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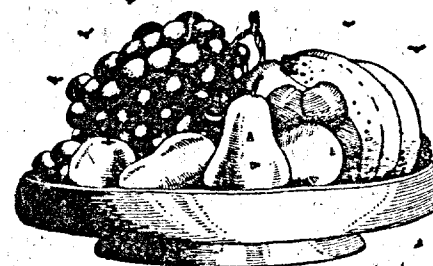
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MISCELLANY

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

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

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29th ALL INDIA MEDICAL CONFERENCE

OF
INDIAN MEDICAL ASSOCIATION
PATNA

The 29th All India Medical Conference will be held in Patna on the 26th, 27th and 28th December 1952. On this occasion a scientific section of the Conference will be organised. Subjects for papers include Medicine, Surgery, Obstetrics and Gynæcology, diseases of the Eye, Ear, Nose and Throat, Pathology, Pharmacology, Preventive Medicine and Medical Jurisprudence and Toxicology, Anatomy and Physiology. Three topical subjects have been selected for symposia namely (1) Place of Antibiotics and Chemotherapeutic drugs in the treatment of tuberculous infection (2) Management of heartfailure and its complications and (3) Bowel disorders.

Facilities for epidiascope and microprojection will be available. Arrangements will be made for the exhibition of interesting pathological specimens and skiagrams.

Eminent leading personalities and leaders of the profession from all over India are being approached to inaugurate and preside over the scientific sessions respectively.

(continued on 3rd cover page)

The MISCELLANY—October, 1952

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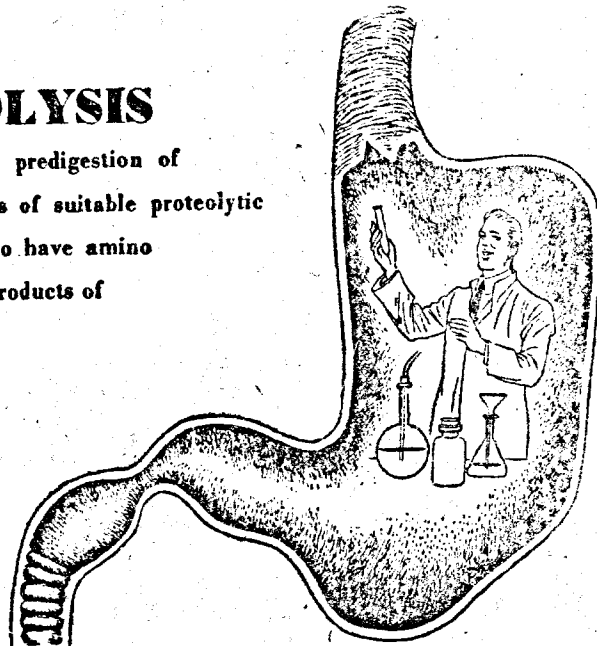
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Vitamin B ₆	1.50 "
Niacinamide	15.00 "
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Inaugural Address

BY

SRI A. B. SHETTY

Minister for Health, Govt. of Madras at the Seventh South Indian Provincial Medical Conference, Palayamcottai on 20-9-1952.

IN the last few decades tremendous advance has been made in medical knowledge. The development of various specialities has become inevitable. Yet the general practitioner must continue to be an important member of the profession. In Western countries specialisation has made such rapid strides that the general practitioners have taken alarm at the way their status is gradually getting lowered. They are seeking to enhance their position in England by setting up a College of General Practice which can confer higher degrees. But in our country specialisation has not yet developed to the extent needed.

The rapid progress of medical knowledge, the development of new methods of diagnosis and the discovery of specific remedies for certain bacterial infections have brought about a great transformation in recent years in the efficacy of medical treatment. To keep yourselves abreast of the changes taking place, you must read books and journals, participate in discussions at your association meetings, visit large hospitals, observe eminent practitioners at work and acquire new skills. Periodic refresher courses are necessary to prevent medical practice degenera-

ting into routine. Government have under consideration the provision of refresher courses at eight of the bigger hospitals in the different parts of the State. Some of you have to undergo post-graduate training for which further facilities will be provided by the upgrading of certain branches of medicine and surgery in Madras and elsewhere and by the All-India Medical Institute which is being established at Delhi. Opportunities for overseas training are being given with the help of international organisations like the W.H.O., UNICEF and the Rockefeller Foundation.

Since 1940 there has been rapid growth of interest in some countries in some form of group practice as an alternative to individual private practice. General practitioners and specialists form a medical team. This enables them to equip their medical centre with the expensive laboratories and appliances needed for diagnosis and treatment on modern lines. Polyclinics with such an organised group of medical men can handle all cases which do not require hospitalization. If you cannot start such group practice, your district associations may set up their own medical stores and laboratories for diagnostic work.

In a country like ours where the financial resources are small and the health problems serious, it is difficult to make medical care reach the entire population. National Health Service on the British model will be an Utopia in the present economic conditions of India. Even the plans of medical relief recommended by the Bhore Committee involve a financial burden far beyond the capacity of the Government. The Five-Year Plan gives the first priority to economic development. The Planning Commission wants us to be satisfied with a modest health programme at present. During this five-year period additional resources have to be concentrated on preventive work rather than curative facilities and rural areas have to be given greater attention than in the past. Encouragement of indigenous medicine synthesising it with modern medicine, production of a large class of medical men with a shorter and less expensive course of study, the establishment of mobile dispensaries—these are the three principal measures suggested for rural medical relief. This subject is now engaging the attention of Government.

In the welfare state of to-day medicine like education must become a public service available to all without charge. Nearly all advanced countries, except the Soviet Union and the United States, have developed the programme of compulsory insurance under which the workers, the employers and the State contribute to a common fund, out of which the cost of medical care is paid. The Soviet Union has socialised medicine completely.

Spurious Drugs—The manufacture and sale of spurious drugs and drugs which are sub-standard in quality in our country is becoming a matter of grave concern to the medical profession, the public and the honest dealers. A committee of the Calcutta branch of the Indian Medical Association and of some of the pharmaceutical associations

has gone into this matter and urged Government to take immediate measures for effectively eradicating this widespread evil. The old containers of the valuable preparations of reputable firms are said to be bought at high prices for bottling the fraudulent products and duping the public as well as the profession. The medical profession, the pharmacists and the public must co-operate with the drug control authorities in putting down these malpractices in the interest of public health as well as of the drug industry and trade in this country.

"Our State hospitals can provide medical relief only to a fraction of the sick people. Medical relief continues to be mainly a service that is purchased by the patient and sold by the doctor under a competitive system. Medicine has become highly specialised. The new drugs are very costly. Doctoring has become too expensive for the low income groups. Many people first go to the cheaper class of unqualified practitioners and it is only when they do not get relief they have recourse to the scientifically trained doctors or specialists. Compounders and quacks have become formidable rivals to qualified medical men. The doctor of modern medicine can make treatment less costly. The bulk of the cases met with in everyday practice are ordinary ailments which can be cured with little or no medicine. Advice regarding proper diet, nursing rest or exercise can do immense good in many cases. Some simple innocuous medicine may probably be necessary to produce a psychological effect.

The preservation of health and the prevention of disease is of far greater importance to the welfare of the community as a whole than remedial medicine. At the present time we have the great bulk of the profession engaged in combating ill-health and a smaller number of health officers occupied in preserving the health of the community. The attitude of the public

towards health and disease is far from helpful or satisfactory. Speaking generally, people are more concerned with cure than with prevention. Your association can well take up as one of its activities the work of disseminating basic information in regard to healthy living. Nutrition propaganda can be done. You are well aware that nutri-

tion is the fundamental factor in human health. Undernourishment is no doubt due mainly to poverty. It is also influenced by the lack of knowledge regarding the selection of available dietary items. You will be rendering a great public service by promoting popular education in matters of health.



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The Seventh South Indian Provincial Medical Conference

PALAYAMKOTTAI

Saturday the 20th of September 1952.

Presidential Address

BY DR. K. C. NAMBIAR, F.R.C.S., MADRAS.

Ladies and Gentlemen.

LET me at the outset thank you for the unique honour you have bestowed upon me by electing me as the President of the South Indian Provincial Branch of the Indian Medical Association. I am today entering into the shoes of my great predecessor Dr. U. Krishna Rao, the Minister for Industries, who had been signalled out early enough as a Political leader of our State. I am immensely thankful to him for the way he has paved for me. I will be failing in my duty if I do not make mention of another quiet and amiable personality, capable of releasing colossal amount of energy in the matter of honorary work in the Public Health field. Dr. Y. P. Vasudevan of Coimbatore, who acted for the President for nearly a year, since Dr. U. Krishna Rao assumed office as the Minister. I have this day taken upon myself the onerous responsibility of guiding the destiny of the Medical Profession in the Madras State, with considerable humility, a fair amount of confidence and some pride. There is no need to make a specific request to you for your unflinching and whole-hearted co-operation in the great task before me, as I feel convinced, that your responsibility in the matter is as great as mine.

Conferences of this type have Social, Educational, Scientific and Political utility. Medical men from various

districts of South India come together, exchange their views and increase their social contacts, forgetting for the time being their worries in Medical Practice. The cinder of knowledge, gradually getting ash-covered by rolling years, is refanned and rekindled by the scientific discussions for a couple of days. This conference also produces a Forum for ventilating the views of the profession regarding Medical and Public Health matters. I have carefully and aptly used the words "Ventilating the Views", because such views invariably escape into the thin Air. In all civilized countries of the world, the Governments of such countries seek the advice of the Medical Profession in Medical matters. On the other hand, we are not even afforded an opportunity to force our views on our Governments. All the same, we shall ventilate our views again and again till the thin air is charged and surcharged to the point of Super-Saturation.

Indian Medical Association was a great friend of the Congress, before the attainment of the National Freedom. Many of our members were incarcerated along with Congressmen in the freedom struggle. The Association was banned by the British Government. All this is gradually forgotten. The chain of friendship is becoming thinner and longer, and we hope it will not snap. The Government of our State have not sufficiently recog-

nized the Association yet. It is one thing to recognize the existence of the Association and, yet another thing to recognize the Association. The former has been achieved and we are hoping to achieve the latter.

It has often been argued that all medical men are not members of the Association and therefore it cannot represent the Medical profession in its entirety. If one lakh of Congress men could represent 350 millions of India very effectively and if a handful of communists could rule the millions of Russia, the Indian Medical Association with membership of fifteen thousand doctors out of a total of about fifty thousand is undoubtedly a much better and more effective representation. If there should come into existence another Medical Association with a greater membership, then and then alone can there be a doubt as to the representative capacity of this organization.

This association is undoubtedly the parent body for all Medical men of the country, belonging to the Modern Scientific System of Medicine. It is rather disheartening to see that every Medical man has not as yet signed up with the Association. Every man has a threefold responsibility; the first to himself; the second to his family and the third to his profession. All of us have recognized the first two responsibilities, but not the last. On the other hand, spare time, energy and money is being spent on multifarious activities in the line of religion, caste, community and other forms of separations, that do not come under the natural responsibilities of any individual. I wish to take this opportunity to plead before you, to make an all out attempt in the coming year to institute a State wide membership drive and to wake up the slumbering medicoes from their habitual lethargy.

With lapse of time, various specialities have formed themselves into their corresponding Associations e.g. The

Association of Surgeons of India, the Association of Physicians of India, the Association of Gynaecologists, Ophthalmologists, Otolaryngologists, Venereologists and Pediatricians and the like. The children have set up separate families, leaving their parents rather lonely; and therefore our Association happens to be composed mainly of general practitioners of the country today. Separatism is gradually raising its ugly head in the ranks of medical men. This could be avoided if we could celebrate our annual conferences along with the conferences of the specialities in one and the same city or town, whatever may be the difficulties and inconveniences in organising such a huge and mammoth gathering of medical men from all over India.

In the problems of medical and Public Health administration, our country stands far behind some of the countries in the west. A much better and more effective concentration on positive health than the treatment of diseases has become the order of the day. Positive health of the body as well as the mind can be achieved only under conditions of good and sufficient food, proper education and wholesome recreation. Average income of an Indian is two rupees per head per annum, smaller than a minute fraction of what is obtained in the West. Food, education and recreation can be had only at the expense of money. How then can we dream of positive health for decades to come! The Government of our State sets apart only 6% of the total budget towards Medical and Public Health relief, while in most other countries, it runs up to 16% of the total budget. It is difficult to understand why our State should lag behind in the percentage allotment, especially in view of the fact that private philanthropies are rarely forth-coming. 90% of major Medical Institutions in London are under private management. More than

half the medical colleges and hospitals in states like Bombay and Calcutta are private philanthropies. In the absence of such, is it not the duty of the Government of our State to allot a larger percentage to the problems of medicine and public health?

Socialisation of medicine partly or wholly has been a recent problem engaging the attention of doctors and laymen all over the world. If socialisation of medicine is good, it ipso facto follows that socialisation of every other department is also equally good. All round socialisation brings in a socialistic society. It is curious to note even those that denounce socialistic set up outright, are willing to welcome the idea of socialisation of medicine. I have always thought that food is more important than medicine and it would be in the fitness of things that socialisation of food precedes that of medicine. To take away the freedom of private enterprise among doctors, while retaining the same among merchants of food and cloth will be an unhappy and invidious distinction that may not well be tolerated by the profession. The British Medical Association strongly protested against such socialisation in Great Britain. The system finally evolved there, became a confused mixture of socialisation plus private enterprise and the people are not too very happy over it. It is very doubtful if the system could be sustained.

Employees' State Insurance Scheme of the Government of India for the factory workers that is now being put into practice touches only the fringe of the problem as it is only a very small minority that can be brought under the orbit of the scheme. It is probably the right step, but a very small one. The problem in India today is not that of the workers, but of those that have no work.

Rural Medical Service is the burning question of the day. The paucity of

doctors in our State has been magnified. At any rate, the number of doctors in large cities and towns is nearly as good as the American proportion of doctors to the populace. The number of allopathic doctors in the city of Madras is in the vicinity of one thousand to a population of fifteen lakhs i.e. one for thousand five hundred. If medical men of all systems including the Vaidyas are taken into account, as it should be, there is no paucity of doctors. It should be admitted that there are many doctors who do not make their ends meet. There is undoubtedly an improper distribution of the doctors of the modern scientific system. There is neither incentive nor compulsion for the doctors to spread towards the rural areas. The problem rather closely resembles that of a father going in search of a bridegroom for his daughter for months and years in vain, while there are as many men as there are women in the country.

In order to provide doctors of the scientific system to the villages, the Government are contemplating to produce cheap doctors with little expense, and in quick time. Certain States in the North have already gone ahead. In other words there is going to be a rebirth of the Licentiates. Years of struggle from all quarters resulted in the successful standardization of medical qualifications all over India. The malady is going to repeat. If the intention of the Government is to see that such doctors are compelled to confine themselves to the villages, it gives me no great alarm. But the constitution of India allows the doctors to practise their profession where they like. If the Government cannot confine them to the rural areas, after producing them in large numbers, great harm will be done to the profession and no good to the people. If they cannot do so, this conference will strongly advise the Government to stay their hands in the matter.

The popular slogan that a class of inferior doctors should not be thrust upon the villagers does not carry much conviction with me. Surely, some doctor is better than no doctor. Half a loaf is better than no loaf. But as a member of the profession, I am in duty bound to oppose the scheme. If I were in charge of the medical administration of the State, I may have a different story to tell. I wonder if Minister Dr. U. Krishna Rao has already changed his mind in this matter.

For decades past, the hospitals of our State have been illmanned and illequipped. The government of the State could not find the means for employing sufficient medical personnel to man the hospitals. Therefore in 1936, during the regime of Dr. T. S. S. Rajan, the Honorary Scheme was launched and expanded. It was not contemplated to remove the then-existing paid medical officers. As such, the grouse that the paid service is being encroached upon by the Honoraries is an incorrect and unformed observation. For the last 15 years the Honorary System has been working quite satisfactorily with a personnel numbering over 350 medical men. This has contributed considerably towards the support of the public exchequer.

The Public Health conference of 1947, held under the chairmanship of the Minister Sri. Shetty, has recommended the expansion and modification of the existing Honorary Scheme. These recommendations were made by eminent men of the State belonging to the paid medical service. If all the recommendations are thoroughly implemented, there will evolve an Honorary System, that would help the government in rendering medical aid to the poor with little or no additional cost. The sub-committee of this conference has specifically recommended to dispense with the designation of District Medical officers and make

them Superintendents of the District Head Quarters hospitals and hand over the inspection of various hospitals in the District to the Deputy Directors of Medical Services. I reliably understand that, at a recent conference of the District Medical Officers, held at Madras, unhappy expressions have been made regarding the working of the Honorary Scheme. I am sure such unilateral reports will not find a place in the records of the Government. At the moment, District Hospitals are manned by a preponderating number of Honorary Specialists in various departments like Eye; Ear-Nose-Throat, Skin and other branches of medicine. If the D.M.O. is made the Superintendent of the hospital and one single speciality assigned to him in addition to his administrative work, with equal distribution of beds as is practised in the teaching hospitals of the city, the vested interests will gradually disappear, and a healthy atmosphere installed in the District Hospitals just as is obtained in the city.

