Secretary read the minutes of the previous meeting held on 12-10-1951 at the Head Quarters, which was passed.

Then the office-bearers for the year 1951-52 were elected by the general body.

I. *President.*—Proposed by Dr. A. R. Tampi, M.B.B.S., D.L.O. and seconded by Dr. S. Chandrasekaran, M.B.B.S., Dr. K. Rama Ayyar, M.B B.S., was unanimously elected as President.

II. *Vice-President.*—Proposed by Dr. V. Kuruvilla, M.B B.S., and seconded by Dr. P. V. Venkatachalam, M.B.B.S., Dr. P. R. Acharya, M.B.B.S., was unanimously elected as Vice-President.

III. *Hony. Secretary and Treasurer.*-Proposed by Dr. P. V. Venkatachalam, M.B.B.S., and seconded by Dr. A. R. Tampi, M.B.B.S., D.L.O., Dr. R. Gopalan, B.A., M.B.B.S., was unanimously elected as Honorary Secretary and Treasurer.

IV. *Members for the Managing Committee.*-Proposed by Dr. R. Subramanian, T.D D. and seconded by Dr. G. Subramaniam, M.B.B.S., the following were unanimously elected as members of the Committee.

(*a*) *General Body*—1. Dr. S. Chandrasekharan, M.B.B.S. 2. Dr. L. Mahadevan, M.B.B.S., D.O.M.S. 3. Dr. R. V. Chockalingam, B.A., M.B.B.S.

(*b*) *Lady Representative.* — Proposed by Dr. K. Rama Ayyar, M.B.B.S., and seconded by Dr. K. Madhava Menon M.B.B.S, Dr. (Kumari) P. Yeshoda, L.M.P was elected Lady Representative.

V. *Member-Auditor.* — Proposed by Dr. L. Mahadevan, M B.B.S. and D.O.M.S. (Lon.) and seconded by Dr. G. Subramaniam, M.B.B.S., Dr. P. V. Venkatachalam, M.B.B.S., was unanimously elected as Member-Auditor.

VI. *Members for the Central Council.*—Proposed by Dr. S. Chandrasekharan, M.B.B.S., and seconded by Dr. L. Mahadevan, M.B.B.S., D.O.M.S. (Lon.(Dr. R. Subramaniam, T.D.D. and Dr. G. Subramaniam, M.B.B.S were elected unanimously.

VII. *Members for the South Indian Provincial Council.*—Proposed by Dr. K. Madhava Menon, M.B.B.S., and seconded by Dr. T. V. Muthiah, M.B.B.S. Dr. L. Mahadevan, M.B.B.S., D.O.M.S. (Lon.) Dr. S. Chandrasekharan, M.B.B.S., were unanimously elected.

The business meeting then came to a close.

The members then gathered for Tea provided by Messrs. Navaratna Pharmacy, Cochin.

After Tea, the meeting began under the Presidentship of Dr. K. Madhava Menon, M.B.B.S. District Medical Officer, Tirunelveli.

The Secretary and Treasurer presented the annual report for the year 1950-51 which was adopted.

Then the President introduced to the members Dr. R. Kesavan Nair, M.B.B.S., F.R.C.S. (Eng.) the distinguished lecturer of the day.

Dr. R. Kesavan Nair, M.B.B.S., F.R.C.S. (Lon.), Superintendent, General Hospital, Trivandrum then read his delightful and interesting paper on "Hæmorrhoids". Prefacing with a short anatomy of the rectum and anal canal; the speaker dwelt at length on the causative and contributory factors on the netiology of hæmorrhoids-their age and sex incidence-the various signs and symptoms they produce—the complications and the stages. He discussed in detail the treatment of piles and the post operative management of such cases.

There was a large discussion by the members.

The President then winded up the meeting.

The Secretary then proposed the vote of thanks. He thanked the illustrious lecturer for the day and also Navaratna Pharmacy, Cochin for the Tea and the Squibb Chemicals for a few films that they were to demonstrate later.

After this, Messrs. Squibb Chemicals demonstrated the medical films 'Anæmia' and 'Malnutrition' which were much appreciated by the members.

There was dinner following this after which the day's function came to a happy close.

* * *

The monthly meeting of the Tirunelveli Branch of the I.M.A. was held at Palayamkottai at the office of the District Medical Officer on Saturday, 29—12—51 when members numbering 38 were present.

After tea provided by the President, Dr. K. Rama Iyer, M.B.B.S., the meeting began with the reading of the minutes of the previous meeting by the Secretary

Then a resolution put up by the managing Committee to open a current account in the Imperial Bank of India, Tirunelveli was placed before the General Body and was accepted nem. con.

After this, Dr. M. Viswanathan, D.M. & S. Medical officer, Borstal School, Palayamkottai read a paper on "Criminal Psychology". He dwelt at length on the various aspects of crime and the psychology underneath them. There was some discussion in which some members took part.

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

Change of Address

Dr. Mrs. Kamallamma Chockalingam
from
Madras to Chittoor

Dr. D. S. Asirvatha Nadar
from
Madura to Palamcottah

Dr. A. M. Francis
from
Coonoor to Madras

ABSTRACTS FROM THE CURRENT MEDICAL LITERATU

AUREOMYCIN—Its use in Chronic and Acute Infections; Preliminary Report—*N. Vern Peterson, M.D., and R. B. Hadley, M.D.—E.E.N.T. Sept., 1949.*

The recent introduction of Aureomycin into the field of therapeutic agents gives promise of a new and effective instrument. Aureomycin, an antibiotic recently isolated from a strain of the Streptomyces group of molds, has been shown to be active not only against many gram-positive and gram-negative bacteria, but also against certain rickettsiæ and viruses. In view of the numerous infective agents associated with sinus infections, as also the frequent difficulties and deficiencies allied with existing antibiotics, sulfa derivatives, etc., it was considered advisable to evaluate the use of aureomycin in chronic and acute sinus infections. Accordingly, in June of this year such a study was initiated which involved the treatment of a series of eighteen patients, nine of whom were chronic sufferers and nine in an acute phase of infection.

Aureomycin was supplied in the form of 50 mg. and 100 mg. capsules. The material itself was in the form of its hydrochloride.

The dosage employed varied in individual instances although a general suggested dosage of 5 mg. per kg. body weight every four hours was followed in most instances. This therapy was continued for varying lengths of time based on the response of the patient. In the chronic cases this period extended from 10 to 25 days, while in the acute cases therapy was continued from 2 to 8 days.

In each instance, before therapy, was instituted, the sinuses were cultured for bacteria in order to determine, if possible, the causative agent of infection.

Chronic Cases

Nine patients who had consistently shown recurrence of infection were selected. Of these, three had been previously subjected to extensive therapy and operations which had not proven effective. The bacteria isolated from these nine patients were identified as: Hemolytic staphylococcus aureus, Hemolytic staphylococcus albus, Escherichia coli, and Hemolytic streptococcus.

Following oral administration of aureomycin, all nine patients showed either a remarkable improvement or complete cessation of their clinical symptoms. This effective therapy, in all instances, took place where instillations and internal administration of sulfonamides and penicillin had failed.

Indicative of the response of this group as a whole were two particularly resistant cases.

Case No. 1—This patient had in past undergone extensive surgery which included a bilateral Caldwell Luc operation, mid-turbinate resections, ethmoidectomies, and radium treatments of the nasopharynx. Continued reinfections had been treated with sulfonamides and penicillin to which the organisms were apparently becoming resistant, and in the case of penicillin, the patient had become sensitive. On June 1st of this year, the patient suffered from severe headaches, general malaise and emission of a heavy purulent secretion. This secretion emanated from a chronically thickened and congested nasal mucosa and from the sphenoid sinuses. Treatment with penicillin was discontinued due to a strong sensitivity reaction. Bacteriological cultures showed the presence of Hemolytic staphylococcus aureus and Escherichia coli. Therapy with aureomycin was then instituted, the patient receiving oral administration of 300 mg. five times a day for a period which finally extended over 25 days. At the end of the second day of therapy a marked improvement was noted; secondary symptoms had been markedly reduced and the purulent secretion was no longer evident. At the end of ten days the patient felt completely well and an examination of her sinuses showed her to be clinically cured. However, this improvement was soon followed by several recurrences of infection. In each instance, administration of aureomycin produced a rapid response. This patient has remained asymptomatic for almost three months.

Case No. 2—This patient had a history of severe chronic sinusitis for years and had been treated by us for over a year. In spite of internal administration of sulfonamides and penicillin, bilateral antrotomies, and repeated irrigations with instillation of penicilin solution, no appreciable relief was

obtained. At every examination a heavy green purulent secretion was seen filling both nasal cavities. Bacteriological cultures revealed a Hemolytic streptococcus. Aureomycin was commenced in a dosage of 300 mg. every four hours, five times a day. After five days of treatment the patient felt greatly improved and there was a marked decrease in the amount of secretion. At the end of one week there was no evidence of purulent secretion and the patient felt well. Treatment was continued for a total of ten days. The patient at present is completely well after three months. It is to be remarked that there were no side effects of a toxic nature noted in either this or the previous patient.

Acute Cases

Nine patients suffering from acute attacks of sinusitis were treated with aureomycin as a separate group. These were typical purulent sinus infections following acute upper respiratory infections. In most instances secondary infections of the throat were also present.

Bacteriological cultures from this group indicated the presence of at least Hemolytic staphylococcus albus, Hemolytic staphylococcus aureus, Hemolytic streptococcus, non-hemolytic staphylococcus albus, and an un-identified gram-negative bacillus.

Therapy with aureomycin in this group also showed a very favourable response. It has been our practice to treat this type of case with oral sulfonamides or parenteral penicillin. The response with aureomycin was at least as effective as the above and considerably easier from the patients standpoint. The duration of treatment in this series averaged about four days, although in most cases a marked effect was noted in 24 hours or shortly thereafter. One case responded where previous treatment with adequate dosages with both penicillin and sulfonamides had proven ineffective. A Hemolytic streptococcus was isolated in this case. All of the nine acute cases were clinically and subjectively free of infection after four days and there were no relapses requiring further treatment. This shorter period of treatment involved a lower intake of the drug, which intake varied from 1·6 gm. to 9·6 gm. with an average of about 4·5 gm.

In all of the cases studied no toxic symptoms were observed. Two of the patients after several days of treatment noted a slight acid stomach which was easily countered by diet or mild anti-acid medication. Three patients noted slight diarrhoea, but not sufficient to require treatment.

Comment

In this series of eighteen chronic and acute sinus infection the use of aureomycin has proved most effective. A rather wide range of bacteria, both gram-positive and gram-negative, have been treated with results which indicate aureomycin as being as effective, if not more so, than penicillin and the sulfonamides. The lack of toxic reactions as well as the ease of administration, comparatively small dosages and lack of sensitivity reactions recommend it highly. The side effects appear to be negligible.

Conclusion

As a result of this study of eighteen sinus infections treated with aureomycin we believe that this antibiotic offers great possibilities as an effective agent in the treatment of bacterial infections. Certainly it warrants a great deal of further study to determine adequate dosage and the range of its effectiveness.

***

THE USE AND ABUSE OF PURGATIVES IN CHILDREN—*The Practitioner—August, 1950.*—In orthodox therapeutics purgation is losing, indeed has lost, its place at the forefront of the attack upon disease, but among the general public, belief in the merits of a good purge still lingers. Ritual catharsis, 'a good clean out on Friday', is widely practised; indeed it seems that the majority of mothers dose their children regularly. To the lay mind (at the mercy of the propaganda of advertisements for proprietary medicines) there are many effects of constipation; present medical opinion on the other hand attributes most of the symptoms supposedly due to constipation to the effects of the laxatives—to the treatment rather than to the disease.

Constipation

Constipation may be defined as bowel actions occurring less frequently than normal, the evacuations being too small in amount or too firm and dry. There is wide individual variation in normal bowel function and it seems well to require a change in bowel habit, or at least two of the above features, before making the diagnosis: thus small firm daily stools, or fæces of normal consistency evacuated on alternate days, do not merit the diagnosis.

There can be no doubt that the most common cause of constipation in children is faulty training in toilet habits, coupled with a dependence upon laxatives, but before this assumption is made each case must be examined with other possible causes in mind: these include change of diet and environment (change of air); dehydration (in fever and in heat waves); lack of muscle tone or generalized weakness (malnutrition, convalescence, rickets and anæmia); bowel disorders (hypertrophic pyloric stenosis, and anal stenosis in infants), particularly disorders of the lower bowel (megacolon, piles, prolapse, and fissure—often a sequel rather than a cause). In intussusception, constipation and vomiting may precede the 'prune juice' stool by some hours. Although the examination of the constipated child will naturally be focused on the gastro-intestinal tract, the axiom that 'cretins are usually constipated' serves as a reminder that the child must be seen as a whole.

Megacolon

Megacolon deserves special mention as an example of chronic constipation. Recent independent work by Zuelzer and Wilson (1948) in the United States, and by Bodian *et al.* (1949) in this country, has shown that children with chronic constipation of long standing and of sufficient degree to cause abdominal distension belong to two groups having completely different pathology. The first group, for which Bodian would reserve the name Hirschsprung's disease, is characterized by a narrow distal segment of large intestine devoid of parasympathetic (myenteric) ganglion cells. The second group—long confused with the first—has no such nerve lesion; the bowel is distended to the anus and the nerve cells are intact throughout the length of the gut. Bodian prefers the name 'idiopathic megacolon' for this second group, because morbid anatomy affords no clue to the etiology; records and clinical observation force one to conclude that this second group is mostly comprised of extreme examples of laxative-induced constipation.

In my own cases of idiopathic megacolon I have been struck by the rapidity with which laxative alterations to the diet and the milder aperients have been tried and abandoned in favour of sterner measures; a whole range of proprietary preparations is explored, and with each, increasing doses are found to be needed; the glycerin suppository and the soap stick are tried and they too fail in their turn. By the time such a child reaches the Children's Out-patient Clinic, daily castor oil and weekly enemas are losing their effect. Although such cases represent the extreme of the abuse of purgatives in children, milder examples of the same fault are common.

Laxative and Purgative Measure

That a child may sometimes need a laxative is not disputed, but the proper treatment of chronic constipation in childhood should entail the more tedious process of re-educating the mother and instituting correct toilet training; aperients should only be prescribed as an adjuvant, the object of treatment being to produce a bowel they depends upon physiological (not pharmacological) stimulation for regular action. Of the many possible laxative measures only a few will be discussed, taking the milder measures first (all the preparations recommended are listed in the National Formulary, 1949).

Diet

The casein of cow's milk is a not uncommon cause of constipation in bottle-fed babies; if adding more water to the feeds or offering more to drink (orange juice) between feeds is ineffective, the milk mixture should be modified by increasing the carbohydrate and decreasing the protein (one measure less milk powder, one teaspoonful of sugar more). The beginning of weaning with farinaceous foods will also have a laxative effect. The laxative properties of vegetables and fruit and fruit juices need hardly be mentioned; a pulp of stewed apples is excellent in this respect.

Drugs

The simple laxative alterations to the diet act principally by increasing the bulk of the intestinal contents. *Agar-agar* and the saline purges act similarly. Agar-agar mixed with a mineral oil as a lubricant makes an excellent laxative for

children. Dose and speed of action vary with the individual case, but two teaspoonsful at night of emulsion of liquid paraffin with agar (B.P.C.) is a useful starting point and may well be used to assure success in the first few days of a renewed attempt at toilet training discipline. As soon as the satisfactory individual dose has been found and regular motions have been produced for a few days, gradually diminishing dosage should begin. The embarrassment of a rectal leakage of plain medicinal paraffin hinders training; agar-paraffin emulsions seem more satisfactory in this respect.

Saline purges are particularly valuable for occasional use; for cases of acute constipation and in conjunction with anthelmintics. Magnesium hydroxide suspensions are much used, particularly for babies; a teaspoonful of the National Formulary 'cream of magnesia' (mixture of magnesium hydroxide, B.P.) is a suitable dose for a child of a year or less. A larger dose may be given to older children, or magnesium sulphate may be used: 60 to 120 minims (3·5 to 7·2 ml.) white mixture (B.P,C.)

Mercury has a time-honoured place as a laxative for children but at present is out of favour and cannot be advised. *Grey powder* (mercury and chalk) and teething powders containing calomel or suspected of causing pink disease which may be a form of mercury polyneuritis (Warkany and Hubbard, 1948); a note in the April number of this journal (1950) emphasizes the warning.

Of the *vegetable irritant laxatives*, cascara sagrada and senna (in the form of syrup of figs) still enjoy wide popularity. In large doses they are apt to cause griping, but they have their place for occasional use. Castor oil affects both the large and small gut, but the rest of this group (senna, rhubarb, aloes and cascara) are selective in their action and affect the large gut only, and their action is therefore relatively slow. Regular use of this group is particularly undesirable; it is irritant stimulation of a naturally willing peristaltic mechanism that probably causes the exhausted over-stimulated colon or the less common spastic colon that usually form the basis of chronic constipation. Sometimes a thief may be set to catch a thief; in treating the milder forms of purgative induced constipation it may be convenient to continue to use an adequate dose of the medicine of the mother's choice, but firmly to reduce the dose as toilet training proceeds and dietary measures take effect. *Phenolphthalein* has a similar action to the vegetable laxatives, but it is cumulative and is not completely excreated for some days; it has no place in pædiatric practice and agar-paraffin emulsions containing it should not be prescribed for children. The more drastic vegetable purgatives, jalap, colocynth, and croton oil, are not needed for infants or children.

Mechanical Measures

Digital manipulation of the anus and the use of soap sticks, suppositories and enemas by the parents, are in my opinion most undesirable; abdominal massage, though relatively innocuous in itself, is the first step in an undesirable direction. When manual removal of fæces or an enema is indicated at the beginning of treatment of a case of serious constipation the services of a nurse should be sought, for the sake of her detached approach and her impersonal skill. It is well to mark that these mechanical measures are quite contrary to the intention of toilet training, emphasizing as they do the dependence of the bowels for relief upon resources outside the child himself.

Conclusion

That purgatives have their appropriate place in pædiatric practice is not denied, but the place is a small one. Except in appendicitis or unless intussusception is produced the unnecessary prescription of a laxative may do little harm to the child, but such an example often strengthens the mother in her commonly misplaced belief in the virtues of purgation. Anyone who uses a cathartic for its more proper purposes and avoids the popular one does a real, if small, service to Child Health.

Printed at St. Joseph's Industrial School Press, Trichinopoly—1952

Endowment

Dr. A. V. S. Sarma, Hony. Physician and Pediatrician, Govt. Hospital, Royapettah, Madras and his wife have endowed Rs. 5000/— to the Andhra University as "Dr. A. V. S. Sarma and Srimathi Lalithamba endowment Lectureship" for the promotion of Pediatrics.

Dr. A. V. S. Sarma has further endowed a sum of Rs. 500/— for a prize in Pediatrics in the Stanley Medical College, Madras, in the name of his parents—"Akkaraju Seetharamiah-Ramamma Garu prize for Pediatrics."

Registered No. M. 4839

ODDS & ENDS

Raptured at seeing a pretty nurse: How wonderful if it will be if I c be a patient under you in your ward!

Nurse: It won't be wonderful, but just a wonder. I am a maternit nurse.

♡△♡

"Did you consult the doctor about your loss of memory?"

"He wants me to pay in advance."

♡△♡

Patient: "How can I take this three times a day before food."

Compounder: "Why not?"

Patient: "I can afford to take my food only once a day."

♡△♡

One cold night a man with reputedly poor eye-sight was driving a friend home. The frost was thick on the windows, and after a couple of near accidents, the friend, tactfully suggested that it might help if they cleaned off the wind shield.

"What is the use"! the driver replied. "I left my glasses at home."

♡△♡

A medical student found the first question in an examination "Nam five reasons why mother's milk is better for babies than cow's milk." H answered "First because it is fresher, second it is cleaner, third, the cats can get it, fourth, it is easier to take to movies and to picnics." Then he thoug for a moment and added "Fifth, it comes in such a cute little container." He passed.

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

सर्वेजनाः सुखिनो भवन्तु

MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

II MARCH 1952 No. 9

'Phone: 22305 Grams: "MEDIGEST"

International Congress of Doctors

INDIAN SECTION

President—DR. R. N. COOPER
General Secretary—DR. U. B. NARAYAN RAO
Treasurer: DR. J. C. PATEL

1 Nagindas Mansion,
Opera House Tram Terminus,
Girgaum, BOMBAY—4.

January 29, 1952

DEAR DOCTOR,

You are perhaps aware that some time ago a representative meeting of doctors held in Bombay declared its support to the proposal to hold an International Congress of doctors in Italy this year.

The details of the proposed Congress are given in the accompanying brochure, which was issued by the convenors of the meeting.

The race for armaments among nations and the mounting war budgets in several countries are already having drastic effects on the health of the populations and one shudders to think of the consequences of an atomic war, if it should ever break out. And yet the drive towards war goes on with increasing fury.