All the hospitals in London, including the great teaching hospitals of the West were entirely manned by Honorary Physicians and Surgeons, except for an Administrative head, until recently, before the Socialised State of Medicine came into being in that country. Hospitals of Bombay and Calcutta followed suit. The Honorary systems in these places differed from that of the Madras State in the fact that the incidental expenses of the Honorary officers—eg. car allowance or telephone allowance were paid in the form of an Honorarium in Great Britain and in other states of India. Here, it is not enough to render Honorary service, but also spend some money for the poor, from the Honorary's pockets. It is still more curious to note that the Government charge the rich patients in the hospitals for surgical operations and do not wish to share with the surgeons who performed such operations. I will not be

far wrong if I say that this amounts to exploitation.

If Honorary appointments are created to suit individuals or individuals are made to fit in certain vacancies, the system is not likely to be a success. The suitability of a doctor to a particular honorary vacancy should depend first on his qualification for the job and next to his local standing and popularity. There is at the moment a group of honorary doctors who are there just because they have nothing else to do and put in applications for paid jobs in the State or look for vacancies in Malaya. Such recruits definitely discourage the system. If the government will appoint a small committee to make a district survey and fix up the possible number of vacancies in each hospital, it will be a great help to expand the Scheme. The need for such posts is not likely to emanate directly from the District Medical Officer himself.

Promotion in the ranks of services paid or honorary should not be a matter of age and seniority alone. Higher qualifications taken or special work done, especially in the line of research or publication of books or paper should be the real criterion. The tendency for better work, higher studies and research has fast deteriorated in services for the last two decades and I request the Government to take particular note of this fact.

The recruitment of professors to the Preclinical subjects in the Medical Colleges has become increasingly difficult for the deplorably poor pay they are receiving. The recommendation of the Public Health Committee to raise their standards must have been the foremost duty of the government, in the interest of the future generation of medical men; and I take this opportunity to assert most emphatically that this has become the first priority demand on the public exchequer. If this is not done, where the

best men should decorate, the worst men alone will creep in.

The young generation of doctors who attempt to start their life and practise today is in much greater distress than the generation to which we belonged. The price of a car or a consulting room has shot up sky high. The paying capacity of the average man is on the descent. According to the Government of India, car and petrol are luxury articles. It may be so to the business man or a High Court Judge; but to a doctor it is an essential commodity, not so much to his personal advantage as to that of the sick public. Where then is the moral justification of taxes and super taxes for the car and petrol of the medical men? For such essential uses, car and petrol must be tax free. And with little vigilance, misuse of such privileges can be prevented.

The University of Madras and the medical degrees of Madras loom large in the various states of India and the neighbouring countries of the Far East. If the Government of Madras could give a filip to the post graduate studies of our university and send our senior members of the profession on a tour to Burma, Ceylon, Indonesia and Java to contact the medical men there, as there is in the near future an opportunity for Madras to become the Mecca of the East. We are today advanced in all branches of medicine like any other countries of the west, except for surgery of the chest and brain. Surgeons in our country are no doubt making feverish attempts to catch up with those in the west. But the red-tapism of our Administration is very much in the way of speedy execution of any work. The instruments that I have indented for, nearly four years ago have not been received yet and nobody knows where that indent lies today.

The General Practitioners in the country form the backbone of the

medical profession. It is surprising to note that they are designated as private practitioners while they practise their profession openly in the streets. Even the government records brand them as private. The officers of the government, besides their official work did some additional medical practice outside the scope of their employment. This really constituted private practice. So it is high time that we expunge this designation and call them "General Practitioners".

The G. Ps. carry on with their professional work in remote villages and towns, far removed from the centres of teaching. The advances in the field of medicine can hardly penetrate them. Most of what they have learnt in younger days has gone out of memory. In order to brush up their knowledge and wipe out the cobwebs, refresher courses were instituted by the government. For some reasons or other, it has not found popularity with the practitioners. The most obvious reason happens to be that the practitioner cannot leave his locality even for a day. I am sure if the practitioners take to these refresher course in larger numbers at least once in five years, the profession as a whole will stand elevated. All the same, I must admit, that here and there, one often meets with a practitioner who has successfully attempted to keep himself abreast of modern development in medical science.

The crest of mother earth is limited in space. The population of the world is increasing by leaps and bounds. It requires no argument to convince that there must be a halt to mass production of human beings. The forest is a natural growth and the garden a human planned one. Family planning is on the model of gardening, in contradistinction to the ill-balanced overgrowth of trees in the forest. We cannot cut off the necks of human plants. So there must be a definite planning in the sowing of seeds.

Certain religious groups in the country are opposed to family planning, as it is artificial and ungodly. Some of them do not even interfere with growth of their beards, lest it would become ungodly. They advise abstinence as against family planning. If all people in the world have developed that amount of will power, most problems of the world are solved. The middle and upper class people have already undertaken to family planning, while the poorer classes are multiplying at a rapid rate, thereby becoming poorer and poorer still. It is certainly the duty of a people's Government to advise the ignorant masses the necessity for a family planning.

It is not for me, nor is this the occasion, to attempt at evaluating the utility of Homeopathy or Indigenous systems of medicine. They all have their places in a restricted manner today under the existing conditions of poverty of doctors and the meagre existence of the masses. The modern scientific system, built on basic sciences like physics, mathematics and chemistry could show no better results than any other system except for the last two decades, in the field of Therapeutics. The recent mastery over bacteria and probably over Tubercle and viruses has resulted in a gigantic summer-sault, in the winking of the eye, and has drastically smothered the boastful claims of all other unscientific systems of therapeutics. Surgery flourishes where medicine fails. The progress of medicine in years to come will be replacing surgery to a very large extent. Carbuncles, Empyemas, Cellulitis etc. have left the surgeons already. More and more diseases will leave the surgeon as years roll by. Then alone can we claim that medicine has progressed.

The profession has a duty by the public to tell them what forms of physical culture will constitute the best for keeping young and living long. I have of late developed an

antipathy against severe forms of competitive exercises, producing strain, and incalculable harm to the heart and lungs, as is obtained in mile runners. It is worthwhile to investigate and find out how many mile-runners have survived their fortieth year of life. Is it not cruel to make a man run a mile in a spirit of competition? Our ancient system of Asanas which exercise and stretch every part of the body without dissipation of energy is a salutary system of physical culture for the preservation of positive health, fitness and longevity. It is high time that we turn our eyes back to it.

Ladies and Gentlemen, let me now conclude my speech by requesting you once again, to go on a state wide membership drive; to remove the bickerings, if any, in the ranks of the members of the association, forging a steel-framed unity; to request the government to take us into their confidence regarding matters affecting the public health; and to help and advise the government whenever called upon. May the dignity and strength of the Indian Medical Association climb up higher and higher.—“JAI HIND”.



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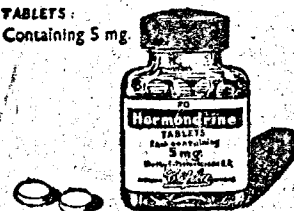
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WELCOME ADDRESS

BY

DR. K. RAMA AYYAR, M.B., B.S., CHAIRMAN RECEPTION COMMITTEE

AT THE

Seventh South Indian Provincial Medical Conference, PALAYAMKOTTAI

Saturday, the 20th of September 1952

Brother Delegates, Ladies & Gentlemen,

AS the Chairman of the Reception Committee it is indeed my proud privilege to welcome you all here on the momentous occasion of the holding of the Seventh South Indian Provincial Medical Conference. The Tirunelveli District Medical Association has every reason to regard this day as the proudest period in its history, for it has succeeded in bringing to this part of the country the distinguished members of our profession from all parts of the Madras State. Conferences such as this give an opportunity to the members of our profession to exchange our ideas and to come into touch with the professional advances of the day. We feel a glow of pride that we have been able to secure the services of our popular Minister for Health, the Hon'ble Dr. A. B. Shetty to open the Conference, Dr. P. Arunachalam, Director of Medical Services, Madras State, to inaugurate the Scientific Section of the Conference, Dr. K. Madhava Menon, M.B.B.S., District Medical Officer, Tirunelveli to open the Exhibition of Medical Implements, Dr. K. C. Nambiar to preside over the Conference and Sri P. S. Subramania Pillai, B.A., B.L., Municipal Chairman, Palayamkottai to hoist the Union Flag. It was very kind of the above mentioned gentlemen to have responded to our invitation to participate in the Conference and encourage us by their distinguished presence and words of

useful advice. On behalf of the Reception Committee, I extend to them a hearty welcome and I dare say that the Conference will devote its best attention to the suggestions that they may make and the advice that they may give in the course of their valuable addresses.

On an occasion like this, when we are gathered in Conference in this historic town, it is in the fitness of things that I should say something about our district. The district of Tirunelveli is hallowed in tradition; it is conspicuous in history, and in the economy of our country it occupies an important place. Tradition says that Sage Agasthya made Pothia Hill in our district as his abode in ages past. History records that Tirunelveli was part of the once glorious Pandya Kingdom. In the history of our Freedom Struggle, Tirunelveli has obtained a celebrity, for Khatta Bhoman, the Naik Chief of Panchalamkurichi was the first Indian to resist British authority towards the close of the 18th century. He fought the East India Company with a courage and tenacity which extorted the admiration of even his enemies. The historic Panchalamkurichi, Khatta Bhoman's 'Gibraltar' is to-day a waste land, not far from Ottapidaram near Tuticorin. At Ottapidaram itself was born towards the middle of the 19th century that great scholar and patriot, V. O. Chidambaram

Pillai, the first South Indian to think of capturing at least the coastal trade from the British and so started the Swadeshi Steam Navigation Company in the first decade of this century. To the memory of this great scholar-patriot a First Grade College has been started at Tuticorin and Indian owned steamships are running between Tuticorin and Colombo. Khatta Bhoman and V. O. Chidambaram Pillai are not the only distinguished patriots produced by our district. Who is not thrilled by the soul-stirring songs of Subrahmanya Bharathi, songs glowing with patriotism and rich with ideas? Poet Bharathi is a National Poet and belongs to every part of Bharatha Nadu but we have a special claim over him as he was born in Ettayapuram in our district.

If in history our district occupies a conspicuous place, in the field of education our district has made considerable progress thanks to the efforts of a noble band of Christian Missionaries. The noble example of the Christian Missionaries has been followed by some of the public spirited men in our district with the result that two colleges have sprung up, one the M. D. T. Hindu College, Tirunelveli which is nearly sixty years old and the V. O. C. College, Tuticorin which is only two years old. To-day in Tirunelveli-Palayamkottai there are three First Grade Colleges for Men and one for Women; at Tuticorin, there are two first grade institutions, the V. O. C. College for Men and the St. Mary's College for Women; and throughout the district there are many High schools for boys and girls.

Our district is not without interest to globe-trotters and sight-seers. In Tirunelveli Town there is the Swami Nellaippar Temple and any student interested in sculpture will be attracted by some of the beautiful specimens within the temple, in the 'Chain Mandapam', 'Mani Mandapam' and 'Tambra Sabah'. The Temple is one of the ancient structures of our land, a

fine piece of Dravidian architecture, probably built before the 7th century A.D., for it has been referred to in one of the songs by the Saivite Saint, Tirugnana Sambandar. Then there are the Papanasam Dam and Hydro-Electric station and the Manimuthar Project standing monuments to show that our popular Government is actuated by the 'Welfare State' ideal. Last but not least, we have in our district the famous Courtalam water falls to which thousands of visitors go every year during the period of the South-west Monsoon to benefit by the bracing climate of the place and the invigorating effect of a bath in the Falls.

It is in such a beautiful and historic district that we are gathered to exchange our ideas and to contribute to the improvement in the health of the people of the Madras State. It is now five years since we became the 'captains' of our souls and the masters of our fate, and during that period though some good work has been done in the way of provision of medical facilities, we have yet to make a lot of leeway in the matter of medical relief according to the standards prescribed by the W. H. O. India is essentially a land of villages and her teeming millions are found in the rural areas. Unfortunately, rural medical relief is the least satisfactory of the medical services rendered at present. Many rural dispensaries have been closed for want of qualified men. In the few dispensaries which are working the doctors are not able to get all the Medicines allotted to them. The remuneration given to the Rural Medical Officers is quite inadequate and consequently, Rural Medical Service is not attracting qualified men. One of the duties of this Conference will be to suggest ways and means of improving medical relief in rural areas and to see that the rural folk, the backbone of our nation lead clean and healthy lives.

Another subject which I should like to touch upon is the 'Honorary System'. The system should be made more popular than now by giving the Honorary Medical Officers the same facilities as the regular government officers. Doctors who are appointed as Honorary Medical Officers are persons with good-qualifications and command a lucrative practice. The best way of getting their services on an honorary basis is to take away the feeling that they are discriminated against.

Ladies and gentlemen, I may be permitted to say that several diseases are caused by the low standard of life among our people and the poor environmental conditions. A higher standard of life, proper housing conditions and a protected water-supply will go a long-way to increase the resistance of our people to disease and pestilence. The Five Year Plan of our National Government will go a long way to establish the conditions for a healthy life among our people but without the co-operation of the people, the Plan will not achieve the objects it has set before itself. We must all co-operate with the Government in the measure they may take. To rich persons in particular, I would like to make a

special appeal to help the Government to equip Hospitals and Maternity Homes. Our Government is a People's Government and it is as much the responsibility of those outside the Cabinet and the Legislature as it is the duty of those entrusted with the task of administration to establish the ideal of a 'Healthy State.'

There are many more problems pertaining to the Medical profession. All these will be referred to by the Honourable Minister for Public Health, the President of the Conference and the Presidents of the Scientific and Exhibition Sections of the Conference. All these distinguished gentlemen have come all the way to Tirunelveli in the midst of their crowded programme of work, to give the benefit of their rich experience and vast knowledge. I thank them all, on behalf of the Reception Committee for responding to our invitation. To all the delegates who have gathered here from several parts of the Madras State, I extend a most cordial welcome. We have done our best to make your stay in our town comfortable, but if we have not come up to your expectations we would request you to treat us with sympathy and indulgence and take the will for the deed. 'Jai Hind'.

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Announcement

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INDIAN MEDICAL ASSOCIATION

SOUTH INDIAN PROVINCIAL BRANCH

OPPANAKKARA ST.

:-:

COIMBATORE

ANNUAL REPORT FOR THE YEAR 1951-52

(Presented at the Annual Provincial Council Meeting on 20-9-1952
at Palayamkottai)

Ladies and Gentlemen,

I consider it a great honour and privilege to present to you this Annual Report of our Provincial Association for the year 1951-52.

This year has been an eventful one for our Association. At the very beginning of the year, we had the pleasure of seeing the first President of our Provincial Branch, Dr. T. S. Thirumurthy having been declared as the President-elect of the Indian Medical Association for the year 1952. Later on we witnessed several of our popular members including our Provincial President for the year, Dr. U. Krishna Rau getting elected to the Provincial Legislatures with the overwhelming support of our peoples. We had also the satisfaction of seeing our President for the year, Dr. U. Krishna Rau being called upon to shoulder the responsibility of a Minister with the Government of Madras. We also witnessed another popular member of our branch, Dr. P. V. Cherian being elected as the Chairman of the Madras Legislative Council. Also several other members of our Association are called upon to shoulder heavy responsibilities of administration in different parts of our country. We congratulate them all on their several achievements, and we hope that these members will continue to have the interest of our profession and of our Association always in view, and we on behalf of our Provincial Association can assure them of our sincere co-operation in the nation-wide efforts of the Governments to improve the health standards of the people of the country.

Our Condolences:

It is with deep regret that I have to note of the passing away of the following 7 members of our Association during the year, and our Council has sent its condolences to the members of the bereaved families:

1. Dr. P. S. Varadarajan, Madras.
2. „ D. Srinivasan, Trichy.
3. „ R. Krishna Iyer, Coimbatore.
4. „ K. N. Ramanathan, Coimbatore.
5. „ U. Rama Rau, Madras.
6. „ K. Govinda Iyer, Tirunelveli.
7. „ G. S. Katre, Madras.

I also regret to record the passing away of Dr. M. A. Nair, a member of Madras Branch, and of Dr. M. G. Kini, a former member of our Provincial Branch at Bombay.

May their souls rest in peace!

The Headquarters of the Provincial Association:

The Headquarters of our Provincial Association during the year was located at Coimbatore, the place of the Honorary Secretary. We are thankful to the President and members of the Coimbatore District Medical Association for allowing us the use of their spacious building for housing the Provincial Office for the year.

Our Constituent Branches:

The year began with a total membership strength of 1,335 through 17 constituent branches. I am glad to report the formation of one more new branch, the Anamalais Branch with a membership strength of 14 in the Coimbatore District and the revival of the North Arcot Branch with 31 members; the Negapatam Branch, which has been dormant for a few months in the beginning of the year, has now sprung back to life with almost all its members intact. The present strength of our Provincial Association comprising of 19 constituent branches is 1,489 showing a nett increase in the membership of 154 members. I heartily congratulate all the office-bearers of our 19 constituent branches, but for whose efforts this increase of membership may not have been possible. But a word of caution here will not be out of place. There are over 4,000 qualified doctors in our area, and unless and until we can claim all these doctors as our members, our claims for cent per cent representation of the profession will be rather flat. I earnestly appeal to the rank and file of our members individually to go ahead in full steam to enrol new members so that by 1953 we could claim that our Association has in its rolls almost every qualified member of the profession in our area. I am giving below the names of our different constituent branches and their respective membership strengths in October 1951 and September 1952.