The situation is so alarming that even professional men like doctors, who do not normally express themselves on political matters, are forced to raise their voices. It is but natural that those, who in their daily work struggle to preserve and save life, should protest against the insane drive towards death and destruction. The question of peace and war is no more a mere political question but has become one of our very existence and which must therefore concern every citizen.

The proposed Congress will study the harmful effects of war preparation among nations. It will approach these problems only from the point of view of the medical profession and is open to all doctors, no matter what political or other views they hold.

The Bombay meeting elected a committee to start work for the Congress in India. It includes such eminent names as Dr. R. N. Cooper, Dr. A. V. Baliga, Dr. George Cœlho, Dr. A. S. Erulkar, Dr. G. V. Deshmukh, Dr. J. C. Patel, Dr. B. P. Banaji, Dr. B. B. Yodh and Dr. A. C. Rebello. Some of the tasks that the committee will set itself are outlined in the brochure.

It is visualised that the committee will become a nucleus around which a representative All-India Committee will be formed. We hope that meetings, similar to the one held in Bombay, will be organised and committees of doctors formed in various provinces, which shall nominate representatives on the All-India Committee.

We are also at the same time inviting leading doctors from other cities to join the All-India Committee. We are pleased to inform that Dr. Tiru Murti, President elect, Indian Medical Association, has agreed to serve on the All-India Committee.

Further, we are approaching various associations and organisations of doctors and other members of the medical profession with a view to seek their co-operation.

One of the activities that the local committees may undertake is to organise symposia on subjects which will form the agenda of the Congress, some of which are indicated in the brochure. This will help greatly in preparing papers for submission to the Congress.

We shall be very glad to receive your comments and suggestions for furthering the work we have undertaken.

Looking forward to your closest co-operation,

Yours sincerely,
R. N. COOPER, *President*

(FOR CIRCULATION AMONGST MEMBERS ONLY)

THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
THE INDIAN MEDICAL ASSOCIATION

VOL. XVIII] MARCH 1952 [NO. 9

PRESIDENTIAL ADDRESS

OF

DR. T. S. TIRUMURTI, B.A., M.B. & C.M. D.T. M. & H.

President of the Indian Medical Association for 1952, at the Annual Conference at Ahmedabad on 17—2—'52

SUMMARY

While presiding over the 28th All India Medical Conference held at Ahmedabad on Sunday, the 17th February 1952, under the auspices of the Indian Medical Association, Dr. T. S. Tirumurti said :—

We are assembled today in the great land of Gujarat which gave us two of the noblest sons of our motherland, the great Mahatma Gandhi, who brought us freedom without bloodshed and Sardar Patel who unified the country, from the Himalayas to Cape Comorin, by a miracle of bloodless political revolution. We hope that the necessary social revolution will also be brought about by such peaceful methods based on Truth, Ahimsa and Dharmic ideals.

RELIGION AND MEDICAL MEN

We belong to many faiths and religions. But we recognise the worth, the dignity and importance of the individual human being. We believe in the Fatherhood of God and Brotherhood of man. History and recent wars have unmistakably shown us how people belonging to the same religion warred with one another and destroyed the people of their own religion they belong to the other nations. They were all democracy loving people. Religion gives us strength for noble endeavour. Religion instils into us that fellow-feeling and desire for social service, which ought to characterise medical men and women. Let us convince the public that medicine is not divorced from religion, and that science and religion are compatible with each other. In the words of G. B. Shaw "what I mean by a religious person is one who conceives himself or herself to be the instrument of some purpose in the Universe; it is a high purpose and is the motive power of evolution i. e. of a continual assent in organisation and power and life and extension of life". The purpose of our profession is a high and noble one and therefore according to Bernard Shaw we may all claim to be religious persons.

WORLD PEACE

It is the ambition of our profession to save life and to preserve it. The present mad rush for armaments and financial aid to many countries to

arm themselves threaten the very structure of our civilization. Medical science may have made some progress in times of War but real progress has been mainly during the years of peace. We consider that life is sacred and that it is our duty to prevent wanton waste of life and particularly young life.

OUR ASSOCIATION

It is a matter of satisfaction that the national Medical Association of India namely, the Indian Medical Association has now attained its due status in this country and in the international sphere. This organisation of ours will soon be mutually affiliated to the British Medical Association and is already a founder member of the World Medical Association. It is also held in high esteem by the World Health Organisation, the American Medical Association and most of the national medical associations of other countries.

In this connection we must recall with gratification that the foundations of this great medical organisation were laid in the year 1928 at Calcutta principally by the late Sir Nilratan Sirkar of Calcutta and Dr. Deshmukh of Bombay. From a very modest beginning with only 250 members it has now over 14,000 members and over 20 provincial and about 400 local branches scattered all over India. Efficiency and unity among the rank and file of the practitioners of modern medicine are essential in order that we may obtain full recognition by the Government and other authorities concerned. In the best interests of the people as well as the profession we must play an important role in advising the Government on all matters connected with medical education, medical relief, public health and medical research. I, therefore, take this opportunity to request all those registered medical practitioners in India, who have not yet joined the Association, to enrol themselves as the members of this organisation at their earliest. "United we stand and divided we fall" is true of the medical profession as of any other profession or organisation.

It is a great pity that at the very start of our infant democracy we and our Government had to face the perplexing problem of the unfortunate displaced persons. In our humble way, our association raised a small fund and opened several centres for relief and rehabilitation of refugees. We have tried to help some of the displaced doctors in their rehabilitation. We realise too well how inadequate has been our help. Wecan, however, assure the Government that they will have our wholehearted and sincere co-operation in solving this important problem.

WELFARE STATE

Government of the people and by the people themselves is democracy. Historians tell us that this system of Government was prevalent in ancient India. We may thus claim that democracy had its birth in India. There is much to learn from the democratic institutions of the World. But most of our people feel that the present parliamentary system of the West is too costly for a poor country like ours. Sri Arabindo expressed his firm conviction that this imported western parliamentary system is not likely to succeed in India. Real democracy must be well-laid on the foundations of the village Panchayats. All matters connected with village reconstruction in all aspects should be entrusted to autonomous village Panchayats leaving only a limited and

circumscribed power in the hands of the Central Government. The great importance of regeneration of our neglected villages, their adaptation to modern requirements and a new orientation of rural health services cannot be overemphasized. We, medical men, feel that the present system of Government should be replaced by a Government having its solid foundations on strong and efficiently functioning small autonomous units.

THE DRINK AND DRUG EVIL

In Mahatma Gandhi's words "the drink and the drug evil" is in many respects infinitely worse than evils caused by Malaria and the like; for, while the latter only injures the body, the former saps both the body and the soul. In no part of the world, is prohibition as easy to carry out as in India, for with us, it is only a minority that drinks. The majority of our people generally considered drinking as disreputable and a menace to the health of our people and a terrible drain on the poor man's slender resources. Madras has been the pioneer to introduce prohibition over a decade ago. It is however regrettable that attempts are now being made by certain politicians to give up prohibition on the plea that the Government has lost a large part of its revenue, which can be utilised for other nation building purposes. We, medical men, should give a lead in this matter and tell them that by ruining the health of the nation in one direction, no advantage can be derived by expenditure in another direction. Our considered opinion should be that prohibition is a very important item in the building up of a welfare State. Our silence in this matter as well as in case of drug addiction may be construed by the people that the medical profession is more interested in disease than in health.

MEDICAL MEN AND MILITARY TRAINING

Having lived through two great World wars and dreading the possibility of a third which looms darkly in the political horizon, I consider it very necessary that, in the long run, all medical men who are physically fit, should be given compulsory military training. Military training shouid be made compulsory for all future entrants into Government medical and health services. Those private medical practitioners who are willing to undergo military training should also be encouraged by all possible means and by constituting a civil medical reserve. Similarly an ancillary reserve of trained nurses, ward orderlies, compounders etc., in the civil department can be constituted to meet emergencies.

POST-GRADUATE EDUCATION

If the medical needs of our country have to be met, proper undergraduate medical education has to be expanded considerably. It is however equally, if not more, important for us to develop a sound post-graduate training, because this not only gives us the teachers who will train the cream of our intelligentsia into responsible medical men and women, but also provides men for medical research, which is the backbone of scientific progress.

In considering post-graduate medical training, two aspects come to our mind. One is the basis of real training and research and the other is a question of acquiring a "Degree" or a "Diploma". So long as the acquisition of such degrees and diplomas help in securing good posts in Government and other

services, the desire to acquire these will continue naturally. If proper standards are maintained, these degrees and diplomas are, of course, certificates of higher value. Because of the dearth of well-established post-graduate medical centres and also because of a lack of proper encouragement, there is a tendency among young medical men and women to seek post-graduate training abroad. Such an exodus should be encouraged under the existing circumstances, as it widens their outlook and makes them more eager to advance medicine in their country on return. Because of the unusual value attached to foreign post-graduate degrees and diplomas, a large number of our young medical men and women in foreign countries concentrate on the theoretical aspect of the subjects from the examination point of view. They, therefore, do not get the desired practical training. Moreover, most of them return to India due to financial and other considerations, as soon as they acquire the degree or diploma. It is very much regrettable that even Government sponsored scholars are allowed to indulge in such practices and on their return they are mere foreign diploma holders instead of being trained surgeons, physicians or specialists.

Hence it must be repeatedly stressed that, though degrees and diplomas have their value, systematic and thorough training in any branch of Medicine or Research is, in the long run much more important. This problem can be solved by establishing fully equipped and well-staffed post-graduate centres in India so that our brilliant young medical men and women can acquire the corresponding post-graduate degrees and diplomas in this country. It is, however, essential for our Government and other authorities concerned to attach the same value to the Indian post-graduate degrees and diplomas. Our post-graduate students and particularly those sent abroad by the Government and local authorities should be allowed to proceed abroad only for further practical and systematic training and research, preferably after acquiring the post-graduate degrees and diplomas in India. Uuless such a scheme is adopted in our country, in the near future, I am afraid, there would not be a real advancement of medical science in this country for years to come.

It should also be pointed out in this connection, that periodic 'brain dusting' is essential for medical teachers to keep themselves up-to-date. For the advancement of medical education, the Government should arrange to send out middle-aged medical teachers, with some more years of service to count, to visit institutions in foreign countries, even for a short period. If the authorities of the medical institutions or the Government are not in a position to afford the full cost, a scheme of sharing necessary expenses with the teachers concerned should be evolved.

ROLE OF I.M.A. ON POST-GRADUATE TRAINING ABROAD

I feel that the Indian Medical association would be ready and willing to give the necessary advice to persons intending to go abroad as post-graduate students or as visiting teachers. It may be advisable for our association to appoint regional advisory committees for this purpose.