Name of Branch	Membership 1950-51.	Membership 1951-52
1. Anamalais	...	14
2. Chettinad	27	21
3. Chingleput	35	29
4. Coimbatore	183	174
5. Erode	11	16
6. Madras	220	279
7. Madura	137	152
8. Malabar	109	143
9. Negapatam.	21	19
10. Nilgiris	59	57
11. North Arcot	...	31
12. Pudukottah	17	15
13. Ramnad	37	21
14. Salem	76	87
15. South Arcot	72	55
16. South Kanara	92	98
17. Tanjore	84	83
18. Tirunelveli	68	95
19. Trichy	86	98
Direct members	1	2
Total	1,335	1,489

The Activities of Our Constituent Branches :

Several of our branches have regular monthly clinical meeting in which subjects of professional interest are discussed and the reports of such meetings are sent to the Provincial Office and are published in full in the "Miscellany" and brief summaries are published in the Journal of the I. M. A. periodically. But at the same time there are a few branches which are virtually dormant, as the reports of their activities, if any, are not made known to others. I take this opportunity of calling upon all our constituent Branch Secretaries to send regular reports of all their activities to the Provincial Office at least in the future, so that other branches and all our members may know what the activities of their sister associations are, and if possible, they could emulate their example.

The Central Office and Ourselves :

The relationship between the Central Office and ourselves has been very cordial. I am glad to report to you that the selections for hospital appointments in American Hospitals have been equitably distributed amongst the several Provincial Units of the I.M.A., and we are able to share with the other units all the other benefits that the I.M.A. has been able to secure for us. Six free copies of the B.M.J. are being supplied to our constituent branches and the other branches can avail themselves of the supply of the B.M.J. at reduced rates. Our representatives to the Central Working Committee or their substitutes are regularly attending these meetings and are of great help to the Central Association in its various activities.

The Journal of the I. M. A.

I find this year that the office of the Journal of the I. M. A. is taking greater pains not only to improve the quality of the Journal but also to see that the Journal reaches all the members of the I.M.A. in time. But in spite of the extreme care with which the Journal office is looking after the despatch of the Journal, I am still receiving complaints from many of our branches and several of our members that they are not receiving the copies of the Journal for periods varying from 3 to 18 months. Apart from requesting the Central office and the Journal Department to ensure more promptness in the despatch of the Journal to our members, I must also request all the individual members to give their complete correct addresses to their respective branch secretaries, to the Provincial office and to the Journal Department and to notify any changes in their addresses then and there, and I am sure with the co-operation of all the members and of the Branch Secretaries, the Provincial, Central and Journal offices will be able to evolve a mutually satisfactory procedure.

Specialist's Associations and the I. M. A. :

There are at present several associations of specialists in different branches of Medicine in our State and in our country not having any connection with the I. M. A. as such, but almost all their members are members of the I. M. A. also. I feel that all such associations should merge with the I. M. A., so that the I. M. A. will be in a position to represent the interests of the entire medical profession in the country. Some sort of an arrangement may be arrived at between these specialists' associations and the I. M. A. whereby the special interests of the specialists' associations may be safeguarded by the I. M. A. also. In this connection I welcome the step taken by the Madras State Branch of the Society for the Study of Industrial Medicine in suggesting to its parent body to come to an arrangement with the I. M. A. similar to the

one that exists between the Industrial Medical Officers' Association in England and the B. M. A.

The Provincial Council—Its working :

We had 4 Provincial Council meetings during the year—the first Annual meeting at Calicut, and then at Madras, Kodaikanal and Courtallam. At these meetings, apart from transacting routine association business, several important resolutions bearing on famine relief, medical education, etc. were considered and adopted. I would request the several Council members from all our constituent branches to take a more lively interest in the affairs of the Council and to attend its meetings in much larger numbers and thus encourage the office-bearers in their difficult task of running such a vast organisation in an efficient manner. I take this opportunity of acknowledging the utmost goodwill and co-operation that I had the good fortune to receive from our two Presidents of the year, Dr. U. Krishna Rau and Dr. Y. P. Vasudevan, and from all the other office-bearers, but for whose encouragement and advice I would have found it more difficult to run the Provincial Office.

In this connection I would be failing in my duty to the Provincial Council and to the Provincial Association if I do not bring to their notice the difficulties experienced by the Provincial office because of want of a permanent staff. The work connected with this office is very much different from the routine office work turned out by the clerical staff in other offices. Our work entails some amount of intelligent study and understanding of our rules and of its working and a critical appraisal of the work done in the previous years. When the Secretary and the clerk happen to be new to this type of work, as it happened in the beginning of this year, the association work inevitably lags behind. Therefore I would strongly urge upon the Council to ratify the recommendations of the Council regarding a permanent staff adopted at the Courtallam meeting of the Council, so that my successor this year will not have to undergo the same difficulties which confronted me at the beginning. Before I close this subject, I may be permitted to acknowledge the efficient work turned out by the clerks of the Treasurer and the Secretary who have been of real help to us in the management of the Provincial Office.

The "Miscellany" :

I am sure that every member of our Association scans through the pages of the "Miscellany", the unostentatious official organ of our Association every month, not only because full reports of the proceedings of our branches which are of immediate local interest to us are being regularly published, not even because of the spicy 'Odds and Ends' that has been so assiduously selected by Dr. P. A. S. Raghavan, but also because of the valuable extracts from reputed foreign Journals and at times of really useful original scientific papers.

The publication of the "Miscellany" has been finally regularised at the meeting of the Provincial Council held at Karaikudi on 9—9—1951, and now the "Miscellany" is being published as our official organ by Dr. P. A. S. Raghavan on behalf of the Trichy Branch, and I hope that it will now be in a position to contribute a reasonable amount to the Provincial Branch out of the profits, if any.

In this connection I earnestly appeal to all our members, especially the Provincial Council members and the office-bearers to improve the finances of the "Miscellany." As it is, we are highly indebted to Dr. P. A. S. Raghavan

who is doing a grand job all by himself without any active help from others in publishing the "Miscellany." I am sure with the active co-operation of all of us, Dr. Raghavan will make it a premier medical journal in the South. My sincere thanks are due to him for publishing in full all the activities of our association and of our constituent branches.

Conclusion :

As I said before, the year has been an eventful one for our association. Much good work has been done in the former years, but much more remains to be done. The present health standards of the people of our State reveals a sorry spectacle. Stretches of innumerable villages are left without any qualified medical aid. The lower income groups of the population are not able to find the wherewithal to feed themselves in times of sickness in their families. It is upto our association to devise some plan by which for a stipulated minimum periodical payments, the people will be assured of medical aid in emergencies. The Employees State Insurance Scheme touches only the fringe of the whole problem in that it fulfils only partly the needs of the organised labour in the State.

These and several other problems are looming ahead of us and these can be tackled only by an association such as ours. It is my hope that the association will grow from strength to strength and will be able to justify the confidence imposed on it by the profession and by the public. Thank you.

COIMBATORE,
1-9-1952.

A. G. Leelakrishnan,
Hony. Provincial Secretary.

Announcement

"DR. R. B. KARNIK, Managing Editor, Indian Medical Journal is proceeding to Athens to attend the World Medical Editors' Meeting to be held on October 17, 1952. He will also be attending World Medical Association Meeting which will be held at the same place from October 12, 1952 as an observer. After attending these two meetings he will tour the Continent visiting important medical centres and will then proceed to United Kingdom. He will utilise his stay there in making a special study of the National Health Service."

COIMBATORE BRANCH

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

A General Body meeting of the Association was held on 2nd August 1952, at 6 P.M., in the Association premises with Dr. I. Pitchai Robert in the Chair. 65 members attended the meeting.

After Tea and light refreshments the Secretary read the minutes of the last meeting which were adopted.

Dr. Y. P. Vasudevan was unanimously elected as President and Drs. Vadamalayan of Madurai and Rama Iyer of Tirunelveli as Vice-Presidents of South Indian Provincial Branch of I.M.A. from this Branch.

The bye-laws of the Association as amended by the Sub-committee and approved by the Managing Committee were placed before the General Body. This was unanimously adopted by the General Body.

The General Body also gave permission to the Red Cross Society and Chemists and Druggists Association for the use of the hall for their meetings free of any charge.

The resignation of Dr. L. Munuswami from the Provincial Council was accepted with regret and recorded with appreciation the good work done by the member.

Dr. A. G. Leelakrishnan, proposed by Dr. C. V. Ramaraj and seconded by Dr. N. Jagannathan, was unanimously elected to the Provincial Council of I.M.A. in the vacancy.

Then the President requested the following Doctors to read their papers on symposium on 'Peptic Ulcer.' Drs. Jayakumar, N. Subramaniam, A. G. Leelakrishnan and Warriar took part in the discussion which were very much appreciated by the members.

With a vote of thanks to the speakers and the host of the evening Dr. J. K. Gnanaolivu, the meeting terminated at 9-30 P.M.

A monthly meeting of the Association was held on the 23rd August 1952 at 6 P.M. in the Association premises with Dr. I. Pitchai Robert in the Chair. About 70 members attended the meeting.

After tea and light refreshments the Secretary read the minutes of the last meeting which were adopted.

The following resolution was unanimously passed :—

"This meeting of the Coimbatore District Medical Association records with deep sense of sorrow at the sad and sudden demise of Dr. M. G. Kini, the Orthopaedic surgeon of International repute, a former superintendent of Stanley Hospital, Madras and Ex-President of the Association of Surgeons of India and requests the Secretary to convey the same to the members of the bereaved family."

Then the President introduced the speaker of the day Dr. V. Ramalingaswami, M.D., Ph. D. (Oxon) of the Nutritional Research Laboratories, Indian Council Medical Research, who gave a very interesting talk on 'Megaloblastic Anaemias'. He stressed the value and limitation of Folic Acid and Vitamin B. 12. in the treatment of these conditions. A lively discussion followed in which a few members took part.

With a vote of thanks to the speaker and the host of the evening Dr. (Miss) K. M. Jalajam, the meeting terminated at 8-30 P. M.

ERODE BRANCH

President: Dr. R. S. K. Raman
 Vice-President: „ E. S. Venkataraman
 Secretaries: { „ N. C. Kuppusamy
 „ M. N. Shenoy
 Treasurer: „ M. M. Shenoy

A Clinical Meeting of the Erode Medical Association was held at Sengunthar High School with Dr. R. S. K. Raman in the Chair. Dr. N. Jagannathan, Specialist in Tuberculosis addressed the gathering on 'Use and Abuse of Streptomycin.' There was a good attendance of doctors.

The learned lecturer dealt with various aspects in the use of Streptomycin. This drug which is a great asset to the practitioner and a boon to the patient, should be used with caution to get maximum results in Pulmonary Tuberculosis. One greatest drawback of the drug is, in the course of its administration, drug resistant strains of Tubercle bacilli develop. So to minimise drug-resistance, Streptomycin should be given with P. A. S. (4 grams 3 to 4 times a day) and the dosage should not exceed 30 grams at a stretch.

It is necessary to remember the absolute indications for the use of Streptomycin before undertaking treatment of Pulmonary Tuberculosis. These indications are:—

1. Minimal lesion in the Lung.
2. To control temperature and toxemia before starting the patient on collapse therapy like A.P.
3. In Miliary Tuberculosis
4. In Tubercular Broncho-Pneumonia
5. In Tubercular Ulceration of Larynx and Tracheo-Bronchus.
6. As an "Umbrella" for surgical treatment of Pulmonary Tuberculosis like Thorocoplasty and Lobectomy.

The drug is useless in chronic caseating type of Pulmonary Tuberculosis with cavitation as a feature.

For the ideal treatment of Pulmonary Tuberculosis, the general practitioner should take the advice of a specialist to plan out the amount of Streptomycin to be given before starting Collapse Therapy. Indiscriminate use results in:—

1. Rendering the patient drug resistant, so that at a time when Streptomycin is necessary as an adjunct to Collapse Therapy or Thorocoplasty the drug is practically useless.
2. The patient develops resistant strains of bacilli and if a contact develops tuberculosis, the drug is rendered useless for his treatment.

Though the drug has toxic effects like vertigo, tinnitus, giddiness, deafness, dermatitis and in rare cases ophthalmic symptoms like paralysis of external orbital muscles, diplopia and in rare instances even blindness, there is no doubt if wisely used with an eye on the limitation of its potentialities, Streptomycin is a useful weapon in the armamentaria of the general practitioner and the specialist alike in the fight against Tuberculosis.

In the discussion that followed Doctors M. N. Shenoy, T. S. Bhaskaran and P. N. R. Setty participated. With a vote of thanks by the Secretary Dr. M. N. Shenoy, the meeting terminated. Tea was provided by Dr. & Mrs. Bhaskaran.

MALABAR BRANCH

President: Dr. C. K. Menon
 Vice-Presidents: { „ C. V. Narayana Iyer
 „ A. Narayanaswami
 Treasurer: „ M. K. Koya
 Hon. Secretaries: { „ C. R. Parasuraman
 „ A. B. Das

A special meeting of the Malabar Branch of the Indian Medical Association was held at 5-30 P.M. on Thursday, the 18th September 1952 at the Hackett Wilkins Memorial Hall in the Old Headquarters Hospital Buildings Kozhikode.

Dr. C. K. Menon presided.

The meeting was arranged to meet Dr. M. V. Ramana Murthy, M.B.B.S., F.R.C.S., Deputy Director of Medical Services, Govt. of Madras.

The members were entertained to a Tea party by the Association.

The President after his introductory remarks requested the Deputy Director of Medical services to bestow the Hackett Wilkins Memorial Hall for the use of the Malabar Branch of the Indian Medical Association. The Deputy Director of the Medical Services assured the members that he will go into the records and do what is possible. Then he addressed the members of the Association stressing the importance on the patient-physician relationship and the personal hygiene and environmental sanitation.

The Hon. Secretary, Dr. C. R. Parasuraman, proposed a vote of thanks and the meeting ended.

TIRUNELVELI BRANCH

(Palayamkottai)

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

Meeting held at Courtallam
 on 26-7-1952.

A special meeting of the Tirunelveli Branch of the Indian Medical Association was held on Saturday 26-7-1952 at the Rock Hall at Courtallam when members numbering about fifty and about ten distinguished guests were present.

The day's proceedings began with breakfast at 7 A.M. after which the members went for a bath in the falls.

The members gathered at 9 A.M. for the meeting.

After the President introduced the distinguished lecturers of the day, the

Secretary read the minutes of the previous meeting.

Dr. K. Chintan Nambiar, F.R.C.S., (Eng.) F.R.C.S., (Edin.) then gave a lecture on "Recent Advances in Neuro-Surgery". He detailed the operation of Prefrontal Leucotomy for certain mental conditions as depressive maniac psychosis and paranoid type of schizophrenia. He described the operations recently developed for hydrocephalus in which short circuiting anastomosis of the third ventricle with the cisterna magna is done. He lastly described the modern concepts of low back ache with special reference to the prolapse of the nucleus pulposus and the operative

treatment for its cure. The lecture was followed by some discussion.

Then Dr. R. Subramaniam, B.Sc., M.D., M.R.C.P., (Lon.) read a paper on the "Management of Hypertension." Dealing with the introduction of the Riva Roccis Sphygmomanometer as the starting of an accurate estimate of blood pressure and discussing the possible causes in the production of high blood pressure, the lecturer dwelt at length with illustrative examples of how best to manage a case of high blood pressure. He described the use

of Methonium compounds in the treatment of hypertension and showed the effect of Hexa methonium bromide marketed as Vagolysin in 15 cases of hypertension treated by him personally. Other drugs as Choline, Nicotinic acid and Vit. A can at best be adjuvants to Hexa methonium treatment.

The meeting then came to an end with the President's concluding remarks and the vote of thanks by the Secretary.

At 12 noon, the members adjourned for lunch and the day's proceedings came to a close.

TANJORE BRANCH

President: Dr. N. R. Subramanyan
Hony. Secy., & Treasurer: „ S. Narayanan.

The monthly meeting of the Tanjore District Branch of the Indian Medical Association was held at the Medical School Buildings, R. M. Hospital, Tanjore at 4-30 P.M. on 31-8-1952. Dr. N. R. Subramanian, M.B.B.S. was in the Chair. Thirty-eight doctors attended.

After tea provided by Dr. (Mrs.) and Dr. Thommi, the minutes of the last meeting were read and adopted. The Secretary then announced that Dr. N. R. Subramanian has been elected as one of the Vice-Presidents of the South Indian Provincial Branch of the Indian Medical Association and congratulated him on behalf of the members present. Correspondence and communications from the Provincial office were then read out. Condolence resolutions on the death of Dr. M. G. Kini and Dr. M. A. Nair were passed. The house then proceeded to the election of one president and three vice-presidents to the Indian Medical Association from among those nominated to those offices and delegates to the ensuing provincial conference at Palayamkottai.

Dr. V. S. Annaswamy, B.A., M.B.B.S.,

of Shiyali then spoke on 'Some Aspects of Hypertension'. He said that Hypertension was variously classified as Essential and Malignant, Simple and Papillomatous and Primary and Secondary. To determine the exact significance and course of hypertension, various factors like Blood Chemistry, Urine analysis, examination of the Fundus of the eye, X-ray of chest and Electrocardiogram, and stability of pressure, Renal function, and Capillary Fragility had to be studied. The causative factor may be Renal, Cardiac, Endocrine or Neurogenic. Coming to the treatment, the lecturer said that there should be moderation in all things and nervousness should be combated. A diet of rice, fruits and milk was advocated. Sedation was important. He commended the use of Vitamin P and Rutin for Capillary Fragility and the use of Hexamethonium Tartarate for controlling the tension.

After the President's concluding remarks, the meeting terminated with a hearty vote of thanks to the lecturer and the hosts of the evening.

(continued from 2nd cover page)

The Reception Committee of the 29th All India Medical Conference, Patna, earnestly appeal to you to contribute useful papers, demonstrate interesting cases and put up illuminating exhibits on the occasion and to take part in the symposia.

Reception: There will be Reception office at the Patna Junction Rly. Station just opposite the First and Second Class booking office. There will also be a Reception office at the aerodrome for persons travelling by air to Patna. Volunteers will be available at these reception offices who will give necessary informations and arrange transport. Arrangements for lodging and boarding will be made if previous intimation is received by the General Secretary not later than 15th November 1952.

Railway concession: Delegates and visitors wishing to attend the Conference should apply for necessary certificate to the General Secretary, on the production of which at the nearest D. T. S. Office, single fair double journey concession authority slip for any class will be obtained. Production of this authority at the railway booking office will enable them to issue concession tickets.

ODDS & ENDS

Obesity is surplus gone to waist.

♡ ♡ ♡

A surgeon in Canada with an assumed name, who was publicly commended for a series of delicate operations was discovered to be a former hospital orderly with no medical schooling.

♡ ♡ ♡

Patient in a Mental Hospital seeing a new man:
Hullo, friend, what is the matter with you?

Doctor: I am the new Superintendent of the hospital.

Patient: Don't worry, brother. That is what I also thought when I came here first. Now I am nearly all right.

♡ ♡ ♡

"How many children have you?"

"Two boys and two girls."

"Four, all together?"

"Oh no, only one at a time."

♡ ♡ ♡

"Can you tell the sex of the flies over there?"

"No! can you?"

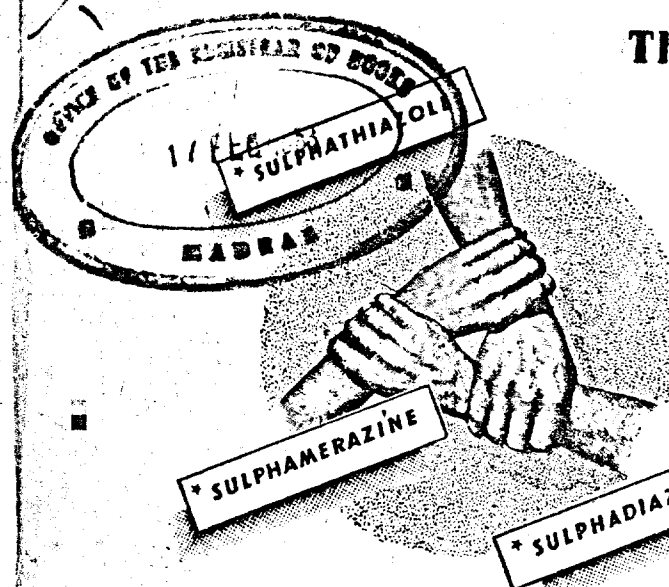
"Quite easy. Those on the whiskey bottle cork are males and those on the mirror are females."

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

THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

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



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29th ALL INDIA MEDICAL CONFERENCE

OF

INDIAN MEDICAL ASSOCIATION

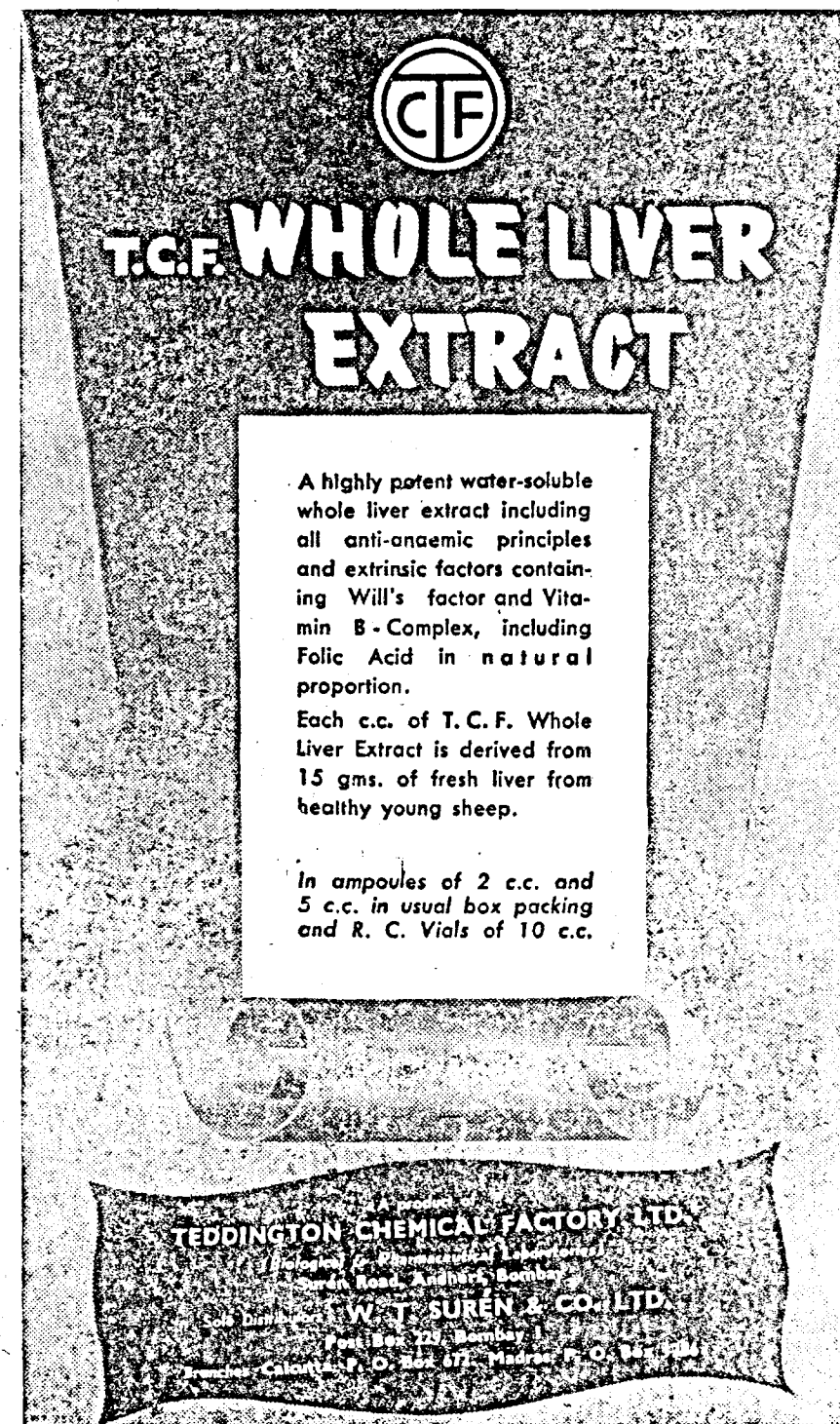
PATNA

The 29th All India Medical Conference will be held in Patna on the 26th, 27th and 28th December 1952. On this occasion a scientific section of the Conference will be organised. Subjects for papers include Medicine, Surgery, Obstetrics and Gynaecology, diseases of the Eye, Ear, Nose and Throat, Pathology, Pharmacology, Preventive Medicine and Medical Jurisprudence and Toxicology, Anatomy and Physiology. Three topical subjects have been selected for symposia namely (1) Place of Antibiotics and Chemotherapeutic drugs in the treatment of tuberculous infection (2) Management of heartfailure and its complications and (3) Bowel disorders.

Facilities for epidiascope and microprojection will be available. Arrangements will be made for the exhibition of interesting pathological specimens and skiagrams.

Eminent leading personalities and leaders of the profession from all over India are being approached to inaugurate and preside over the scientific sessions respectively.

(continued on 3rd cover page)



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THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
THE INDIAN MEDICAL ASSOCIATION

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[No. 5

DISEASES OF THE PROSTATE AND THEIR TREATMENT

BY

MAJOR P. GOVINDA RAU, M.B.B.S., F.R.C.S.

Associate Member of the British Association of Urological Surgeons.

(continued from previous issue)

Benign hypertrophy of the prostate occurs in from one third to one fifth of all men over fifty years of age.

of the bladder occurs in the same age group.

Many theories have been advanced as to why the prostate tends to hypertrophy with age. The chief theories are (1) that the hypertrophy is due to true tumour formation; (2) that it is a fibroepithelial growth akin to Myoma of the uterus; (3) it is due to a cystic glandular hyperplasia having its basis in infection of longstanding; and (4) the hyperplasia is endocrinopathic and due to an improper balance between male and female hormones. Benign hypertrophy of the prostate affects most frequently the middle and the lateral lobes of the prostate.

Symptoms. An alteration in the act of micturition is one of the earliest features of the disease. If the patient is watched when he passes urine, we see a slow vertical stream of urine with delay in *starting* and terminal dribbling. Increased frequency of micturition especially annoying in the early hours of the morning is the symptom which disturbs the patient most. Pain is usually absent and its presence should arouse the suspicion of infection or stone. Haematuria, if present, calls for complete investigation as cancer

Rectal examination still provides the most reliable sign on which the diagnosis is based. It should be done after micturition, when some idea of the residual urine (in the bladder as a result of the hypertrophy and consequent obstruction) may be obtained. The patient is best placed lying on his back, with hips and knees flexed and legs separated; then with the index finger of the right hand in the rectum, and the left hand pressed into the hypogastrium, it is possible to get an idea of the residual urine as well as an idea of the intravesical projection of the prostate in thin individuals. Backward projection of the prostate can be felt easily, and the increased width of the gland also must be tested by passing the finger from side to side. The consistence of the adenomatous prostate is the same as that of the thenar muscles with the thumb outstretched. True tenderness is more often felt in carcinoma than in benign hypertrophy.

General physical examination with special reference to the cardiovascular system is necessary. Cerebral arteriosclerosis with sluggish mentality is a most serious condition. A crystal clear

urine will show absence of gross infection, and a high (1020) or a low (1002) Sp. Gravity indicates absence of serious renal impairment. A fixed specific gravity of 1010 is a sign of serious renal damage, and the presence of albumin in the absence of pus is also a danger signal. It is best to avoid instrumentation until immediately before operation.

Complications. Infection and stone formation may occur. Infection is to be avoided by not using a catheter as far as possible, and when it has to be used doing it very carefully. The most important complication is, however, retention of urine, which may be chronic or acute. Retention of urine is so common as a presenting symptom in cases of hypertrophy of the prostate that it is necessary to take up the problem of its management in detail.

Acute retention is of sudden onset and is painful. It follows congestion or may even be due to enforced holding of urine, when the call comes. A painful acute retention may be superimposed on a degree of chronic retention. The clinical picture of acute retention is unmistakable. There is a constant urge to micturate, but inability to expel more than a few drops, with severe pains in the penis and lower abdomen. The relief when the bladder is emptied is dramatic. By contrast, chronic retention is relatively painless, and the patient may have no idea at all that he has an abdominal swelling.

Treatment of acute retention: (1) The usual hot hipbath and a morphine suppository is not likely to help. (2) A catheter may be passed. The passage of a catheter, however, should be regarded as of the same importance as a major operation. Avoidance of trauma with its attendant sequela of rigors and sepsis is of prime importance. This is to be achieved by injecting about 10 c. c. of water-soluble lubricant (the K. Y. Jelly as sold by the I. C. I. is easily available) into the

urethra, by means of a record syringe, to which a rubber nozzle has been fitted. The glans penis is compressed to prevent the jelly escaping. The beak of the catheter (No. 8 or 9 English size) the open end of which has been closed with an artery forceps, is now introduced into the meatus and digital compression of the glans immediately applied. The catheter is now advanced along the urethra, and as an air lock is present in the catheter as a result of the closure of its end, a column of lubricant is pushed in front of the catheter. This acts as a dilator of the mucous membrane, removing any folds or light obstruction, which may impede the passage of the catheter. After the catheter is passed, urine is let out and the bladder irrigated with 1 in 10,000 Silver nitrate, or 1 in 8000 Acriflavine. In acute retention, complete decompression of the bladder can be carried out at once without any danger. (3) When catheterization has not succeeded, suprapubic aspiration must be carried out. This is done by, first assuring ourselves that there is definite bladder dulness, as made out by percussion, for about three inches above the pubic symphysis. Then, a little local analgesic is injected 1 inch above the pubic symphysis in the middle line, and a spinal needle is pushed in and the bladder is aspirated. When very essential, this procedure may be repeated, although a different site should be used for the puncture, and the bladder should not be allowed to get as much distended as the first time. The patient should be sent for specialist treatment without any more delay.

Carbachol is unlikely to relieve retention when there is mechanical obstruction. Once retention is relieved, it is likely to recur and so radical treatment should be carried out at an early date.

Chronic retention. As mentioned above, this is the more dangerous condition of the two. The patient is

often aware of the distended bladder and has all the symptoms of uraemia. At present, it is considered, that sudden decompression of such a bladder also is not dangerous, but accidents have happened, and it is better to treat the condition with great respect. The new school considers that the dangers are only due to infection, and if infection is controlled there is no danger of renal failure, whereas, the conservative school regards that sudden decompression may cause intrarenal haemorrhage and tubular blocking, because of the sudden release of tension on the renal blood vessels, which had become adapted to the increased pressure. Preliminary decompression may be carried out by indwelling catheter, suprapubic cystostomy or suprapubic catheterization. Every one of these procedures is associated with a certain degree of mortality of which the highest is as a result of suprapubic cystostomy.

For the indwelling catheter, a Foley catheter can be used or an ordinary catheter can be tied in. Slow decompression is carried out by first letting out only 15 Ozs. of urine and closing the catheter with a spigot; two hours later another 10 Ozs. of urine is removed and this is repeated at the same intervals until the bladder is emptied, which may take place in about 48 hours.

Suprapubic catheterization has been recommended as a safe method, and it leaves the abdomen free from scar for the subsequent radical operation. This is done when the bladder contains at least about 15 Ozs. of fluid, which leaves an area of about three inches above the pubes, which is bare of peritoneum. Under local anaesthesia, an incision is made over the middle line 2 inches above the pubes, the rectus separated, the bladder punctured with a trocar and cannula under vision, (the cannula being of sufficient size to admit a No. 10 English size catheter), trocar pulled out, the 10 E catheter pushed in through the cannula, which

latter also is pulled out carefully leaving the catheter in place. This catheter is held in position by a stitch through the skin the ends of which pass twice through the catheter. This catheter is now connected to a drainage apparatus for two days after which it can be closed with a spigot and the patient allowed to move about.

Recently Wilson Hey has popularised immediate prostatectomy for retention of urine, both acute and chronic. A follower of his method, has quoted a mortality of only 2% in a series of 50 cases following immediate prostatectomy in such cases. These are excellent figures and have been possible with the frequent use of blood transfusions during operation and the employment of antibiotics chief of which has been streptomycin. Even here Wilson Hey's mortality figures have been instructive. Where the Blood Urea was below 80 Mgm. per 100 c. c. it was only 3.4%; between 80 and 200 Mgm. per 100 c. c. it rose to 16.1%; and over 200 Mgm. blood urea the deaths were 4 in 6 cases. Some of these latter cases may have been saved by preliminary drainage and so the two stage methods are still, especially in our country, of great use.

For the uncomplicated case of prostatic enlargement, a preliminary investigation is carried out. A blood urea estimation gives a reasonably good idea of the degree of renal impairment. An intravenous pyelogram gives complete information as to the degree of kidney secretory activity. (Occasional polycystic kidneys are thereby diagnosed and operation with its inevitable fatal outcome avoided.) It also gives an idea of the intravesical projection of the adenoma. The presence and nature of any infection present should also be determined.

Treatment. Early cases (it is hard to get them) have no obstructive symptoms. I had one such from whom I had removed a vesical stone; he was

of the prostatic age and he had a large sized adenoma; prostatectomy was not carried out as the patient was a paralytic and his heart was not good; in this patient, the frequency and recurring infection were kept under control by passing a fairly stiff rubber catheter (about 12 E size) and giving vesical irrigations once a week. Periodical dilatations of the urethra and the vesical neck and urethrovesical irrigations are helpful in many of these early cases.

Hormonal treatment. As mentioned above among the theories of causation of prostatic hypertrophy, a popular one is that the condition is due to an improper balance between the male and the female hormones. (in both the males and females there is present both male and female hormones; in the male the female hormone is said to be derived from the Sertoli cells of the testis). Both testosterone and oestrogens have been used in the treatment of prostatic hypertrophy. Testosterone produces slight improvement because of an increase in bladder tone, but it is a dangerous drug to use as it might activate latent cancer rests which are commonly found associated with adenoma of the prostate. Claims have been made about the beneficial effects of oestrogens in the treatment of hypertrophy. The most promising line of experimental work, however, is believed to be concurrent administration of male as well as female hormones, but the proportion in which they have to be given in order to restore the disturbed balance remains to be determined.

X-ray therapy has been used with definite alleviation of symptoms but is no substitute for surgery.

Surgical treatment is necessary whenever there is more than 2 Oz. of residual urine, in a case of enlargement of the prostate. The methods available are:—

(1) Transurethral resection,

(2) the Punch method as used in the Mayo Clinic,

(3) Suprapubic prostatectomy,

(4) Perineal prostatectomy,

(5) and the last and anatomically the best, the Retropubic prostatectomy.

Transurethral resection requires costly equipment, is not to be undertaken lightly heartedly, recurrences are frequent and very tight strictures are likely as a postoperative sequel. On the other hand, resection can be undertaken in patients who are not likely to stand open operation.

The Punch method has as its adherents only those of the Mayo Clinic and their disciples.