I may, on your behalf and my own, acknowledge with thankfulness the yeoman services Dr. S. C. Sen, our Honorary General Secretary, is rendering, as our, may I say, 'Ambassador' to the great medical associations and institutions of the West to establish personal contacts. It is a noteworthy achievement of this association that Dr. Sen has been able to arrange for our

young medical men and women, a large number of internships and other similar places, by which they can specialise in the various departments of medicine. The training facilities obtained by him in Mount Sinai Hospital, New York has been followed up by similar training facilities in other American and Canadian teaching and other well-equipped hospitals. For the future of Medical Education in India, we know how useful such training abroad is.

WORLD HEALTH ORGANISATION

I shall be failing in my duty if I do not mention the part played by my friend, Sir A. Lakshmanaswami Mudaliar, in the W.H.O. We look to him to achieve greater progress in obtaining adequate financial help, specialist personnel, world university co-operation of students and staff, facilities for travel, fellowship facilities for post-graduate studies and research etc., We are grateful to him for his services regarding the scheme of up-grading some of the medical institutions in this country, sponsored by the Government of India.

INDIAN MEDICAL COUNCIL AND MEDICAL EDUCATION

The Executive Committee of the Medical Council of India is understood to have recommended one and half years of pre-clinical training in pre-clinical subjects, three years for clinical subjects, followed by a year of internship in a hospital recognised by the University. Further, in order to increase the number of medical men and women, that a double-shift system in instruction to medical students will be introduced where suitable arrangements can be made by the Universities. Sir A. Lakshmanaswami Mudaliar has stated in his address at the recent annual celebrations in the Madras Medical College that he was shocked to hear these suggestions. In his opinion, the responsibility of increasing the number of medical men in the country is not the duty of the Medical Council of India which has been statutorily constituted to establish minimum standars of qualifications in University education. He doubted whether the Council can dictate to the Indian Universities as to what they should do and thus interfere with the autonomy of the Universities.

We should certainly urge on the Government and the fortunate philanthrophists to start more medical colleges and find finances for them to increase the number of qualified medical practitioners, who are required to meet the health needs of the people.

CENTRAL INSTITUTE OF MEDICINE

One of the important recommendations of the Bhore Committee is the creation of an All Indian Medical Institute where professors of repute and standing would train medical teachers and where a number of medical graduates can carry on research work under guidance. This recommendation could not be implemented owing to financial difficulties. In view of the generous grant of £ 1000,000 made by the New Zealand Government under the Colombo plan for the specific purpose of starting a Central Medical Institute, it is hoped that the Institute may be brought into fruition at a not too distant date. It is learnt that the Central Institute may have a small under-graduate medical college attached to it.

MEDICAL RESEARCH

Medical Research in this country is at present confined mainly to the few Research Institutes. We have also to admit, with regret, that the amount

of research work that is being carried out in our medical colleges is very limited. The reasons for this state of affairs are many. Our young men cannot get a living wage if they take to research as a career. Therefore, research does not generally attract many brilliant young men and women who have the enthusiasm for research. Only a few of the medical colleges have research facilities worth the name. The Indian Council of Medical Research has been playing an important role in the advancement of medical research in our country. Instead of simply calling for the proposals for research, the I.C.M.R. should take the initiative, consult a small group of experienced workers actively engaged in the research pertaining to the subject and ascertain after deliberations the most important and pressing problems, awaiting solution and chalk out roughly the profitable lines of further enquiry and investigation which are likely to yield useful knowledge. The success of any research project depends mainly on the selection of the proper worker. In order to ensure that the worker put forth his or her best efforts, the I.C.M.R. apart from paying a decent wage to him or her should assure him or her that the entire credit for the work done by him or her would go to him or her.

MEDICAL MISSIONS

The medical profession in general and our Governments specially have much to learn by a study of the Missionary Medical organisations. The one in mission medical field enters the fold as a "calling" rather than as an "employment". This mental attitude makes a lot of difference. Barring specified salary, the mission organisations ensure economic security and other necessary facilities for medical missionaries. In our country, the rural medical relief may be tackled by a well-organised medical mission organisation sponsored by the Government. It is no use mere preaching that medical men and women should settle down in rural areas and work with missionary spirit, without a missionary organisation which will look after their comforts and which will place them above want and enable them to work with dignity and honour. Insurance of the workers and their families, provision of a scheme of provident fund, provision for holidays and study leave, provision for education of their children, old age pension etc., must be the incentives for attracting the best persons to the mission medical service for rural and outlying areas, not mere preaching to medical men and women about missionary zeal and spirit for rural medical relief.

MEDICAL REGISTRATION ACT AND SUPPRESSION OF QUACKERY

It is a pity that no serious attempts have so far been made by the Government for the supression of quackery. It is probably not realised by our authorities that this is necessary not in the interests of qualified medical men but for the real advancement of health measures for our people. It may not be possible or desirable for any Government to legally prevent any of the unqualified practitioners from practising their professions and take away the bread out of their mouth. What can however be done is to prevent by legal steps the further creation or influx of unqualified practitioners in any system of medicine. I had the privilege to be associated with the drafting of the Travancore Medical Practitioners' Act by which all practitioners of different systems of medicine were registered under suitable categories. All these who were in the practice of the profession at the time were eligible for registration, if they produced certificates from recognised Government officers to the effect

that thy had been in the practice of the profession, weather Allopathic (Modern Scientific), Ayurvedic, Unani or Siddha. Such an Act is necessary, if fresh unqualified persons are not to be allowed to flourish in increasing numbers. When unqualified legal practitioners cannot practise, why should it be different in the case of medical practitioners? The Indian Medical Association has been requesting the Government to take effective measures to prevent such unqualified practice. The health of the people should not be played with by irresponsible quacks. Quacks usually thrive on the gullible public who are illiterate and uneducated. This is made possible to a large extent, owing to the fact that qualified and scientific medical help does not reach or is not available to the large percentage of the population, who live in the villages.

STATE INSURANCE OF WORKERS

Our Government has recently introduced the Employees' State Insurance Scheme which is the first of its kind in South East Asia. By working the Pilot Scheme in Delhi, the cause which might delay its implementation in the State could be avoided. The introduction of the scheme by stages will enable Dr. Katial to recruit and train the staff in a planned manner. We, however hope that efforts to implement the scheme in other States will be taken as, early as possible.

AMALGAMATION OF I.M.A. WITH A.I.M.L.A.

It is unfortunate that in spite of repeated attempts to bring about an amalgamation between these two All-India Associations of Medical men, it has not been possible so far to achieve the desired result, even though the majority of members of the A.I.M.L.A. are also members of the Indian Medical Association. I am, however, proud to say that, so far as Madras is concerned, the A.I.M.L.A. has practically merged itself with the I.M.A. It is regrettable that certain members of the A.I.M.L.A. who may have vested interests wish to maintain this class and caste distinction among the members of the profession. The medical Licentiates are in the majority in the I.M.A. Why then this inferiority complex on the part of the Licentiates who are the backbone of the profession. We must sink all our differences and unite.

CONCLUSION

Quoting Lord Horder who said:— "For thousands of years medicine has united the aims and aspiration of the best and noblest of mankind. To deprecate its treasures is to discount all human endeavour and achievement as naught.

As I am not one of those who think that former days were better than this, I look forward as well as backwards. I think the wiseman was a bit billious, when he apportioned dreams to the old and visions to the young. Through the Science and Art of Medicine, i.e. Doctoring can attain the highest place in social economy of the future that it has ever done in the past. It has been said that the Technology of medicine has outrun its Sociology. It will fall to you to make this adjustment and make it without sacrificing the inviduality of the patient, who places himself in your hands with such confidence and with such hope."

Dr. Tirumurti concluded his address with the following quotation from Louis Pasteur:—

"Do not let yourselves be tainted by a barren scepticism, nor discouraged by the sadness of certain hours that creep over patients. Do not become angry at your opponents, for no Scientific theory has ever been accepted without opposition . . . . . Say to yourselves first 'What have I done for my instruction?' and as you gradually advance 'What am I accomplishing?' until the time comes, when you may have the immense happiness of thinking that you have contributed in some way to the welfare and progrees of Mankind."

COMMON PATHOLOGICAL LESIONS OF THE CERVIX UTERI AND THEIR CLINICAL SIGNIFICANCE

BY

DOCTOR MRS. ANNA VAREED, F.R.C.S., M.B.B.S., L.M., D.R.C.O.G., F.R.F.P.S.,
COIMBATORE

(*contnued from previous issue*)

T. B. ulceration of the cervix is just as common. In fact T. B. of the female pelvis is much more common than we presume and very many cases of sterility turn out to be T. B. of the tubes with occlusion. Amenorrhoea and tubal occlusion lead to infertility. Biopsy of the cervix will show typical giant cell system and in one case the discharge of pus showed tubercle bacilli also.

Mycotic infections:

Trichomonas and monilia infections: These can affect the vaginal portion of the cervix along with the rest of the vagina causing discharge, irritation, pruritis etc. Correct treatment depends upon correct diagnosis, the parasite trichomonas or monilia will be seen in fresh smears. Treatment: Acid or vinegar douching or swabbing, gentian violet touching and later arsenical vaginal compounds to be inserted into the vagina. But treatment must be repeated after every menstrual period for 3 or 4 times as an alkaline reaction favours their growth.

Propionate jelly application is a satisfactory method and can be used even during pregnancy. The appearance in trichomonas infection is typical with small pin point ulcerations here and there.

Chronic cervicitis and endocervicitis are common sequalae of acute infection, gonorrhoeal or streptococcal, and they are a frequent concomitant of old infected lacerations of the cervix, as already explained. In recent years chronic cervicitis has been the subject of a great deal of discussion. Cervix is now included among other septic foci like tonsils, teeth and nasal sinuses, and the unhealthy infected cervix is now said to be the primary focus of systemic infection causing such diverse conditions as arthritis rheumatic trouble, sciatica and various psychoses; cervix can be called the "gynaecological tonsil".

I would like to mention just one case to illustrate this statement. A lady by name Mrs. D of Coimbatore aged 36 was ailing from a severe pain along her sciatic nerve, more marked on one side, for nearly two years. Her doctor tried all sorts of remedies like soda salicylas, vitamin B complex injections and pills, novalgin and later she was drugging hereself with calcioid tablets and codopyrin—with no relief to speak of. In the end the doctor referred the case to me for a complete examination. I found pus coming from her urethra on milking the same, and she had a very unhealthy cervix with an yellowish discharge from the OS. I advised sulpha drugs and penicillin (5 × 4 lacs) followed by a few milk infections, and of course, her cervix condition was also locally attended to. There was a dramatic improvement in a week's time and very soon all the pain ceased, and she has remained free from all troubles for the last one year, without any recurrence. I met her even a fortnight back. I am more than convinced that chronic gonorrhœal cervicitis was the cause of her trouble, as her husband also took treatment along with her, though he very proudly denied having had any trouble at any time but it proved otherwise when he was actually examined.