The suprapubic operation is the one commonly performed. The perineal approach has never become popular outside of America. The retropubic approach, revived by Millin, has been advocated by him as the ideal approach for the prostate. It goes at the prostate directly through the Space of Retzius, formerly considered so dangerous, and it is a very suitable approach also for the complete removal of the prostate.

The average mortality of prostatectomies in these days ought not to be more than about 5%. Two important features of present day operations are the employment of Streptomycin to prevent infection, and the use of gelatin sponge to stop haemorrhage from the prostatic bed.

Marion's disease or bladder neck stenosis. This condition also known as "Prostatism sans prostate" occurs in a younger age group. Although they show all the symptoms of a prostatic enlargement, rectal examination however does not reveal any sign of prostatic enlargement. A rubber catheter gets held up at the level of the neck of the bladder and gives us the diagnosis. Panendoscopic examination will give a correct picture distinguishing

the condition from a stricture of the urethra. Treatment. Most cases are relieved by periodical passage of large sized metal sounds and vesical irrigations. Radical treatment is by transurethral resection or after a retropubic exposure a V shaped excision of the posterior lip of the vesical neck.

Carcinoma of the prostate gland.

According to Young, a fifth of the male patients who seek relief, for obstruction of the vesical neck, have carcinoma of the prostate. In autopsies on men over 50 years of age, carried out at the Johns Hopkins Hospital, Baltimore, 14% showed carcinoma of the prostate, and of these 68% had not shown any symptoms. Thus it is that is only in 5% of cases is diagnosis made sufficiently early for radical treatment to be carried out successfully. However with the present method of treatment suffering may be lessened and life prolonged even in the other cases.

As with carcinoma elsewhere, aetiology of prostatic cancer is unknown, but a very important relation has been shown between androgenic hormones and carcinoma of the prostate.

Prostatic carcinoma is insidious and slow growing, and may remain confined to the prostate for long periods, but there is a high frequency of skeletal metastases and the pelvis and the lumbar vertebrae are specially affected.

Symptoms are the same as in benign hypertrophy. However, advanced prostatic cancer, arising as it does most commonly, in the posterior lobe of the prostate, may show no urinary symptoms. Pain referred to the sacroiliac regions, penis or scrotum is a relatively early symptom, and may be due to bone metastases.

Diagnosis. Responsibility for the early recognition of prostatic cancer falls primarily on the general practitioner. A routine check up of men over 45

years of age should include a rectal examination. Especially important is this procedure, when the patient complains of urinary symptoms.

Rectal palpation reveals a board like hardness of the prostate. In some cases a single hard nodule may be felt. Occasionally the nodule has ridges and this is specially characteristic of cancer.

This clinical diagnosis has to be checked by other methods before it is confirmed. Semple has shown that in a series of 62 cases considered as malignant by clinical examination, only 34 were found to have cancer. The other methods are radiological examination, serum phosphatase estimation, examination of the prostatic secretions, and biopsy.

X-ray skiagrams of pelvis and lumbar vertebrae reveal spotty areas of increased density in the presence of metastases. They are commonest in the rami of the pubes and ischium, then the ilium and sacrum, and lastly in the lumbar spine.

Serum acid phosphatase estimations are useful evidence of cancer; when the readings are above 10 King and Armstrong units. But in only 40 to 50% of cases of cancer of the prostate are the readings raised. In Semple's series, in 15 cases with secondary metastases, only 6 showed readings above normal limits.

Examination of the prostatic secretion, derived either by massage, or by centrifuging the early morning urine, show evidence of malignancy of the prostate (the stained prostatic smear shows larger cells with deeply stained multiple nuclei.) but this is found in only about 50% of malignant prostates.

The only conclusive evidence is said to be a needle biopsy of the gland (got from a special instrument passed through the perineum into the prostate) or examination of material derived by perurethral resection.

Treatment. Total prostatectomy by the perineal or the retropubic route may be done for the few early cases. Transurethral resection will give relief in other cases.

Radon seeds can be implanted in the prostate after a conservative perineal prostatectomy. Surface application of radium and deep x-ray therapy have been used in some cases.

Hormonal therapy. Dr. Huggins of Chicago was the first to show that carcinoma of the prostate was responsive to depression of the level of the androgenic hormones in the organism. He suggested elimination of the gonadal androgens either by castration or by neutralizing their activity by oestrogen therapy. In 21 patients who were castrated, 15 showed great clinical improvement as evidenced by marked diminution of pain, increase of body weight shrinkage of the primary lesion and regression of metastases. Castration can be carried out aesthetically. Dr. Lowsley's method is not to do an orchidectomy, but to incise the tunica albuginea, scrape out all the testicular tissue, leave a bit of fat in the empty cavity, and sew up the incision. This procedure does not cause any psychic trauma to the patient. Supervoltage irradiation of the testicles may also produce the same results.

Administration of the female sex hormones is routine treatment in cancer of the prostate with skeletal metastases. This inactivates the gonadal androgens and sometimes even after castration, it may be necessary to deal with

androgens still in the body. It is administered as follows: stilboestrol in one Mgm. doses is given t.d.s. on the first day; two Mgm. t.d.s. on the second day and so on to 5 Mgm. on the fifth day. The dose of 15 Mgm. daily is usually sufficient. It may be gradually reduced to 5 Mgm. or less daily according to progress. This maintenance does must be continued indefinitely. If signs or symptoms reappear it is sometimes effective to increase the dose again, even to 100 Mgm. daily. Because of the favourable initial response, it is sometimes justifiable to use stilboestrol for therapeutic trial in a case of doubtful malignancy; but if there is no improvement after about three weeks trial, other means have to be adopted. Side effects of this treatment are enlargement of the breasts and pigmentation of the areola; the testes become small and erections are absent, occasionally there may be nausea. These reactions are too significant considering the seriousness of the disease and the only permissible thing to do is to change to some other form of the female sex hormone. It must however be remembered that in a certain proportion of cases this treatment is of no use.

In this paper the common diseases of the prostate have been described and details of such of these procedures only as can be carried out by a general practitioner mentioned. It will be seen that in the hands of this backbone of our profession lies most of the diagnosis and much of the treatment of diseases of the prostate.

(Concluded)



ASSOCIATION NOTES

ANAMALLAI BRANCH

On the second anniversary in April, of the Anamallai Medical Association, after it was formed as a separate branch of the I. M. A. The following Office-bearers were elected for the year.

President: Dr. P. Dharmapal
Vice-President: „ M. K. R. Jayachandran
Hony. Secretary: „ K. John
Joint Secretary: „ P. A. Narayanan

The total strength of the Association now is 15, though it was only 14 in April. One of the old members of the Association, Dr. Myellappa Mudaliar passed away during this period.

Below is given the details of the meetings etc., held during this period.

Date.	Particular.	Host & Place where meeting was conducted.
27-4-52.	Annual Meeting—After adoption of previous year's report and accounts, Dr. S. Dorai Raj, retiring President gave a talk on various topics of medical interest concerning Plantation Medical Practice	... Pachaimallai Estate.
25-5-52.	Talk on 'Anti Biotics' by Dr. M. K. R. Jayachandran	... Dr. P. Dharmapal, Mudis.
21-6-52.	Show of Medical Film, Respiratory and Cardiac arrest; Handling and care of Patients; Operative shock; and Physiology of the Kidney	... Dr. Krishnamoorthy, Sholayar.
26-7-52.	Talk on 'Malignant Malnutrition' by Major R. S. Rao of Coimbatore	... Dr. P. G. George, Pannimade.
24-8-52.	Talk on Obstetric Shock by Dr. Gopalswamy	... Cinchona Doctors, Cinchona.
21-9-52.	'Redness of the Eye' by Dr. S. P. Subramaniam	... Dr. Narayanan, Iyerpadi.

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 Association was held at the S. M. S. High School, Karaikudi on 26-10-'52 at 5 P.M. Dr. S. Subramaniam, M.B.B.S. presided. After tea interesting case reports were given.

Dr. T. S. Shetty, M.D. spoke about the prevalence of Diphtheria and its seasonal incidence. His experience for the last 3 years in a municipal town made him believe that a sort of epidemic occurred in during September to November. He said that a thorough examination of cases should be done and gave instances of cases proving fatal due to late attention. He requested doctors to forget the theory that Diphtheria is rare in these parts.

Dr. D. O. Sendel, M.B.Ch.B. M.R.C.S.,

agreed with Dr. Shetty and said that in his hospital also there is a seasonal prevalence of Diphtheria during September to November.

Then Dr. S. Subramaniam read an interesting case report of a full term Vesicular mole for which a Caesarian section was done and 3 case records of Rupture of Uterus. There was a discussion about these cases in which the members took part.

After this there was a Film Show on 'Intravenous Anaesthesia' which was appreciated by the members. The film was kindly supplied by I. C. I. With a Vote of Thanks to the School authorities and to the I. C. I. the meeting terminated.

COIMBATORE BRANCH

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

A meeting of the Association was held on 12th October 1952 at 4-30 P.M. to meet Sri. A. B. Shetty, Minister for Health, Government of Madras. About 90 members attended the meeting.

Dr. I. Pitchai Robert, the President of the Association presided and members of the Managing Committee were at home. After light refreshments, the President welcomed the guests and presented a Memorandum. He requested the Minister to help in securing the adjacent site which was proposed

to be sold to us by the Municipality but the approval of the Collector was delayed. He also mentioned the opinion of the Association against the proposed scheme to introduce a short medical course. He suggested to the Minister that in all matters concerning the public health, the Government may consult the official representatives of the Indian Medical Association.

The Minister in his reply promised to consider the request about acquiring the site and their request to consult

the representatives of the Indian Medical Association. Regarding the proposed scheme for introducing a short medical course, the Minister defended the scheme as at present the rural medical relief is not properly given for want of medical men in rural areas and he hoped by some sort of compulsion the medical men trained in this scheme may go to the villages.

With a vote of thanks by Dr. R. Sundararajan the meeting terminated at about 6 P.M.

**

The monthly meeting of the Association was held on the 13th October 1952 at 6 P.M. Dr. I. Pitchai Robert presided and 80 members attended the meeting.

After light refreshments, the President introduced the speaker, Dr. P. Arunachalam, M.D., M.R.C.P. (Lond.),

D.M.R., T.D.D., Director of Medical Services, who gave a very interesting talk on "Nocturnal Symptoms" which was very much appreciated by the members. He also requested the members to lend their support for the proposed scheme to introduce BCG vaccination shortly in Coimbatore. He made it clear that it is absolutely harmless and this will be one of the Anti-tuberculosis measures in addition to other measures like improving general standard of health and providing more beds for tuberculosis patients.

The President in his concluding remarks thanked the speaker and promised to lend all support for introduction of BCG vaccination.

With a vote of thanks by the Secretary to the speaker and to the host of the evening Dr. N. Jagannathan, the meeting terminated at 8-30 P.M.



LATEST TREATMENT MYOCARDIAL DAMAGE

MYOCARDIAL DAMAGE does not respond to sedatives, stimulants, analeptics and other usual routine treatment. If the damage to heart muscle is not remedied in the early stages, it may lead to cardiovascular diseases.

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MADURA BRANCH

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

A monthly meeting of the Association was held on the 25th October, 1952 at the Government Erskine Hospital, Madurai. Dr. M. N. Rajan occupied the chair. The minutes of the previous meeting were read out and adopted. On behalf of the Association Dr. M. N. Rajan congratulated Dr. N. Suryanarayanan on his election as a Councillor of the Madura Municipality. The following resolution moved by the Honorary Secretary and seconded by Dr. K. G. Ramabadrnan was passed unanimously.

"Resolution No. 1. This meeting of the Association authorises the Governing body to scrutinise the final bill of the contractor and to pay the amount due to him now as per terms of the contract. The expenses incurred over and above the schedule of estimate attached to the agreement are approved subject to final audit."

This meeting further authorises that the Governing Body to incur such other expenses in connection with the building such as required for electrification, furniture etc. as it considers necessary. A sum of Rs. 356 is also sanctioned from out of the General Funds for purchase of furniture for the building".

Moved from the chair it was "Resolved the Sub-Committee of the Association consisting of the following members with powers to co-opt others if necessary as recommended by the Governing Body, be constituted to conduct the Silver Jubilee Celebrations of the Association early next year."

List of Members of Silver Jubilee
 Committee

1. Secretary Dr. P. Krishna Menon-
 Convener,

2. President Dr. M. N. Rajan—Chairman.

3. Dr. T. S. Renga Iyengar.
4. " P. Vadamalayan.
5. " S. V. Joseph.
6. " K. A. Kalyanam.
7. " K. Balasubramaniam.
8. " N. Suryanarayanan.
9. " G. A. Naidu.
10. " A. S. Annamalai.
11. " M. Venkatachalam Chetty.
12. " K. Ramachandran.
13. " K. S. Krishnan.
14. " T. V. Venkatesan.
15. " M. S. Yegnanarayanan.
16. " K. G. Ramabadrnan.
17. " M. S. Krishnamurthi.
18. " N. Krishnamurthi.
19. " K. Gopal.
20. " K. Balakrishnan.
21. " A. Narayana Menon.
22. " Muhammed Ismail.
23. " Miss. G. A. Kennett.
24. " H. S. Thomas.
25. " K. P. Joseph.

The Secretary then placed before the members circulars Nos. 33, 34, 39, 40 and 43 of 51-52 of the Central office of the Indian Medical Association and the circular letter from the General Secretary of the Reception Committee of the 29th All India Medical Conference, Patna, for information.

The President then called upon Dr. P. A. Menon, F.R.C.S., District Medical Officer, Southern Railways, Golden Rock to deliver his lecture on "SOME COMMON SURGICAL CONDITIONS". The Lecturer referred at the outset to two Conditions in infants viz., irritation and ulceration of the prepuce of the orifice due to ammoniacal decomposition of urine and the umbilical polypus (adenoma) and described their treatment. He then explained

the rationale of treatment in common to his recent experience with the ex-injuries such as contusion, hematoma, abrasions, cuts, and wounds; and modern trends in their treatment and next The lecture was followed by a very outlined the therapy of boils, cellulitis fruitful discussion. The meeting terminated after a vote of thanks.

THE INDIA THORACIC SOCIETY, MADRAS

The above Society has been formed and registered under the Societies Registration Act 1860, and its present headquarters is Madras.

Membership is of three categories:—

Ordinary Members. Medical Practitioners registered in India and practising the Speciality of Chest Diseases, either by itself or along with general medicine, shall be eligible for membership under this category.

Associate Members. Persons engaged in the practice of branches of medical science auxiliary to chest diseases, may be admitted as Associate Members.

Honorary Members. Persons deemed by the Governing Body to be suitable and desirable for membership of the Society, may be enrolled as Honorary Members.

Life membership fee is Rs. 100/-, Ordinary membership fee is Rs. 12/- per annum and Associate Membership fee is Rs. 6/- per annum.

The next meeting of the Society will be held on Saturday the 5th Dec. 1952, in the Common Hall of the Madras Medical College.

For further information apply to:

368 China Bazar Road,
 G. T., Madras 1.

DR. D. DAMODAR DAS, M.B.B.S., T.D.D.
 Organising Secretary.

Telephone: 55470

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Proceedings of the meeting of the South Arcot Branch of the I.M.A. held at
Cuddalore on 30th September 1952

The Annual meeting of the South Arcot branch of the Indian Medical Association was held in "The Hindu Hostel" on 30th September 1952.

The following members were newly elected to the Committee for the year 1952-53.

President: Dr. S. Soundararajan,
District Medical Officer, South Arcot

Vice President: „ P. Vaidyanathan, Cuddalore

Secretaries: „ N. D. Ramaswamy
„ N. Ramachandran

Members of the Committee: „ V. Viswanathan
„ K. G. Sadagopan
„ Miss. Radha Bai
„ Janakiram
„ C. S. Swaminathan

Members to the Central Council: „ V. Krishnamurthi, Cuddalore
„ P. Vaidyanathan, Cuddalore

Members to the Provincial Council: „ V. Krishnamurthi
„ Seshachalam Naidu, Cuddalore O.T.

**Representative on Hindu Kush
Nivaran Sangh:** „ S. Sankara Raman, Cuddalore O.T.

Dr. K. S. Sanjeevi, M.D. Professor of Medicine, Medical College, Madras, who had been specially invited to address the Association, spoke on "Common Medical Problems in South India" and dealt with diseases like Malaria, Amœbiasis, Infective Hepatitis, Diabetes, Hypertension, and some of the common lesions of the lung, as Tuberculosis and Esinofelia of the lung. He dealt with some of the cardinal symptoms of the above diseases and mentioned the latest lines of treatment.

The members of the Association had "Tea" before the meeting and dinner at night.



SOUTH ARCOT BRANCH

Secretaries: { Dr. N. Ramachandran
„ N. D. Ramaswami

A Monthly Meeting of the South Arcot Branch of the Indian Medical Association was held in the premises of the Government Hospital, Cuddalore N.T., on 25-10-52 with Dr. S. Sundara Rajan, M.B.B.S., in the chair.

After 'Tea' and 'Business', Dr. M. Santosham, M.B., F.R.C.S., of Santosh Memorial Tuberculosis Sanatorium, Madras, who had been specially invited, spoke on the "Drug Treatment of Tuberculosis".

Of the drugs that were in use during the previous years, medicines like Calcium, Cod Liver Oil, Thiocal, Creosote, etc., have no place in the modern line of treatment except that Calcium could be of some use in Haemoptysis.

"Gold" which had been used with some success has nowadays been for-

gotten. He stressed that Gold has still a place in the treatment of Non-Toxaemic Exudative type of Tuberculosis.