An erosion of the cervix often follows confinement or abortion. How? A clean 3rd stage, when the placenta and membrane are expelled intact, when

the uterus gets firm and well contracted, is a prerequisite for correct involution of the uterus, whereas retained products of conception keep up a discharge indefinitely and the uterus remains sub-involuted. By the continuous outpouring of this discharge the stratified epithelin of the vaginal portion of the cervix gets replaced by columnar epithelium. This overgrowth of the portio vaginalis by the columnar epithelium is called an erosion which is really a pseudo adenomatosis.

As a cause of one child sterility, chronic cervicitis and endocervicitis are of great clinical importance. The abnormal secretion acts as a barrier to the ascent of spermatozoa. Cure of the cervical lesion is often followed by relief of the sterility.

Treatment of chronic cervicitis. (1) Large doses of penicillin and sulphanamides to combat the infection. (2) Electric cauterisation or (3) surgically by conisation and then covering the denuded area by healthy vaginal epithelium or by trachelorrhaphy and tracheloplasty.

Vaginal hysterectomy in selected few cases where the cervix is very unhealthy and where there are uterine diseases also.

Old infected lacerations and chronic cervicitis have an important bearing upon the later development of carcinoma of the cervix. A healthy cervix and a clean cervix seldom develop carcinoma. For this reason alone chronic cervicitis must be regarded as a very serious lesion and very often a precancerous condition. Cervical erosion in itself is not necessarily pathological in every case and may not require any treatment. According to an article in B.M.J. Nov. 18th 1950, 1/3 of girl babies have it at birth, and when it persists in adult life, we call it the congenital variety. Only when erosions are secondarily infected and are defi nitely producing symptoms, is treatment really necessary.

Symptoms of cervical erosion and chronic cervicitis :—(*Copied from B.M.J. Sept. 16, 1950*).

1.	Leucorrhœa	80% complain of it.
2.	Back ache	Constant ache in the lumbosacral region due to the congestion and weight.
3.	Abdominal pain	Either a dull aching pain and constant or acute and lancinating type of pain.
4.	Frequency of micturition :	Cervicitis can even cause recurrent cystitis, urethritis very often accompanies cervicitis.
5.	Memorrhagia :	Either prolonged loss or too frequent periods due to congestion and hyperaemia.
6.	Pruritis vulva.	The discharge is the cause of the pruritis.
7.	Dysmenodea.	Spasmodic type of pain due to the congestion.
8.	Dyspareunia.	
9.	Cervical hoemorrhage.	Intermenstrual spotting, also post—coital or post—douche bleeding.
10.	Sterility.	Already discussed.
11.	Sense of pelvic weakness :	Simulates prolapse due to the weight of the swollen organ. Entirely eliminated by treating the condition.
12.	General fatigue :	Vague pain along nerves and muscles.

Remarkable improvement in the general health of women is noticed frequently among the patients when their cervicitis is cured. In mild cases of cervicitis 3 or 4 daily injections of 4 lac units of penicillin (either the beeswax—or the aqueous solution or the variety with aluminium monostearate), together with local application of 10% sulpha pyridine solution instillation have effectively cleared up the condition. Some gynaecologists use small doses of stilboestrol with the sulpha—penicillin therapy, to produce oestrogenic enhancement of the resistance of the cervical mucosa.

As I mentioned already, in more severe cases, the erosion—bearing area may be sliced off after reflecting the vaginal mucous membrane and the raw area covered over by healthy vaginal epithelium. Due to the possibility of cervical carcinoma developing on these chronic diseased cervics, some gynaecologists are of opinion that the lasting cure to this condition is only by total hysterectomy, abdominal or vaginal. By the way, sub—total hysterectomy has fallen into disfavour now—due to the possibility of cancer development in the cervical stump. I read in the 1950 year book of obstetrics and gynaecology that a surgeon doing a sub—total hysterectomy must explain why he leaves behind the cervix in each particular case.

Tumours of the cervix uteri: Benign and malignant: Of the benign tumours only polypi need mention here. Polypi may be mucus i.e. adenomatous, or fibroid, or thirdly fibroadenomatous. The mucus type is more common in the cervix while the fibrous type arises more commonly in the body of the uterus. The mucus type arises usually in the lower part of the cervical canal, in and around the os externum but it can also occur in the body. Mucus or adenomatous polypi are small, soft, pedunculated structures which are usually multiple, varying in size from that of a pea to that of a cherry and very often bright red in colour. Two symptoms only are usually associated with mucus polypi viz. Menorrhagia and leucorrhoea. A small polyp can cause very severe and prolonged homorrhage sometimes. Diagnosis is very simple for they can be felt by the finger and also seen through a speculum. The treatment is to seize it with a pair of forceps and twist it off by tearing through the pedicle. It is well at the same time to curette the uterus as hyperplasia of the endometrium usually accompanies mucus polypi. Fibroid polypi much larger than the adenomatous kind, are really submucous fibroid tumours from the body usually undergoing a process of extrusion and may present even at the vulva due to stretching of their long pedicle. But all polypi removed from the uterus, whether from the body or cervix, should be sent for biopsy to rule out any question of malignancy. The most common type of malignant tumour encountered in polypoidal form is sarcoma. Polypiodal sarcomatous growths have been seen even in little girls. Sarcoma of uterus and cervix is not a very rare condition.

Carcinoma of the cervix. I do not intend going at great length into this subject, as much has been said and heard about carcinoma cervix during the last few years. With all that it still remains the greatest scounge, so to speak, among women in India. Because our women still pay very little attention to the early prodromal symptoms and they do not know that the cervix can be the seat of early carcinoma and still be free of all classical or alarming symptoms. Women may present themselves with the common gynaecological complaints such as leucorrhoea, backache, sterility, dysmenorrhoea and abdominal pain and the early cancerous or precancerous condition may be discovered during a routine examination. Such cases are early stages and promise complete cure. But when lower abdominal pain, intermittent or continuous bleeding and a foul-smelling whitish discharge, with marked anaemia and cacheia are encountered, one can be certain that

the disease is much advanced. "Symptoms of cancer therefore are the symptoms of death," said Jeff Miller. Early diagnosis before the patient notices these alarming symptoms, is the only saving grace. It is impossible to make a diagnosis of very early cancer without laboratory procedure: A healthy cervix rarely becomes the seat of carcinoma as I said before, and 80-85% of parous women have chronic cervicitis and infected erosions of varying degrees. The advisability of careful postnatal and periodic gynaecological check up and treatment of unhealthy cervices cannot be overstressed.

The suggested predilection of cervical cancer for multipara is now said to be not to the traumatizing effects of delivery alone, but to the excessive hormone stimulation to which the cervix is exposed in each pregnancy, according to an article in the Am. Jl. of Obs. Gynae., July 1951. Whatever be the explanation, multipara are more prone than other classes of women.

Prophylaxis. All unhealthy, chronic and infected cervics should be properly treated. The electric cautery or surgery should be freely made use of to get rid of the unhealthy irritated area. All erosions which have not healed well after a 2nd cauterisation should be considered as being precancerous of the pre-invasive type hitherto known as "carcinoma in situ," unless and until proved otherwise by biopsy.

Papanicolaou vaginal smear test: This has to be more routinely adopted in all gynaecological centres but it should not be used to replace biopsy.

Schiller's iodine test is a simple test and can be done in all outpatient clinics. It should be used only as an aid in obtaining suspicious areas for biopsy as carcinomatous cells are glycolytic and fail to take up and show the iodine stain whereas the rest of the vaginal mucous membranes shows a mahogany brown colouration. Chrobak's probe test for friability is yet another routine procedure. While many women are asymptomatic at least 58% reported by an American doctor (Dr. Te Linde) had some type of irregular bleeding or serosanguinous discharge—most often postcoital spotting, which ought to give them sufficient warning.

Leukoplakia of the vagina and vaginal portion of the cervix needs special mention. The terms chronic atrophic vulvitis, kraurosis and leukoplakia have been used interchangeably but the last two are better used to describe specific features of chronic atrophic vulvitis. Atrophy of the vulvar structure is part of the aging process. It affects the cervix also. There should be no symptoms. But chronic vulvitis sets in when infection is superimposed on the atrophic changes. Leukoplakic areas develop as single or multiple discrete plaques on any part of the vulva or vaginal portion of the cervix. Multiple vitamin preparations, vitamin A concentrates with acid hydrochlordil and cod-liver oil tamponade will help clear the condition. If there is no immediate improvement, the condition must be considered as being pre-cancerous and biopsy taken.

We have to keep abreast clinically and histologically with the trend of times. That is our only salvation towards early detection of cancer. We must be able to evaluate competently the cervical epithelial changes in the increasing multitude of women, so that we can be said to be working towards a national cancer drive. Subtotal hysterectomy leaving behind a cervix vulnerable to this malady is to be avoided as far as possible, as I mentioned a little while ago. Deal promptly and effectively with all unhealthy cervices.

Early symptoms: These are nil or very often not noticed by the patient as I said at the beginning.

1. Leucorrhoea most common of all gynaecological symptoms. Leucorrhoea can mean a diseased cervix and demands scrupulous examination and treatment.

2. Bleeding between periods without apparent reason or prolonged menorrhagia or post menopausal bleeding—should be reasons enough to advice curettage, endometral biopsy and cervical biopsy.

3. Post coital and post-douche bleeding or the presence of blood on underwear or bed linen should make one suspicious of cancer. This bleeding is first evident when the tumour is beginning to outgrow its blood supply.

4. Intermittent frank bleeding pain and smelly pinkish discharge when encountered, one can be certain that the disease is very much advanced and well established.

5. It is impossible to differentiate between a chronic infected cervix and a cervix with early cancer except by biopsy.

Electro cauterisation of the chronic cervicitis is a valuable prophylaxis. It will cure 85% of patients even with carcinoma in situ, now termed the noninvasible type i.e. when the disease is limited to the surface of the cervix, in contradistinction to the adenocarcinomatous type or the invasiee type. Therefore all chronically infected cervices should be treated by electrocautery as a prophylaxis against cancer developing on them at a later date.