The Modern medicines are Streptomycin, PAS and Isonicotinic Hydrazide. The Doctor emphasised on the value of these drugs and how and when these drugs are indicated. He advocated the value of injection of 1 gm. Streptomycin every third day—the course to run for 90 days, over the other shorter and intense course of treatment. With all the advantages, the above drugs can claim, still they can only stun and stupify the T. Baccilli, but not kill them.

There was a lively discussion before the meeting terminated.

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**Resolutions passed at the open session of the 7th South Indian Provincial
Medical Conference held at
Palayamkottai on 22nd September 1952**

1. This Conference places on record its deep sense of sorrow at the demise of the following members of our Association during the year:

1.	Dr. P. S. Varadarajan	—	Madras
2.	„ D. Srinivasan	—	Trichy
3.	„ R. Krishna Iyer	—	Coimbatore
4.	„ K. N. Ramanathan	—	Coimbatore
5.	„ U. Rama Rau	—	Madras
6.	„ K. Govinda Iyer	—	Tinnevely
7.	„ G. S. Katre	—	Madras
8.	„ M. A. Nair	—	Madras
9.	„ M. G. Kini	—	Bombay

Moved from the chair.

2. This Conference congratulates all the members of the medical profession who have been elected to the Parliament and to the various State Legislatures in the country and those who have been shouldering the responsibilities of the administration.

Moved from the chair.

3. This Conference views with concern the reported move of the Government of Madras to turn out Medical Men in three years by giving training to young people in the Government Headquarters Hospitals which is fraught with danger as these young men will not be equipped with sufficient basic knowledge and will not necessarily settle in villages.

Proposed by: Dr. P. A. S. Raghavan

Seconded by: Dr. N. Chandrasekar

4. This Conference resolves to request the Government of Madras to treat the attendance of their service personnel at the District Medical Association meetings as on duty and attendance at the Provincial and All India Medical Conferences of the India Medical Association as on special casual leave whenever they attend such meetings.

Proposed by: Dr. R. V. Chokalingam

Seconded by: Dr. T. S. Balasubramania Iyer

5. This Conference requests the Government of Madras to Provincialise all Allopathic Medical Officers in the State including the Local Fund and Rural Medical Officers at an early date.

Proposed by: Dr. T. S. Tirumurthi

Seconded by: Dr. P. A. S. Raghavan

6. This Conference resolves to request the Government of Madras to implement the proposals of the Public Health Conference of 1947 regarding the increase in the emoluments of the teaching staff in the Medical Colleges of the State at a very early date.

Proposed by: Dr. K. C. Nambiar

Seconded by: Dr. R. V. Chokalingam

7. This Conference requests the Government of Madras to consult the Provincial Council of the Indian Medical Association on all matters of Medical Relief, Medical Education etc. and to include the representatives of the Association in all their Committees pertaining to Medical and Health problems.

Proposed by: Dr. K. C. Nambiar

Seconded by: Dr. R. V. Chokalingam

8. (a) This Conference places on record its deep appreciation of the excellent work done by the Tinnevely branch of the Indian Medical Association in organising the 7th South Indian Provincial Medical Conference at Palayamkottai and in looking after the visitors, delegates, and members of the Provincial Council and making the Conference a grand success.

Moved from the Chair.

(b) The Conference places on record its appreciation of the help given by the authorities of the St. John's College, Palayamkottai and thank them for their co-operation.

Moved from the Chair.

(c) This Conference places on record its appreciation of the help given by the Volunteers, the Sanitary and Health Staff, the Police and others during the Conference.

Moved from the Chair.

A. G. Leelakrishnan,

Hony. Provincial Secretary.

TIRUCHY BRANCH

President: Dr. R. Kalamegham

Vice-President: „ L. S. Ramachandran

Secretary: „ A. Dharmarajan

Treasurer: „ T. V. Sundaram

A monthly meeting of the association was held on Wednesday the 3rd September 1952 in the premises of the District Board Meeting Hall, West Bouliward, Tiruchirapalli under the presidency of Dr. R. Kalamegham. About 50 members were present. After Tea kindly provided by Dr. T. V. Ranganathan and Dr. T. M. Krishnamurthy, the President moved the following condolence resolution and it was passed all members standing for 2 minutes. "This meeting of the Tiruchirapalli District Medical Association records with deep sense of sorrow at the sad and sudden demise of Dr. M. G. Kini, the Orthopaedic Surgeon of International repute, a former Superintendent of Stanley Hospital, Madras and an Ex-President of the

Association of Surgeons of India". Then the President informed the members that one President and 3 Vice-Presidents should be elected for the I. M. A. Centre for the coming year and read out the proposed names sent by the Centre. Dr. B. V. Mulay of Sholapur as President and Drs. S. Samaddar of Patna, Dr. A. C. Ukil of Calcutta and Dr. D. V. Venkappa of Madras as Vice-Presidents were elected. The President read out the Circulars from the Provincial Office and as the circulars are being published in the Miscellany, discussion did not take place. Then the President intro-

duced Dr. B. Ramamurthy, MS. F.R.C.S.E. Member of the Society of British Neurological Surgeons and Neurosurgeon, General Hospital, Madras to the members and requested him to give his talk on Spinal Cord Lesions. After the lecture a lively discussion took place in which many members took part. Then the Secretary proposed a vote of thanks to the lecturer for his excellent lecture, to the hosts of the evening for their fine tea and to the President, District Board for kindly placing their meeting hall for our meeting and the meeting came to an end at 8-30 p.m.

TIRUNELVELI BRANCH

(Palayamkottai)

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

The Annual meeting of the Council of the South Indian Provincial Branch of I. M. A. was held at 10-15 p. m. on 20-9-51 at the St. John's College Premises, Palamcottah.

Dr. K. C. Nambiar, the President elect for 1952-53 presided. About 34 members were present.

1. Condolence resolution on the death of Dr. M. A. Nair of Madras and Dr. M. G. Kini of Bombay a former member of the Provl. Branch was moved from the chair and passed unanimously all members standing for a minute.

2. The suggestion of the Govt. of Madras to turn out medical men in three years by giving training to young people in various Govt. Hd. Quarters Hospital was wrought with danger as these young men would be ill equipped with knowledge and not likely to settle in villages.

3. The Provl. Council decided to accord a fitting reception to Dr. L. H. Bauer (The President of the American

Medical Association and Secretary General of the World Medical Association) during his forthcoming visit to Madras and requested the Madras Branch to make necessary arrangements for the reception and sanctioned a sum of Rs. 100/ towards the expenses. Dr. K. C. Nambiar the President generously offered to contribute the balance amount towards all the expenses incurred in this connection.

4. The Council elected the following office-bearers for the year 1952-53:

1. Dr. A. G. Leelakrishnan, Coimbatore. Hony. Secretary.

2. Dr. K. Rama Rao, Madras Hony. Jt. Secretary.

3. Dr. A. K. Rajagopalan, Madurai Hony. Treasurer.

Dr. K. C. Nambiar of Madras, Dr. P. A. S. Raghavan of Tiruchy, and Lt. Col. T. S. Shastry of Madras were elected to the Central Working Committee (I. M. A.).

The following were elected to the Joint Standing Committee of the Andhra and South Indian Provl. Branches:

- (1) Dr. K. C. Nambiar of Madras,
- (2) Dr. K. Rama Rao of Madras,
- (3) Dr. P. A. S. Raghavan of Tiruchy,
- (4) Lt. Col. T. S. Shastry of Madras,

(5) Dr. S. Subramaniam of Karaikudi.

5. The Annual Report and Auditor's Report and the Statement of Accounts by the Treasurer and the Budget for 1952-53 were all approved and passed.

6. After a vote of thanks the meeting terminated.



Sub: Education—Educational concessions to children of Non-Gazetted Officers and others—Applicability to the Rural Medical Practitioners—Orders Passed.

Read Again: G. O. No. 1250, Education, dated 31-5-52.

Read also: From the Honorary Provincial Secretary, Indian Medical Association, South Indian Provincial Branch, Coimbatore dated 7-8-52.

The Government direct that the educational concessions granted to the children of non-Gazetted employees of the State Government in the G.O. cited be extended to the children of Rural Medical Practitioners and Maternity Assistants employed in recognised Rural Dispensaries (Subsidised or non-subsidised) serving under local bodies or Government.

K. M. Unnithan,
Secretary to Government.

To

The Director of Public Instructions.
" Director of Medical Services.
" Health Department.
" Accountant General through Finance Department.
" Director of Information and Publicity.
" Director of Public Health.
" Hony. Secretary, Indian Medical Association, South Indian Provincial Branch, Oppanakara Street, Coimbatore.
To all Departments of Secretariat.

Forwarded/By Order

Sd.

Superintendent.

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

ABDOMINAL PAIN AND ANAEMIA
DUE TO MEPHENESIN (TOLSEROL*)

Robert J. Kositchek, M.D. and Garfield S. Burnet, M.D. Beverly Hills, Calif.

Mephenesin (tolserol*), which is 3-ortho-toloxyl-1, 2-propanediol, has been recommended for the relief of muscle spasm. Toxic reactions have not been previously reported following the oral administration of this drug. In the following case there developed severe abdominal pain and a decrease of the hemoglobin and red blood cell count after the patient consumed 50 Gm. of this drug.

Report of Case

B. G., a white married woman aged 34, had been treated for four years with different drugs and physical therapy for cervical dyskinesia. This resulted from the fracture of the sixth cervical vertebra following a diving accident in 1945. Roentgenograms of the cervical portion of the spine in 1949 revealed a loss of the cervical curve and residual compression of the sixth cervical vertebra. The resulting muscle spasm was intense, with limitation of motion and severe head and neck pain. The patient was otherwise in excellent physical condition. The past history was noncontributory except for an appendectomy in 1947.

All the usual forms of treatment failed to relieve the patient's pain and disability, and she was given mephenesin in 1949. The patient consumed 4 Gm. of the drug daily in divided doses for ten days. The pain was completely relieved, but the patient became nauseated on the tenth day. At this time examination of the patient's blood revealed: haemoglobin 94 per cent; 4,900,000 red blood cells per cubic millimeter, and 7,400 white blood cells per cubic millimeter, with a normal differential. She was then given 3 teaspoons of the elixir of mephenesin four times daily for two days. She again became nauseated on the morning of the third day and stopped taking the drug.

At approximately 9 o'clock that evening she suddenly had severe rhythmic, cramp-like, pain in the right upper abdominal quadrant occurring at five minute intervals

and doubling the patient up with each recurrence. This pain did not subside, and one of us (R. J. K.) was called by the husband of the patient at about 10:30 p. m. At this time the temperature was 98.4 F., the pulse rate was 94 per minute and the blood pressure 118 systolic and 80 diastolic. The respirations varied between 16 per minute when the pain lessened and 24 per minute when the pain became intense. The essential physical observations were all confined to the right upper quadrant of the abdomen, where the patient had extreme tenderness to palpation and muscle spasm whenever the pain occurred. The liver, kidneys and spleen were not palpable, and abdominal masses were not felt. Peristalsis was hyperactive. The vaginal and rectal examinations revealed normal conditions. The biceps reflexes were absent bilaterally. Two hundred milligrams of meperidine hydrochloride (demerol hydrochloride*) and $\frac{1}{2}$ grain (0.03 Gm.) of morphine sulfate administered subcutaneously over a period of one and one-half hours did not relieve the pain, and the patient was hospitalized.

A blood cell count on arrival revealed a hemoglobin of 65 per cent (10 Gm.); 3,530,000 red blood cells per cubic millimeter; color index 0.92, and a white blood cell count of 8,800 per cubic millimeter with 76 per cent neutrophils (13 nonsegmented), 18 per cent lymphocytes, 4 per cent monocytes, 1 per cent basophils and 1 per cent eosinophils. The blood smear showed normal platelets and anisocytosis of the red cells. The red cell volume was 34 per cent; the sedimentation rate was normal. A catheterized urine specimen was essentially normal. A noncatheterized urine specimen revealed 30 to 40 red blood cells per high powered field and a trace of albumin; the patient was just completing a normal menstrual period. The icterus index was 4.8. The Van den Bergh test was negative. The total serum proteins were 5.8 Gm. per hundred cubic centimeters (albumin 4.5 Gm. and globulin 1.3 Gm.)

The following morning, the patient still had recurrent pain in the right upper abdominal quadrant. Examination of the blood revealed: haemoglobin 68 percent (10.6 Gm.); red blood cells 3,500,000 per

cubic millimeter; color index 0.98, and white blood cells 9,400 per cubic millimeter, with 51 percent neutrophils. The icterus index was 10.6. The urine urobilinogen test was positive in a dilution of 1:30.

Treatment consisted of the administration of large amount of sedatives to relieve the abdominal pain and intravenous fluids to insure a daily fluid intake of over 3000, cc. The pain subsided in forty-eight hours, at which time examination of the blood revealed: haemoglobin 75 percent (11.5 Gm.); red blood cells 3,900,000 per cubic millimeter, and white blood cells 5,800 per cubic millimeter, with a normal differential count. The icterus index and urine urobilinogen values returned to normal. Results of the cephalin flocculation, thymol turbidity and serum amylase tests were also within normal limits.

By the fourth day, the haemoglobin had increased to 79 percent (12.2 Gm.) and the red blood cell count to 4,200,000 per cubic millimeter. The nonprotein nitrogen determination was 31 mg. per hundred cubic centimeters. The phenolsulfonphthalein sodium renal function test showed 44 percent excretion of the dye at the end of two hours. Roentgen examination of the gallbladder and the entire gastrointestinal tract revealed no abnormalities. The intravenous pyelogram disclosed essentially normal conditions. At the end of the fourth day of treatment, the patient had fully recovered from her attacks of abdominal pain.

Comment

Mephenesin is a spinal cord and brain stem depressant. Its exact metabolism in the body is unknown. After administration it is widely distributed in the tissues and body fluids, with the highest concentration in the brain and pancreas. The later localization might have provided the basis for the abdominal pain encountered in this case. The blood serum amylase value was normal, however. Mephenesin is almost completely metabolized, only a small fraction being excreted in the urine.

Intravenous administration of a 2 per cent solution of the drug will cause increased fragility of the erythrocytes. Other reactions include horizontal and vertical nystagmus, circumoral numbness, a mode-

rate drop in the blood pressure and dryness of the mouth. In high concentration the drug causes a quinidine-like reaction and prolongs the refractory period of the cardiac cycle.

Examination of various organs of animals treated with mephenesin fails to reveal any toxic effect. Nausea has been reported after oral administration of the drug. Gammon and Churchill reported a drop in the leukocyte count in 2 patients taking large doses of mephenesin by mouth.

This drug is having wide use and distribution at the present time. It is considered that the acute abdominal pain and the decreased blood cell count represented a toxic reaction to mephenesin. The mechanism of this untoward effect is not apparent. There is need for careful supervision during the administration of this drug, despite reports of data indicating the absence of undesirable side effects.

Summary

1. A case is reported in which the patient exhibited a toxic reaction to mephenesin (tolserol) characterized by severe abdominal pain and anaemia.

2. Future reports of toxic effects of this drug may be anticipated, and due precautions should be exercised during its administration.

**

TERRAMYCIN IN THE TREATMENT OF VENEREAL DISEASE—*The Journal, May, 1950.*

The discovery of terramycin, an antibiotic produced by *Streptomyces rimosus*, has only recently been reported, yet an extensive clinical program is already under way to evaluate this new addition to the group of drugs useful in the treatment of infectious diseases. In vitro and in vivo studies indicate that terramycin has a wide bacterial spectrum effective against both gram-positive and gram-negative bacteria, certain of the rickettsias and viruses. It appears in many respects to be comparable to aureomycin in its antimicrobial activity. The drug is readily absorbed from the gastrointestinal tract and produces significant and continuous

blood concentrations when 250 mg. are given orally every six hours. It is readily excreted by the kidneys and appears in the urine in an active state. The amount of terramycin excreted depends on the dose and varies from 10 to 35 percent of the total amount of drug ingested. This is somewhat higher than the amount of aureomycin excreted when the dose is the same. Similarly the concentration of terramycin per cubic centimeter of urine is considerably higher than that obtained with aureomycin when these drugs are given orally in comparable doses. As with aureomycin and chloramphenicol, after its ingestion terramycin can be recovered in the active state from the feces. It is of interest, however, that with all three of these drugs a higher percentage of the drug ingested can be recovered from the feces after low oral doses (0.5 Gm.) than after higher doses (1.0 to 2.0 Gm.). As a matter of fact, after ingestion of 0.5 Gm. of terramycin 75 per cent of the dose can be accounted for in the feces and urine.

Terramycin hydrochloride has been shown to be effective in the treatment of pneumococcal and streptococcal pneumonias, urinary tract infections, whooping cough and bacteremia due to *Salmonella choleraesuis* var. *Kunzendorf*. Terramycin was used in the treatment of venereal diseases at the Polk Health Center and the Rapid Treatment Centre of Gallinger Municipal Hospital, District of Columbia Health Department. A total of 81 patients have been treated, including 73 with gonorrhea, 6 with syphilis and 2 with granuloma inguinale.

The patients with gonorrhea were given single doses of 250 to 1,000 mg. of terramycin hydrochloride, followed in some instances by a second dose of 500 or 1,000 mg. Only male patients with acute anterior urethritis showing gonococci both by smear and culture were utilized. These patients had no previous treatment for this infection. The criteria for cure were cessation of symptoms with negative smears and cultures taken on alternate days for one to two weeks. The dosage schedule and results obtained are given in the accompanying table.

Six patients, 3 with primary and three with secondary syphilis, all with dark-field-positive lesions, were given terramycin

in doses of 60 mg. per kilogram of body weight per day for eight days and the time required for disappearance of the organisms from the lesions determined. In 1 patient the organisms disappeared from the lesion within twenty-four hours and in 1 within forty hours; in the remaining 4 patients organisms were not observed after the forty-eighth hour.

Three of the 6 patients in this group have been checked serologically one month after treatment. Prior to treatment 2 of these patients had positive reactions to Eagle precipitation tests for syphilis in 1:2 and 1:8 dilutions of serum, and 1 was negative. Serologic reactions in all 3 were negative one month after treatment.

Results of Cure of Gonorrhoea after Treatment with Terramycin Hydrochloride

Number of Cases	Dosage in Gm.	Number Cured	Percentage Cured
15	1.0 every 6 hr. (2 doses)	15	100.0
10	0.5 every 6 hr. (2 doses)	8	80.0
3	1.5	1	33.3
3	1.00	1	33.3
29	.75	16	55.2
10	.50	3	30.0
7	.25	1	14.3

Two patients with early granuloma inguinale were given terramycin orally in doses of 60 mg. per kilogram per day for twelve days. Donovan bodies (*Klebsiella granulomatis*) which were present on institution of treatment disappeared from the lesions by the third day. Clinical healing was excellent in each case.

In general terramycin was well tolerated in the 81 patients treated, although some evidences of toxicity were observed in 6 patients. Three of the 73 patients with gonorrhea experienced nausea, faintness and/or dizziness. Two of the 6 patients with syphilis complained of nausea, and 1 of these had vomiting and diarrhoea. Fever and ulcerations of the throat developed in the last-mentioned patient but disappeared when he was given penicillin. One of the 2 patients with granuloma inguinale complained of nausea.

Summary

Terramycin at proper dosage levels effects a satisfactory cure rate in the treatment of gonorrhea, although the dose required for cure is somewhat higher than has been necessary with chloramphenicol. From 1 to 2 Gm. of terramycin hydrochloride in divided doses gives a cure rate of 80 to 100 per cent, while single doses of 750 mg. of chloramphenicol give similar cure rates. Clinical healing of lesions of both syphilis and granuloma inguinale occurs promptly with terramycin hydrochloride given orally in doses of 60 mg. per kilogram of body weight per day.

**LARGE DOSES OF VITAMIN A—
The Journal, June, 1950.**

TO THE EDITOR:—1. Could a daily intake of 300,000 units of vitamin A by an adolescent or young adult for six months or more be harmful? 2. What is the "toxic" dose?

ANSWER.—1. A daily intake of 300,000 international units of vitamin A by an adolescent or young adult male for six months or more would probably not be harmful.

2. Acute intoxication by vitamin A is suggested by the report of Rodahl and Moore (The Vitamin A Content and Toxicity of Bear and Seal Liver, *Biochem. J.* 37:166, 1943). Eskimos have long known that the ingestion of polar bear liver may cause severe illness. The first signs occur in two to four hours, sometimes later—drowsiness, sluggishness, severe headache and vomiting. In twenty-four hours, the skin about the mouth begins to peel off; there may be loss in other areas or, occasionally, over the entire body. Recovery usually occurs. Rodahl and Moore found that the toxic polar bear livers contained from 13,000 to 18,000 international units of vitamin A per gram and, in experiments with the white rat, that vitamin A was the sole toxic agent in the livers. They estimated that the quantity of vitamin A in 375 Gm. of liver (the amount ingested) was about 7,500,000 units.

Chronic intoxication by vitamin A in children was first reported by Josephs (Hypervitaminosis and Carotenemia, *Am.*

J. Dis. Child. 67:33, 1944). A boy had received, from the age of 2 or 3 months, teaspoonful or more of halibut liver oil daily—at least 240,000 international units of vitamin A. By 18 months, his appetite failed; at 28 months the liver and spleen were enlarged, the fingers were clubbed and the hair was dry, coarse and falling. Roentgenograms showed an irregular cortex in phalanges and metacarpals, vacuolated medullary cavities, mottled epiphyses at the upper end of the humeri and tibiae and advanced bone age. The serum vitamin A was greatly elevated. After the discontinuance of halibut liver oil, improvement was immediate. In two months the appetite improved, weight increased and hair began to grow. At 30 months the liver and spleen were still enlarged and the fingers were clubbed. Josephs reports observation on 3 other children, who ingested from 120,000 to 500,000 international units of vitamin A daily for several weeks to four months, who had no symptoms. The levels of serum vitamin A were not greatly elevated.

The observations of Josephs and of Toomey and Morissette (Hypervitaminosis A, *Am. J. Dis. Child.* 73:473, 1947) appear to show that infants may tolerate daily doses of about 240,000 international units of vitamin A for a year or more without the development of symptoms and that they may not tolerate daily doses of 500,000 international units of vitamin A for even short periods of time. On the basis of body weight, this would indicate that the toxic daily dose of vitamin A for an adult would lie between 1,500,000 to 3,000,000 units daily.

**LOSS OF SENSATION IN HANDS—
The Journal June, 1950.**

TO THE EDITOR—A 70 year old farmer, who has never been seriously ill, complains of loss of sensation, numbness, burning, stinging and pain of the fingers of both hands, particularly the left. There is a weakness of both hands, the grip of the left being extremely weak. The palm of the left hand is somewhat tender on pressure and thicker than on the right. None of the fingers can be straightened without pain, and the joints are enlarged.

There is severe atrophy of the right thenar eminence, which is the major clinical finding with the exception of missing tactile sensation of varying degree in the finger tips approaching normal sensation as one progresses towards the wrist. The patient states, "Below the wrists I am all wrong; above the wrists I am okay." He has burned and cut himself severely several times, because of his loss of sensation. Please advice.

ANSWER.—The loss of sensation plus the weakness and atrophy of the muscles of both hands progressing slowly would indicate some disturbance in the spinal cord at the level of the sixth, seventh and eighth cervical segments. The lesion must be extensive to cause such changes, and it is unusual for a lesion at this level not to be expansive enough to cause pressure on the lateral columns with secondary spasticity of the legs, increased deep reflexes and Babinski sign. There is nothing in the history to indicate the condition of the patient's legs, which would be an important factor if the disease is in the spinal cord and not peripheral. If one considers, moreover, the peripheral aspects as a possibility, the lesion must be a complicated one below the level of the wrist, for there is decided weakness, atrophy and loss of sensation. Missing from the record also is any description of the reflexes in the arms, which would help localize the process.

In favor of a local lesion in the hands is the enlargement of the joints with pain on extension of the fingers. The burns on the hand without sensation are suggestive of syringomyelia with the lesion again at the level of the spinal cord indicated previously.

A definite diagnosis cannot be made in a case of this type without data consisting of results of a more complete neurologic examination, giving the condition of the reflexes in the arms and the legs, an examination of the cerebrospinal fluid and a roentgenogram of the lower cervical spine. It is possible that there would be found sufficient spondylitis in the cervical region to account for local pressure on nerve roots and, secondarily, on the changes found in the hands. There is some indication that the root most involved would be the sixth cervical root on the right, but the lesion is more extensive than that and is also bilateral. Spinal cord tumor is also a possibility, and, if any indication of a block in the cerebrospinal fluid pathway were found on lumbar puncture, myelograms are indicated. Conditions somewhat similar to that described are also seen in the polyneuritis of the arms associated with leprosy, and, although this does not seem a possibility in the case described, one would have to think of all types of chronic neuritis that would lead to symptoms of weakness and loss of sensation.



Announcement

Dr. N. A. SUBBARAYAN, L.M.P., is removed from the list of members of the Trichy Branch of the I.M.A. for non-payment of subscription.

(continued from 2nd cover page)

The Reception Committee of the 29th All India Medical Conference, Patna, earnestly appeals to you to contribute useful papers, demonstrate interesting cases and put up illuminating exhibits on the occasion and to take part in the symposia.

Reception: There will be Reception office at the Patna Junction Rly. Station just opposite the First and Second Class booking office. There will also be a Reception office at the aerodrome for persons travelling by air to Patna. Volunteers will be available at these reception offices who will give necessary informations and arrange transport. Arrangements for lodging and boarding will be made if previous intimation is received by the General Secretary not later than 15th November 1952.

Railway concession: Delegates and visitors wishing to attend the Conference should apply for necessary certificate to the General Secretary, on the production of which at the nearest D. T. S. Office, single fair double journey concession authority slip for any class will be obtained. Production of this authority at the railway booking office will enable them to issue concession tickets.

ODDS & ENDS

A bill in the Mississippi Legislature proposes to require each applicant for a marriage license to present a certificate signed by a registered physician certifying freedom from venereal diseases.

♡ ♡ ♡

Mandy came to Parkland Hospital, Dallas, with what looked like a small Sunday School Class ranging from five years up. Dr. D. M. was trying his best to get an intelligent history of her numerous ailments:

"What does your husband do, Mandy?"

"He's been daid fo' fifteen years."

"He's dead! Then whom do all these children belong to?"

"Dey's mine."

"I thought you said your husband was dead."

"He is, but ah ain't!"

J.A.M.A.

♡ ♡ ♡

How is your lawyer patient, doctor?

Poor chap, he is lying at death's door.

What, at death's door and still lying? It's unbelievable.

♡ ♡ ♡

Doctor: I am not able to make any diagnosis. I wonder whether it is drink.

Patient: Then, I shall come other time when you are sober.

♡ ♡ ♡

"Have you any medicine for a floating kidney?"
Chemist: "There is no medicine for a floating kidney."

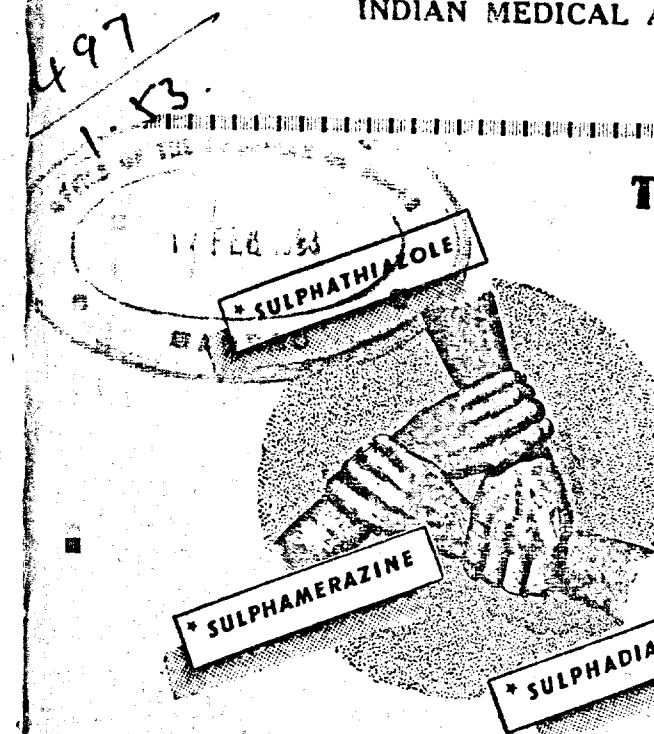
"You advertise medicines for loose livers, haven't you one for a floating kidney?"

Edited and Published by Dr. P. A. S. Raghavan, Z. M. R. E. (Vienna), Teppakulam, Tiruchirapalli and
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MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

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



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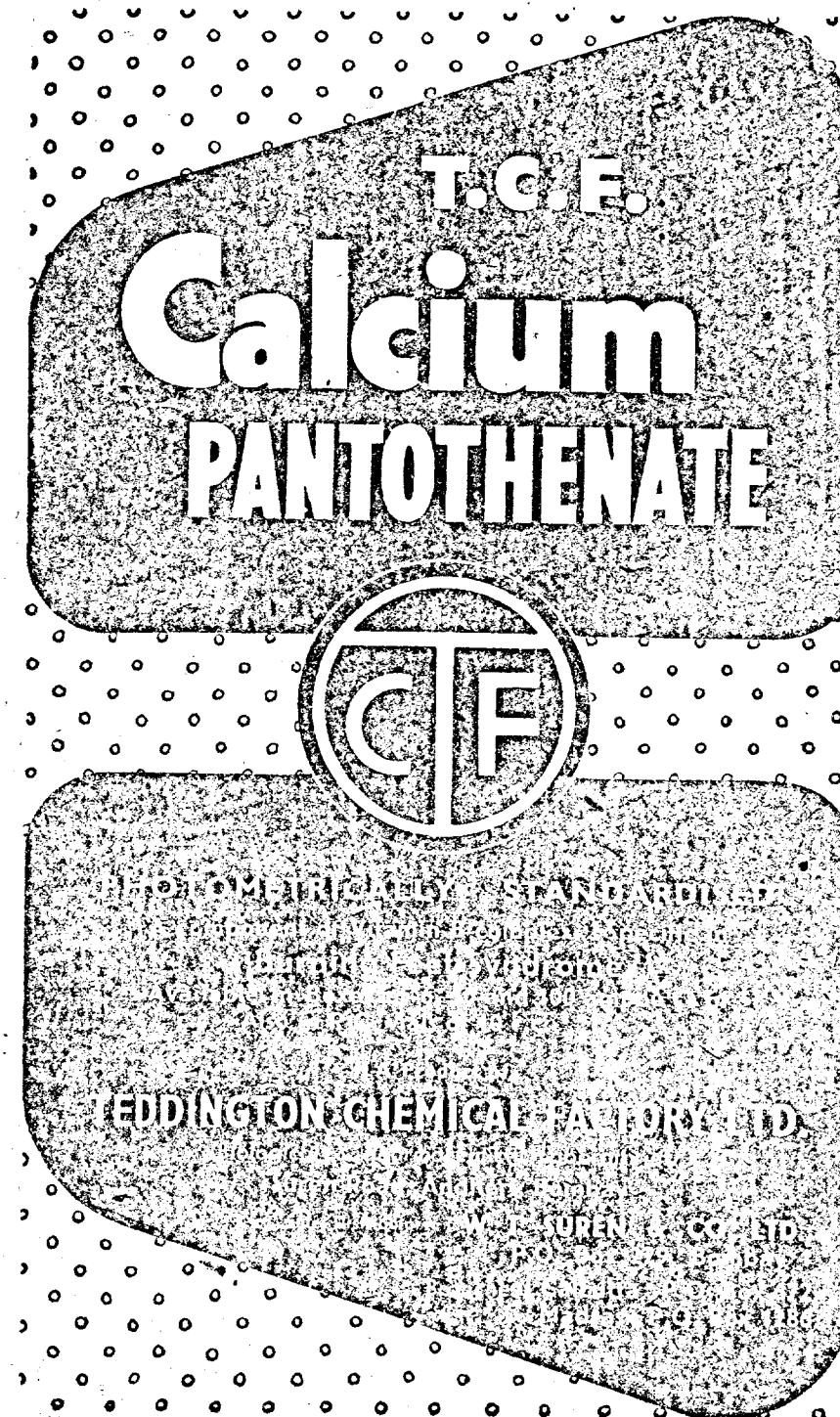
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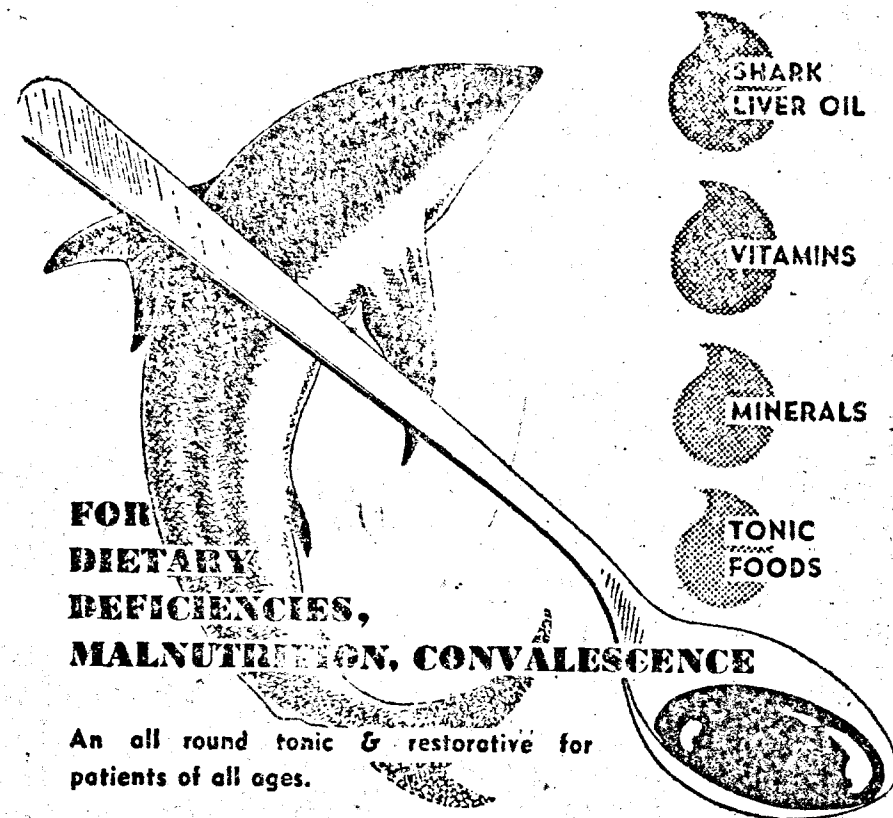
How to Become a Charlatan

If you are determined to become a charlatan, the first thing to do is to take full advantage of the present taste for obscurity in expression and of contemporary leniency towards unsupported assertions. You will, by that means avoid exposing your incapacity for thought and the meagreness of your knowledge. Thus what would otherwise be serious drawbacks may actually become advantages. And on no account neglect to pepper your writings with jibes at the inadequacy of reason and assertions about the trust-worthiness of instinct. With regard to your personal behaviour, which is so important in the career of a charlatan, I have very few suggestions to offer, but be careful only to praise a competitor whom you have obviously surpassed, and then, *most* emphatically, for the least of his talents. This will give others a high opinion of your generosity and at the same time do him very little good. And if you praise yourself, which you must do from time to time, adopt a plaintive and indignant tone as if you had been forced to do it by the injustice of the world. Boast frequently in talking to women, but in talking to men content yourself as a rule with speaking in carelessly disparaging tones of great men and great work. Also when you attack your enemies, attack them *en bloc*; this has an air of courage while it is far less dangerous than attacking individuals. In choosing subjects select, if possible, those on which better men than you have, after much research and thought, failed to reach a conclusion. Such objects will supply you with hopeful readers, and spare you the toil of original enquiry. Where evidence for your assertions is wholly lacking, a generous but discrete use of the words "of course" is to be recommended.