In a series of 50 cases of cervical stumps examined later, 11 had adenocarcinomas of the cervical stumps. This incidence, together with the high incidence of squamous celled carcinomas also in cervical stumps, strengthens the conviction that panhysterectomies are preferable to supravaginal hysterectomies. In those cases where a hysterectomy must be supravaginal instead of complete and when the cervix is unhealthy, conization or Sturmdorf operation on the cervix will be particularly helpful in eliminating the menace of continuous cervicities in the cervical stump.

The ratio of cervix to corpus cancer varies much in different series reported, average being about 5 to 1 i. e. 80% being cervix. "Considering the periods of observation and making generous allowance for possible developments after observation, we feel justified in claiming that the removal of the chronic cervicitis prevented cervix cancer in at least 25 of 1005 cervicitis patients". Am. Jl. of Obs. Gyne., Jan. 1949. I do not want to discuss the *treatment of cancer cervix* here. Once the condition of carcinoma cervix is established or even suspected the patient should be rushed to a cancer institute for proper evaluation of the case and adequate treatment by irradiation or surgery or both combined. So the responsibility that rests with each one of us is great. Never, never consider the complaints our cervicitis patients make as being trivial. Don't say that its only an erosin and hence it does not matter. Never rest contented unless and until the cervix has been made healthy or it has been certified as being nonmalignant. Educating the mass of women that intermenstrual bleeding or spotting after the menopause, even the most minor degree of genital bleeding, is a dangerous warning, should form part of the propaganda scheme. Cancer propaganda is the need of the hour. That means life-saving education.

Well, ladies and gentlemen I hope I have not bored you. I thank you all for your patient hearing. I thank the committee of this conference for giving me this opportunity and honour.

Long live the South Indian Provincial Branch of the I. M. A. Jai Hind. Namaskarams.

References: 1. Extracts copied from Journals viz. B. M. J., Practitioner Am. Jl. of Obs. Gyne. and Jl. Obs. Gyne. of the British Empire.
2. Text book of Gyne. by Eden and Lockeyer.
3. Human Sterility by Meaker.
4. Human sex anatomy by Dickinson.
5. Year book of Obs. and Gyne, 1950.

ASSOCIATION NOTES

COIMBATORE BRANCH

President: Dr. I. Pitchai Robert
Vice-President: Dr. N. Jagannathan
Hony. Secretary: Dr. S. Ganapathy
Associate Secretary: Dr. C. Arumugam
Hony. Treasurer: Dr. T. V. Sivanandam

The 27th Annual General Body meeting of the Coimbatore District Medical Association was held on the 3rd February 1952 at 4 P.M. in the Association premises with Dr. M. G. Nair, the President in the Chair.

126 members attended the meeting. After Tea and light refreshments the meeting started with prayer. The Secretary read the 27th Annual report of the Association together with the statements of accounts and Auditor's report which were adopted unanimously.

Then Dr. I. Pitchai Robert was proposed and unanimously elected as the President for the year 1952. He then occupied the Chair.

The retiring President Dr. M. G. Nair thanked all the members for the cooperation and help given to him during his tenure of office.

The following office bearers were elected for the year 1952 unanimously:

President:	Dr. I. Pitchai Robert
Vice-President:	„ N. Jagannathan
Hony. Secretary:	„ S. Ganapathy
Associate Secretary:	„ C. Arumugam
Hony. Treasurer:	„ T. V. Sivanandam.

Managing Committee Members:

Dr. S. V. Appaji
„ M. G. Nair
„ L. Munuswami
„ Y. P. Vasudevan
„ C. N. Santhanam
„ S. V. Subramanyam
„ S. Durairaj, Murugalli Estate
„ M. Narayana Shenoy, Erode.
Dr. K. V. Subramanyam (Path)
„ A. G. Leelakrishnan
„ C. V. Ramaraj
„ N. K. Sampath
„ S. G. Rajarathnam
„ Miss K. M. Jalajam
„ K. G. Vaidianathan, Tirupur.

The following members were elected to the Council of South Indian Provincial Branch of I.M.A.

Dr. K. V. Subramanyam, R. S. Puram
„ M. G. Nair
„ D. Sundareswaran
„ L. Munuswami
„ S. Ganapathy (Ex-Officio.)
Dr. C. Arumugam
„ T. V. Sivanandam
„ Major Krishnaswami
„ Miss S. V. Swornambal.

The following members were elected to the Central Council of I.M.A. Dr. V. Govindan Nair, Dr. N. K. Sampath, and Dr. Mrs. Anna Vareed. It was then resolved to record with appreciation the good work done by the retiring managing committee. Then Dr. C. P. Viswanatha Menon, M.S., F.R.C.S. (Eng.) of Madras gave a very interesting lecture on Gastric Surgery which was very much appreciated by the members. There was a lively discussion in which several members took part. Then Dr. D. O. Sendel of Ramnad—Tirupattur gave a lecture on "Experiment in Therepy" in which he dealt his experiences in treating Gastrities with mild antiseptic wash, Lumbago with local Anaesthesia and Masodialators and Uterine Inertia with Calcium Gluconate.

Then the Secretary proposed a vote of thanks to the distinguished lecturers and to all the members of the Association who attended the meeting and the meeting terminated with a sumptuous dinner at 9 P.M.

MADURA BRANCH

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

A meeting of the above branch was held on 16-2-52 at the Erskine Hospital, Madurai. The minutes of the meeting held on 12-1-52 were passed. Dr. K. S. Krishnan, M.B.B.S., Honorary Surgeon, Erskine Hospital, Madurai then delivered a very exhaustive and interesting lecture on the anatomy and the operative treatment of Uterine Prolapse. He explained with the aid of epidiascopic illustrations the anatomy, pathological anatomy and mechanism of uterine prolapse. The lecturer dealt at length on "Enterocele" and its treatment. Dr. Krishnan advocated the operation of Vaginal Hysterectomy in patients over the age of forty years suffering from prolapse. The lecturer discussed the advantages and disadvantages of various other operative procedures and suitably replied to a number of questions.

Earlier the members were treated to a pleasant tea-party by Dr. M. N. Rajan and Dr. T. S. Renga Iyengar.

TANJORE BRANCH

President: Dr. E. K. Menon
Vice-President: „ T. M. Pillai
Secretary: „ N. R. Subramanyan

After tea at 4-30 P.M. given by Dr. Mrs. K. A. Selvanayagam L. M. & S. Woman Assistant Surgeon, Raja Mirasdar District Headquarters Hospital, Tanjore, the members adjourned for the regular monthly meeting with Dr. E. K. Menon, president of the Association in the chair. About 30 members attended the meeting.

The minutes of the last meeting were read and adopted.

Condolence resolution on the death of Dr. V. P. Naidu a former member of our branch was passed all members standing in solemn silence for a minute. The Secretary was authorised to convey the resolution to the members of the

bereaved family 'This Branch of the Indian Medical Association places on record its deep sense of sorrow on the demise of Dr. V. P. Naidu a former member of our branch.'

After reading out of the routine correspondence Dr. G. A. Sundaram, B.A., M.B B.S,, Civil Assistant Surgeon, Mayuram was requested to his talk on 'Tetanus'. The subject was nicely dealt with touching upon the signs and symptoms, etiology, pathology with latest advances in treatment of this common ailment.

There was a short discussion after the end of the lecture. The meeting terminated with a vote of thanks to Dr. Sundaram for his excellent lecture and to Dr. Mrs. K. A. Selvanayagam for the tea provided.

TIRUCHY BRANCH

President: Dr. R. Kalamegham
Vice-President: „ L. S. Ramachandra Iyer
Secretary: „ A. Dharmarajan
Treasurer: „ T. V. Sundaram

A meeting of the association was held on Thursday the 31st January 1952 in the premises of the S. M. E. S. Corporation, Tennur, Tiruchy. About 75 members including from outside were present. After Tea kindly provided by a Committee of hosts, the President Dr. R. Kalamegham read the circular received from the Centre regarding the All India Medical Conference to be held in December 1952. The members unanimously approved of inviting the above Conference in Tiruchy in December 1952.

Then the President introduced Dr. Stoll of Sandoz Laboratores to the members and requested him to give his talk. After the talk, the Secretary proposed a vote of thanks to the lecturer, the hosts of the evening and to the authorities of S. M. E. S. Corpn. for allowing their hall to hold the meeting, the meeting came to a close.

***

A monthly meeting of the association was held on Sunday the 17th February 1952 in the premises of the Govt. Head Qrs. Hospital, Puthur, Tiruchy under the Presidency of Dr. R. Kalamegham. About 50 members were present. After Tea kindly provided by Dr. R. Seshadri of Jeeyapuram. the President moved the following condolence resolution for the untimely and tragic demise of Dr. D. Srinivasan, a life member of our association and it was passed all members standing for 2 minutes.

"The Tiruchirapalli Branch of the Indian Medical Association records with regret the tragic and untimely demise of Dr. D. Srinivasan, one of our Life members, who has done signal service to the association, and requests the Secretary to communicate the resolution to the members of his family."

The President then read a letter from one of our members Dr. O. Janakiram regarding the pay and status of doctors in Railway service and after some discussion the subject was postponed to next meeting.

Then the President introduced Dr. S. T. Narasimhan, the Director of the Neurological Institute of India, Madras to the members and requested him to give his talk.

The lecturer gave a very interesting lecture on Epilepsy and Electro Encephalography which was followed by a discussion in which many members took part.

The Secretary proposed a vote of thanks to the lecturer, the host of the evening and to the Supt. of the Govt. Hd. Qrs. Hospital for allowing the premises to hold the meeting, the meeting came to a close at 8 P.M.

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

THE CAUSES OF POST-MENOPAUSAL BLEEDING—*A. L. Deacon, F.R.C.S., M.R.C.O.G.—The Clinical Journal —Feb. 1950.*

The occurrence of bleeding from the vagina after the cessation of the menses is fortunately a symptom so definite that the majority of sufferers will be led to seek the advice of their physicians. Uterine malignancy, developing about the time when the menopausal metropathias are occurring, with consequent periods of amenorrhoea and prolonged bleeding, is more liable to be neglected by the patient, and even occasionally by the physician. That bleeding occurring after the menopause is likely to be due to some disease is, however, a fact generally known to most women. Neglect to seek advice at this time is probably less commonly due to ignorance than to the tendency to repress into the subconscious the fear of cancer.

Definition

What do we mean by post-menopausal bleeding? In order to define this accurately we must, of course, first satisfy ourselves that the patient is past the menopause. This will be obvious when bleeding recurs several years after the last menstrual period in a senile patient, but for practical purposes we may assume that any bleeding occurring six months after the last period in a woman of menopausal age should be placed in this category. If we also remember that any bleeding in any woman lasting for more than ten days must also be assumed to be pathological, then the danger that we are ever seeking to avert, of allowing malignancy to progress undiagnosed or uninvestigated, will be lessened.

A prolonged loss occurring in the menopausal patient after a period of amenorrhœa lasting for a few months is of common occurrence. Though such a happening, if the patient reaches us before the loss has ceased, will require investigation to exclude an intrauterine malignancy, the majority of these losses will be of metropathic origin. The endometrium during the amenorrhœic phase preceding the loss will be hyperplastic, and it is only with regression of the follicle that bleeding begins. Frequently such a loss ushers in the menopause.

We are, of course, relying entirely on the statement of the patient for our estimation of the origin of the bleeding unless subsequent examination confirms the source. It is possible that the patient may be mistaken. If blood stains the clothing or necessitates the wearing of a diaper there can be little doubt that it has a vaginal source. It is, however, necessary to inquire directly on these two points, for lay observation is often inaccurate, and occasionally it will be found that the blood is seen only after micturition or defæcation. In the last few years the writer has, indeed, twice seen a carcinoma of the bladder in senile patients subjected to exploratory curettage, a cystoscopy only being carried out because blood had been discovered in the routine examination of urine.

History

Having satisfied ourselves that we are truly dealing with a case of post-menopausal bleeding, some further inquiry will be necessary in the search for subsidiary symptoms. Since malignancy is uppermost in our minds we shall first inquire of any discharge preceding the onset of the bleeding. A discharge, commonly described as resembling dirty water, may be due to a senile vaginitis, but usually means that a carcinoma of cervix, or occasionally of body, is present. Bleeding on coitus, will again occur most frequently when a cervical carcinoma is present, though sometimes a polyp is happily found to be the only cause. Scalding on micturition may indicate a caruncle, though it must be remembered that a caruncle rarely causes more than a little staining of the cloths. Last of all, one of the most frequent causes of bleeding is therapy with stilbœstrol, which may have been given by another practitioner or purchased by the patient herself. Treatment of menopausal symptoms with any œstrogenic substance will often be followed by bleeding if large doses are used. For this reason care to use only minimal doses (and 0·5 mgm. of stillbœstrol daily will usually be adequate) should be taken. Bleeding persisting for

more than two weeks after withdrawal of treatment will necessitate a curettage.

Examination

All patients complaining of post-menopausal bleeding must be subjected to a vaginal examination. Many investigations to apportion the blame for delay in the diagnosis of uterine cancer have been carried out, and though frequently this is due to failure on the part of the patient to report early to her physician, in an equal number of cases, the delay is due to his failure to carry out an early pelvic examination. Such necessity will apply, of course, as much to irregular bleeding before the menopause as after, and until this necessity is looked upon as a sacred duty so long will we ourselves be responsible for allowing the operable and curable cancer to become incurable. Uterine cancer particularly has a good prognosis if treated early, and if diagnosis was always made within a week or two of the onset of the first symptom, we could expect to cure 80 per cent. of all body carcinomas and probably over 50 per cent. of all cervical carcinomas. It is important to remember that whatever benign cause for the bleeding is found it must not be assumed to be necessarily the only cause of the bleeding. Behind many an innocent polyp, caruncle or vaginitis, lies, a carcinoma of the uterine body, and an exploratory curettage must always be carried out.

Clinical examination will reveal many of the causes of bleeding.

Carcinoma of the vulva.—This tumour is usually diagnosed first by the patient feeling a swelling, and bleeding due to ulceration occurs only late in the disease.

Urethral caruncle.—This may be seen after separation of the labia minora as a small, often pedunculated, granulomatous lesion growing from the lower end of the posterior wall of the urethra. Occasionally it may recede into the urethra and may only be found when milked down with a finger in the vagina. Partial prolapse of the same area of urethral mucous membrane is common in the senile patient, and similar in appearance but lacks a pedicle.

Carcinoma of the vagina.—A primary vaginal carcinoma may very rarely be found as digital examination is carried out. This will consist of friable tissue, bleeding readily on touch, with induration in the surrounding vaginal wall. The granulomatous mass of tissue growing up from a pessary ulcer may have a similar appearance, though induration is usually absent. Moreover, removal of the pessary will lead to a fairly rapid disappearance of the granuloma with epithelialization.

Polypus.—A polyp may be felt projecting through the cervical external os. This will rarely be of the fibroid type in the post-menopausal patient. More commonly the fibroadenomatous type will be seen, projecting as a tongue-like process on a fleshy pedicle almost to the introitus. Even more frequently it will be of the mucous type, a bright red swelling, little larger than a cherry stone, attached to the cervix by a pedicle so short as to be invisible on inspection.

Carcinoma of the cervix.—This is by far the commonest malignant condition to be found on clinical examination. Digital examination usually shows friable, bleeding growth, either of the proliferative type, or, more commonly in the senile patient, an ulcer crater proceeding upwards from a contracted vaginal vault. The less obvious endocervical growth will be characterized by a stony-hard cervix, expanded on rectal examination and perhaps associated with parametrial involvement and fixity of the cervix, while in most instances friable carcinomatous tissue will have grown as far as the external os.

Occasionally an eroded cervix may be found with a supspicious area which may bleed on touch. In such a case the diagnosis can only be made after a biopsy has been taken from the selected area. Schiller's test, consisting of the application of Lugol's iodine to the cervix, may be used. Areas failing to take up the stain are suspected of carcinoma, though the clinical impression is probably as reliable. The colposcope of Hinselmann, by which one can inspect the cervix under considerable magnification, will again require long usage before becoming of any value. Perhaps the best course in the doubtful case will be to take a shaving biopsy, suggested by Novak, which consists of a thin layer of tissue from the whole circumference at the muco-cutaneous junction, the point where carcinoma of of the cervix is said most commonly to begin.

Basal-cell hyperactivity and *carcinoma in situ* hardly come into the scope of this subject, for it is doubtful whether either are responsible for bleeding, though either may be present in association with this symptom. Basal-cell hyperactivity is recognized as an entity only by certain pathologists, and consists of a changed type of basal cell at some point in the stratified epithelium of the cervix, a change which is considered to be a precursor of carcinoma. Carcinoma *in situ*, or intra-epidermal carcinoma, is a further stage in the process, and must be looked upon as a definite carcinoma, which, however, has not yet broken through the basement membrane. Such cases have been written about principally by American investigators, and there is as yet no controlled follow-up to prove that basal-cell hyperactivity will inevitably or probably develop into a true cancer. Thus, at the present stage of our knowledge, the discovery of such a case is an indication for nothing more than careful watching. Carcinoma *in situ*, on the other hand, cannot be allowed to progress, though there is as yet no general agreement on the correct line of treatment.

Finally it must be mentioned that rarely, what appears to be an obvious carcinoma of the cervix will, on biopsy, be found to be a tuberculous ulcer.

Senile vaginitis.—This can only be diagnosed if inspection of the vagina is carried out by means of a speculum. Atrophy, with reduction in the number of layers of cells of of its stratified squamous epithelium, is usual after the menopause, and gives the vaginal skin a thin, shiny appearance with complete absence of rugae. Commonly, even in the absence of infection, there may also be seen punctuate red patches, suggesting small sub-epithelial haemorrhages. If infection occurs, which may easily happen in view of the decreased vaginal acidity, the erythema of a true inflammation may be added to this picture, with a thin, purulent bloodstained discharge. Bleeding may be increased by the abrading examining fingers, though the amount of loss in senile vaginitis is rarely great.

Exploratory Curettage

If clinical examination reveals no abnormality an exploratory curettage must always be performed. Indeed, this will always be necessary whatever has been found, unless a carcinoma of the cervix is the obvious cause of the bleeding. Causes of bleeding lying above the level of the external os can only be found in this way.

A *polyp*, fibroid or fibro-adenomatous, growing from and still retained within the cavity of the uterus, will only rarely be found as a cause of post-menopausal bleeding. This may elude the curette and may require exploration with a small ovum forceps.

Endocervical carcinomas have usually reached the external os when first seen, but cases reporting early may still be confined to the cervical canal. If increased bulk and hardness is apparent on rectal or vaginal examination, or some fixity of the cervix has occurred owing to parametrial extension, the diagnosis may only require confirmation by biopsy. The first stage growth, however, may not be suspected clinically, and for this reason it is important to decide at curettage whether any carcinomatous tissue is derived from body or cervical canal. Though two-thirds of endocervical growths are epitheliomata and so fairly conclusively of cervical origin, the remaining adenocarcinomata will be indistinguishable pathologically from the adencocarcinoma of the body. The adenoacanthoma of the body (i.e. adenocarcinoma undergoing squamous metaplasia) is usually readily distinguishable from the cervical epithelioma.

Carcinoma of the body of the uterus will rarely be diagnosed with certainty on clinical examination, though usually the macroscopical appearance of the curettings will be conclusive. Probably 98 per cent. of cases of carcinoma of the body occur after the age of 45 years, and it is said to occur three to four times more commonly in the patient who has suffered previously from dysfunctional bleeding. Though there may be invasion of the myometrium by the time bleeding begins, the progress of the tumour is usually sufficiently show to allow an excellent chance of cure if combined treatment by surgery and radiotherapy is carried out shortly after the

onset of symptoms. Persistent uterine haemorrhage in a patient past the menopause where clinical examination shows no abnormality will, in many cases, be found to be due to a carcinoma of the body of the uterus. The uterus may be enlarged, but it is surprising how much carcinomatous tissue may be found in an atrophic senile uterus.

The diagnosis of this condition is usually made on the macroscopical appearance of the curettings, which are brain-like in appearance instead of the normal strips of endometrium. Doubtful cases will, of course, require microscopical confirmation before treatment is carried out.

Uterine fibroids—If sarcomatous degeneration has not occurred, these will not cause postmenopausal bleeding unless a submucous fibroid becomes polypoidal and ulcerates. Fibroids found in a patient who has begun to bleed after the menopause increase considerably, however, the difficulty in deciding upon the course of action to be taken. The bleeding may be due to sarcomatous degeneration, to an associated carcinoma of the body, or to some cause which cannot be found. A negative curetting, however, will not now fill us with the same confidence in pursuing a conservative policy. A sarcomatous degeneration may not be revealed by curettage, and though this development will usually be accompanied by rapid increase in size of the fibroid, with pain as well as bleeding, it may be difficult to exclude this complication. Moreover, a uterine cavity deformed by a fibroid may contain a carcinoma of the body lurking in a corner out of reach of the curette.

Sarcoma.—This may develop in the uterus in three situations: The endometrium, the myometrium and with a fibroid. Sarcomatous change in a fibroid may be found only after removal has allowed examination by the pathologist. In general, the sarcoma in a fibroid is less malignant than that which commences in the endometrium or myometrium. The latter type may grow so rapidly that even after an apparent total removal of the growth, secondary local deposits may be obvious within a few weeks. The sacromatous fibroid, on the other hand, may give rise to secondary local growths appearing only many months or a few years after operation, and these may grow so slowly as to justify further operation to help to prolong the life of the patient.

The apparently simple cervical polyp may undergo both carcinomatous or sarcomatous degeneration, and it is for this reason that microscopical examination must always be carried out. Simple removal of the polyp may be followed by a rapid reappearance of the disease in the remaining uterus.

Endometrial hyperplasia.—The return of œstrogenic activity is by no means uncommon in senile patients, but will only present as a problem when accompanied by uterine bleeding. The administration of œstrogens is, of course, the commonest cause of this condition, and must be excluded before further investigation is carried out. As the follicular activity in the ovary has been exhausted at the menopause, the return of any spontaneous œstrogenic activity must either be from an extra-ovarian source, or from neoplastic cells in the ovary. The most important extra-ovarian source of œstrogens is the adrenal gland. Since there is little variation in the level of secretion from this source, however, it is unusual for this to be responsible for uterine bleeding.

Ovarian carcinoma.—The association of ovarian carcinoma with post-menopausal bleeding had been recognized for many years before the granulosa-cell tumour was distinguished from the other types of ovarian carcinama. In most instances it will be found that ovarian carcinomata associated with post-menopausal bleeding are in fact granulosa-cell tumours, and the bleeding is due to the œstrogenic secretion of the tumour causing a rejuvenation of the uterus and its endometrium. Though the granulosa-cell tumour may develop even before puberty, the majority arise in the post-menopausal years. Their size and malignancy vary considerably, though as a rule they are of low malignancy, and secondary deposits have made their appearance as long as eighteen years after the removal of the primary tumour. Usually they will be sufficiently large to be palpable on bimanual examination, but occasionally a small impalpable tumour will cause bleeding. The œstrogen output of these tumours is high and may approximate to the high levels reached during pregnancy. It laboratory facilities for œstrogen estimation are available, this may occasionally assist in the diagnosis of the impalpable tumour. In any case, the discovery of a hyperplastic proliferative endometrium on curettage, with a recurrence of bleeding and a further regeneration of the endometrium, are strong indications of the diagnosis.

It is interesting to note that carcinoma of the body of the uterus may be associated with a granulosa-cell tumour, sufficiently frequently, compared with the normal incidence of the former condition, to suggest that the œstrogenic stimulation has been a factor in the development of the endometrial carcinoma. Such an observation should act as a warning against the prolonged administration of œstrogenic substances.

The theca-cell tumour is another oestrogen-producing growth of the ovary which causes post-menopausal bleeding, and occurs with about the same frequency as the granulosa-cell tumour. This tumour, however, is benign. Macroscopically it resembles the fibroma, and has the same hard consistency, though areas of yellow tissue may be seen on examination of the cut surface.

Post-menopausal bleeding may occasionally be associated with other types of ovarian carcinoma, when a secondary growth in the endometrium, usually at the fundus, may be responsible. Bleeding with a simple ovarian cyst may be due to the co-existence of a small granulosa-cell tumour, and a search should be made, in the specimen after operative removal for a suspicious solid area of tissue.

It must be admitted that, not infrequently, by the end of our investigations we are still unable to name the cause of the bleeding. It is perhaps better to admit our ignorance than to attempt to lay the blame on some general condition such as hyperpiesia. This is a common condition after the menopause, but is no more likely to be responsible for bleeding from the mucosal lining of the uterus than from that lining bladder or rectum.

Finally, a word of warning is necessary concerning the advice to be given to the patient in whom a curettage has revealed no carcinoma. She should, indeed, be reassured that there is no further cause for concern, but she must not be left with the impression that post-menopausal bleeding is a normal occurrence. If there is any persistence or recurrence of bleeding it must be realized by the patient that this cannot be allowed to continue without, if necessary, repeated investigation, The writer has had this brought forcibly to his attention by a patient, with a senile vaginitis and negative curetting, reporting after the lapse of a year with a fourth-stage carcinoma of the cervix.

***

ABNORMAL UTERINE BLEEDING—*Clinical Journal—July 1950.*—A. L. Deacon reviews the causes of postmenopausal bleeding in the present number of this Journal. G. Van S. Smirh,[1] when recently reviewing the subject of abnormal uterine bleeding, included those conditions which occur at an earlier age.

Uterine bleeding during childhood and pre-adolescence is usually a manifestation of precocious puberty associated with one of the following conditions: certain case of mid brain damage, Albright's disease, exceptional cases of tumour of the adrenal cortex, granulosa cell tumour of the ovary and, very exceptionally, chorion-carcinomatous teratoma of the ovary.

Between the menarche and the menopause the common causes of abnormal uterine bleeding are intrauterine tumours and infections, pathological pregnancy, retained products of gestation, submucous fibroids, some oestrogenic tumours of the ovary, the hæmorrhagic diseases of the blood and ovarian dysfunction. Myometral and subserous tumours, pelvic inflammations, endometriosis, retroversion of the uterus and non-œstrogenic tumours of the ovary may also cause abnormal bleeding.

The management of the case depends firstly upon making a diagnosis and, secondly, upon selecting the correct treatment. This will usually be by surgery, radiation or hormone therapy.

During the early teens the bleeding is usually due to ovarian dysfunction of undeterminable cause, and responds to progesterone therapy. It is therefore usually not until after the age of 18 that surgery is

[1] *New Eng. Journ. Med.*, 1949, 241, II, 410.

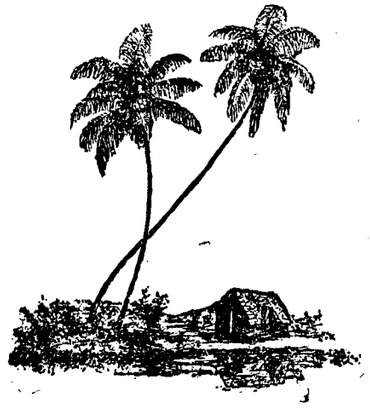
indicated either for diagnostic or therapeutic purposes.

From the age of abont 18 until the menopause it may be necessary to arrest abnormal uterine bleeding, either by hysterectomy or by producing an artificial menopause by irradiation. Quite apart from the constitutional disadvantage of producing an artificial menopause, radiation tends to favour the development of pelvic symptoms at a later date.

In those cases of extensive fibroids and dysfunctional uterine bleeding, therefore, where symptoms are sufficiently severe vaginal or complete abdominal hysterectomy appears to be the treatment of choice, especially in women between tne age of 35 and the menopause.

***

OUABAIN IN SHOCK—*The Practitioner, Aug. '50*—For the treatment of the myocardial depression that sometimes occurs in shock B. B. Sankey and T. I. Crawford (*Current Researches in Anæsthesia and Analgesia*, May-June 1950, 29, 148) recommend the administration of ouabain. It should not be used as a routine measure, but only in patients who do not respond well to the usual restorative measures and in whom myocardial depression is present. Such depression is usually indicated by a progressive and continued narrowing of the pulse pressure, a rapid pulse and a slow capillary refill time. The use of ouabain is contraindicated if digitalis has been administered recently and in severe cerebral arteriosclerosis. It should be used with special care in cases of thyrotoxicosis and of coronary sclerosis and angina. The dose is 0 3 to 0·5 mg. intravenously, and an effect is usually seen in one to eight minutes. As calcium salts and ouabain are synergistic, they must never be given together. Ouabain is eliminated from the body in twenty-four hours, and following the administration of one dose of the drug, steps should be taken to ensure that the patient is fully digitalized by the time the ouabain effect has worn off. Details are given of 30 patients who received ouabain following the onset of shock during anæsthesia. Twenty-seven of them responded satisfactorily. It is stated that since the completion of the report, 37 additional cases have been treated with 'satisfying results'. The final conclusion is reached that 'using the indication for ouabain judiciously, after the usual restorative measures have failed to elicit a satisfactory response, and with awareness of the potential dangers and contraindications to its use, we believe that ouabain has proved to be a valuable aid in treatment of shock, and in acute and incipient cardiac failure during anæsthesia'.



Printed at St. Joseph's Industrial School Press, Trichinopoly—1952

Indian Medical Association South Indian Provincial Branch

Post Box No. 530

Oppannakara Street, COIMBATORE

CIRCULAR NO. 4

COIMBATORE,
21—12—1951

Dear Doctor,

You are aware that as per resolution of the Council of the South Indian Provincial Branch of the I. M. A. held at Karaikudi on 9-9-1951, the Trichinopoly branch of the I. M. A. was authorised to continue the publication of the "Miscellany" as the official organ of the Provincial Branch and that the Managing Editor of the "Miscellany" should render accounts to the Provincial Council through the Trichinopoly branch and to pass on a share of the profits to the Provincial Association.

No doubt you are also aware that the "Miscellany" has so far been able hardly to maintain itself because of poor response from manufacturers of medical products. Only when the "Miscellany" is able to secure more number of advertisements, it will be possible to earn any profit out of the "Miscellany". Hence I would request you to impress upon the representatives of medical firms and to request all your members to do likewise, that the members of your association should patronise the products advertised in the "Miscellany". Such co-operative effort on behalf of all the office-bearers of the Provincial Association, of all the Secretaries of the local and district branches under their jurisdiction of the South Indian Provincial branch, and all the members of our Association would help in improving both the standard of the publication and for increased profits from the "Miscellany".

Doctor P. A. S. Raghavan, the Managing Editor of the "Miscellany" is doing a grand work all by himself so long, and with the co-operation of every individual member of our association, we could expect him to do much better.

(Sd.) A. G. LEELAKRISHNAN,
Honorary Provincial Secretary.

Registered No. M. 4839

ODDS & ENDS

The stomach is a bowl-shaped cavity containing the organs of indigestion.

What is a 'grasswidow'?
Wife of a vegetarian, I suppose.

Niece: Do you know what makes the tower of Pisa lean?

Fatty aunt: I don't know child. If I knew I would myself take it.

"I shot a man eating crocodile" proudly said a shikari.

"He deserves that" replied his fair admirer, "Why should that man be so mean as to go and eat a crocodile."

The doctor was tired of the sales agents. When a new one arrived, he shouted "I can't see you, I can't see you."

Agent: "Then, I am the right man, doctor. I represent an optical firm."

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