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MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
THE INDIAN MEDICAL ASSOCIATION

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[No. 6

DONOVAN'S DISCOVERY

(A GLORIOUS CHAPTER IN MEDICAL ANNALS OF MADRAS)

DR. D. V. S. REDDY, MADRAS

The 19th century is rightly regarded as the Century of Progress in all branches of human activity, including advances in Medicine like development of Anesthesia, Hæmostasis, birth of Bacteriology, Antiseptic and Aseptic surgery, and preventive inoculation and control of spread of disease. It was, however, the last quarter of the 19th century that witnessed the most brilliant discoveries in tracking down the micro-organisms of Epidemic and Endemic diseases of the Tropics and the agents that spread the diseases, like Filaria, Malaria and 'Kala-azar.'

A new era in history of medicine was commenced when superstitions, speculations, dogmas and doctrines in tropical medicine were replaced by observation, experiment and scientific demonstration. The harbingers of this New Age in India were Vandyke, Carter and Lewis, whose researches deserve to be better known to the present generation. Manson's pioneer work in connection with Filaria is better known. Having noted the nocturnal periodicity in his patient, and correlating the exact time of appearance of brown mosquito of Amoy, Manson deduced and forecast that this insect might act as a carrier of Filaria. This theory, he proved to be correct, by his experiments and demonstrations of the life history of

Filaria Bancrofti, in Culex Mosquito, in 1879.

On 6th November 1880, Alphonso Laveran, a French Army Surgeon, working at Constantine in Algiers, made the great discovery of the parasite of Malaria. 'It was in some degree, a chance discovery' says Manson-Bahr. Though the Italian Malariologists to whom the preparations were shown were still highly sceptical, Laveran's finding was confirmed in 1882. There was still divergent opinions regarding the transmission of Malaria. The turning point in the investigation of malaria occurred in 1894 when Manson published mosquito hypothesis "In it, with cold logic and cogent argument, Manson drew an analogy between transmission of Malaria and that of Filaria". Then commenced a remarkable "partnership in science", beneficial to the Tropical World. Manson wrote a series of letters in which the veteran instructed, guided and encouraged youthful Ronald Ross, full of enthusiasm and energy but lacking knowledge and experience in medical research. On 20th August 1897, Ross discovered in a small laboratory attached to a hospital at Secunderabad pigmented oocysts in the stomach wall of dapple winged mosquitoes (Anopheles Stegomyia). The rare and precious preparation was sent to Manson in London, who confirmed

Ross's findings and cabled back the assurance "You are on the right track at last". Under the capable guidance of Manson, Ross started and continued his experiments in Calcutta on bird malaria. The complete cycle was worked out in the sparrow and the liberated sporozites were traced to the salivary glands of the mosquito. But an unexpected obstruction blocked further investigation. On account of intensive local prejudice, Ross was not able to complete, at that time and at the same place, the enquiry into the transmission of human malaria. In 1898, the Italian workers, by working on human volunteers observed pigmented oocysts in a mosquito fed in Rome on a patient harbouring coccidia in blood. They also succeeded in infecting a volunteer with malaria by mosquito bites. In 1900, Grassi, who had no medical training, published a monograph on transmission of malaria. In the same year, Manson clinched the problem of transmission of malaria by exposing his son, P. T. Manson, in London, to the bites of a mosquito infected in Rome by Grassi. Manson also performed the reverse experiment by the erection of a mosquito proof hut in Ostia in Roman Campagna in which three of his pupils lived during the most malarial months, July to October, 1900, without contracting malaria.

Towards the beginning of this century, the attention of medical investigators in Africa was focussed on Trypanosomiasis while the American workers were struggling to prevent the devastation caused by Yellow fever. This was the background of medicine when Captain Donovan joined the Madras General Hospital as a Physician and found cases of long continued fever which baffled investigators at that time. The exact sequence of events leading to the announcement of the discovery of the causative organism of Kala-azar and the naming of the parasite as Leishman-Donovan body deserves to be

retold in view of the semi-centenary, next year, of the discovery by Capt. Donovan, at Madras.

An article in B. M. J. (May 30, 1903) by Major W. B. Leishman, then Professor of Pathology in the Royal Army Medical College, NETLEY, referred to the then recent discovery of Trypanosomiasis in Africa and suggested the possibility of the occurrence of Trypanosomiasis in India. He spoke of certain class of cases which he called, for want of a better name, cases of Dum Dum Fever, Dum Dum being a notoriously unhealthy station seven miles from Calcutta. Leishman writes, "I had a short personal acquaintance with this station in 1890 but the present remarks refer to the features of this form of Indian fever as presented by soldiers invalided on account of it from Dum Dum to Royal Victoria Hospital, Netley, during the past three or four years. . . . The cases were, as a rule, regarded as malarial in origin and presented on admission, an extreme degree of cachexia. . . . clinically these cases presented no very definite features distinguishing them from other and commoner forms of Tropical Cachexia, the chief symptoms being an irregularly, remittant type of fever, grave anoxmia progressive muscular atrophy and great enlargement of the spleen. In none of these cases were malarial parasites found in the blood, which I now think to have been due to Trypanosoma infection. It was at the necropsy of one of these cases of Dum Dum fever that the appearances described below were noted in the spleen. Private J. B., aged 23 years, invalided from Dum Dum, was admitted to Netley Hospital in April 1900 and died 7 months later after presenting all the features of the Dum Dum fever. Repeated examinations of blood smears did not reveal any parasite. At the necropsy, the spleen was found to be greatly enlarged (2 lbs., 7 ozs.) and much congested. Spleen pulp was extremely soft and friable, the organ sterile on

culture. To quote Leishman again "on making smear preparations on the splenic pulp, I was struck by the curious appearance, among the spleen cells and red corpuscles, of enormous numbers of small round oval bodies, 2-3 μ in diameter which corresponded to nothing I had previously met with or had been figured or described. They stained faintly with methylene blue and with hematin showing with these stains a sharply contoured circular or oval shape but no definite structure, but on staining them by Romanowsky's method they were found to possess a quantity of chromatin of a very definite and regular shape which clearly differentiated them from blood platelets or possible nuclear detritus. . . . These little bodies were freely scattered among cells—as a rule isolated one from the other but here and there aggregated into clumps composed of 20 to 50 members. As to their meaning I was at the time completely at a loss, nor could other observers to whom I have from time to time shown give me any clue as to their nature." That was in 1900.

After cases of Trypanosomiasis in man were reported in parts of Africa in 1902 and 1903, Leishman was studying the disease in rats. On examining a rat which died of Trypanosomiasis, he found in the blood and organs, bodies practically identical in shape and staining reactions with those found in the spleen of Private J. B. Leishman therefore considered these "Chromatin bodies represented the macronuclei and micronuclei of the adult trypanosomes", and that these structures were practically all that remained of the parasites, the rest of the body and the vibrator membrane being less resistant to degenerative changes, having disappeared". As Dum Dum fever or kala-azar might be due to Trypanosomiasis, he suggested that necropsies of such cases should include staining of smear preparations from spleen and liver for degenerative forms

of parasites and also careful examination of blood films of fever patients with the newer techniques and modifications suggested by Laveran, Ross and Leishman.

Donovan who had been for some years working as a Physician in the Government General Hospital, Madras, was also well versed and keenly interested in Hematology. He, too, had been studying smears taken post-mortem from enlarged spleens of native patients, said to have died of chronic malaria and had noted bodies similar to those described by Leishman in three consecutive cases on April 9th, 23rd and 24th, 1903. He thought at first that he had discovered the long-sought-for, resting stage of the malarial parasite in man but later seeing the same bodies, he changed his views and considered that they were probably post-mortem degenerations of the matter of the splenic pulp.

It was at this time that he had an opportunity of reading Major Leishman's paper in the B. M. J. Donovan at once recognised the similarity of the so-called degenerations of Trypanosomata mentioned by Leishman to those found by himself in the spleens of the cadavers in Madras. Then, with courage and faith, Donovan went ahead with his investigation which won for him and Madras a small niche in the temple of fame.

This is what he wrote on 18th June 1903, in a short communication published in B. M. J.; July 11th, 1903. "Yesterday (June 17th) I had occasion to puncture intra vitam the spleen of a native boy, aged 12 years, suffering from irregular pyrexia, with no malarial parasite in his peripheral blood (careful examination of stained films on four occasions) and found identical bodies in the blood from the spleen, thus removing any doubt there was as to the products being due to post-mortem changes."

"It is unwise to theorise on the insufficient grounds at present in hand.

I hope to contribute something more definite on the subject after further and more prolonged study of these organisms. My films were stained by the Maurer-Romanowsky method. I am familiar with the appearance of the Trypanosomata—T. Evansi, T. Sewsi and a species doubtful, occurring in the blood of the common Indian squirrel (*Sciurus Palmarum*). There was nothing resembling Trypanosomata in the peripheral blood of the boy in question."

It must be clearly understood that Donovan's discovery was not due to chance or good luck. It was the outcome of profound and extensive knowledge of various problems in Tropical Medicine combined with indefatigable industry and complete mastery of the theory and technique of investigation. Probably, he had moments of inspiration, coupled with a spark of genius. He certainly had in abundance the spirit of enquiry.

During the next few months, Donovan did not relax but worked with renewed enthusiasm and greater vigour. He sent the slides of smears from the spleens in the post-mortems as well as from splenic punctures to Major R. Ross, already famous for his discoveries relating to transmission of malaria by mosquito, a Nobel Laureate and Professor of Tropical Medicine in the University of Liverpool and to the equally illustrious Monsieur Laveran in Paris, for their inspection and confirmation and opinions. He continued to study cases of irregular pyrexia with enlargement of spleen and liver and by 10th November 1903, had observed 17 cases. The symptoms in these cases tallied very closely with those of Kala-azar. So, he was led to believe that the cause may be identical but he had never seen a case of typical Kala-azar. So he wrote in the correspondence columns of *I. M. J.* December 1903, requesting medical officers in endemic areas to send him slides of smears of spleen juice, of blood obtained by puncture intravital

from spleen, fixed by absolute alcohol or ether. He offered to communicate the result of his examination by return post. To assure the practitioners, he mentioned that he had punctured the spleen 25 times with no untoward results. His letter concludes with the following words, "I am studying the disease and hope to publish a full account shortly; blood from spleen of real Kala-azar cases would be of great service in determining the inclusion or otherwise of this disease in the same category as mine."

Meanwhile Major Ross studied the slide sent by Donovan and in *B. M. J.* dated 14th November 1903, confirmed the findings of bodies agreeing exactly with Leishman's descriptions. He could not however find either entire trypanosomes or remains of dead ones. He also expressed the opinion that the size, shape and arrangement of chromatin was so constant and characteristic that it was scarcely possible to doubt that they were parasites of some kind, probably Protozoa. In this connection, Ross's weighty opinion may be quoted, "For my own part I find some difficulty in adopting Leishman's view that they represent involution changes of trypanosomes in the post-mortem spleen... As Donovan observed, his two preparations made intra-vital exclude post-mortem changes altogether, and should therefore, contain some unaltered trypanosomes. *Prima facie* then, I am strongly inclined to believe that we have to do with some quite a novel organism. As it has already been found in eight cases of fever and cachexia, it promises to be a common and important one. The charts of two of Donovan's cases sent by him to me certainly recall the chronic pyrexia with enlarged spleen so frequently observed in India, and are, indeed not a little suggestive of Kala-azar."

Laveran and Mesnib, identified the parasites as belonging to the genus *Piroplasma*, Species new. Monsieur Laveran also communicated a scientific

paper to the Academic De Medicine, Paris on November 3, 1903, describing the parasite on the strength of the specimens sent to him by Captain Donovan. M. Laveran believed that the parasite was *Piroplasma* and proposed the name *P. Donovanii*. This was published as a small note in the *B. M. J.* 21st November 1903.

Major Leishman wrote to *B. M. J.* dated November 21, 1903 offering a few comments on Major Ross's communication. He admitted that he had the opportunity of examining films made from Donovan's cases and that he saw in one of them bodies identical with those he himself had described. "This identity", he added "was in the case of post-mortem film and it was complete... the other films made from splenic puncture during life contained forms which were present neither in my own films nor in Donovan's post-mortem films... They appear to me undoubtedly of the same nature as those met with in post-mortem films. The chief differences consist in the larger sizes of the intra-vital bodies and in their being, in most instances, surrounded by a red stained ring. These differences may, I think, be sufficiently accounted for, by the changes due to commencing post-mortem decomposition of the spleen." With regard to Major Ross's criticism of Leishman's view that, these bodies might possibly be involution forms of trypanosomata, Leishman was unyielding and wrote that with all deference due to Major Ross's great authority on such questions he still believed that a connection between these bodies and trypanosomata might yet be established. He even hazarded the conjecture that the red staining ring surrounding the chromatin bodies in the intra-vital smears might be of the nature of the cyst or a capsule. He felt that it was impossible at that stage to decide whether these little bodies were new

parasites or altered trypanosomata but he was prepared to affirm that they were undoubtedly parasitic in origin and that they occurred in the spleen in a form not encountered before. He expected that Captain Donovan would publish details of his cases and that researches of others more favourably situated as regards materials than himself might soon settle the question as to the nature and pathological significance of these little bodies. Towards the end of his letter he referred to a small but personal matter to clear up a possible misconception regarding the priority of observation. Though Leishman published his article in May 1903 he had observed these bodies in November 1900 in Nettley while Captain Donovan had seen these in April-June 1903, in Madras (in post-mortem smears on April 9th and splenic smears from patient on 17th June.)

In the next communication entitled "Further notes on the Leishman Bodies" in the *B. M. J.* November 28, 1903, Ross published pen and ink drawings and some additional remarks, and also announced that water colour drawings by Donovan and himself would shortly appear in Thompson-Yates Reports. He described in detail, the difference between the appearances in the intra-vital preparations, between the free forms and those embedded in a matrix and added that Donovan himself had observed well all these forms and differences. Ross also refers to M. Laveran's paper and his view that these bodies are neither trypanosomes or hematozoa but belong to the group *Piroplasma*. On the whole, Ross was inclined to think that these bodies belonged to the class Sporozoa. In the concluding paragraphs, he offered his apologies to Major Leishman for overlooking the fact that he had found these bodies in 1900 and suggested that the specific name to be adopted for the new genus should, in all fairness be, *Leishmania-Donovani*.

ASSOCIATION NOTES

COIMBATORE BRANCH

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

A meeting of the Association was held on the 23rd of October to receive Hon'ble Sri Rajkumar Amrit Kaur, Minister for Health, Government of India at 3-30 P.M. in the Association premises Dr. I. Pitchai Robert presiding. About 100 members attended the meeting. After tea and light refreshments the Minister was welcomed by the President and a Memorandum submitted. The Minister in her reply promised to consider the suggestion and appealed to the professional men to do some honorary work in the rural areas.

With a vote of thanks by the Honorary Secretary to the distinguished guest and to the hostess of the evening Dr. Miss. M. K. Saraswathi the meeting terminated at 6 P.M.

ERODE BRANCH

President : Dr. R. S. K. Raman
 Vice-President : „ E. S. Venkataraman
 Secretaries : { „ N. C. Kuppusamy
 „ M. N. Shenoy
 Treasurer : „ M. M. Shenoy

A meeting of the Association was held at Sengunthar High School with Dr. B. S. Viswanathan in the chair. Dr. P. N. Krishnan, Superintendent, Rajaji Sanatorium, Tiruchirapalli spoke on "Some aspects of Pulmonary Tuberculosis-useful to General Practitioners." About 25 doctors attended.

The learned lecturer stressed the following points:

1. It is axiomatic that in a chronic case, Tuberculosis and Syphilis have to be eliminated before thinking of other diseases.

2. Early diagnosis is to be aimed at to give best treatment to the patient.

3. In every case skiagram of the chest is to be taken and tubercle bacilli demonstrated in the sputum.

4. The General Practitioner should be in the vanguard of the fight against tuberculosis since it is he who first sees the patient. He is also able to trace the disease in the family and must segregate the contacts and establish the presence or otherwise of the disease in them.

In the treatment part, rest and collapse therapy still from the sheet-anchor of treatment. He warned the practitioner of the indiscriminate use of streptomycin which can compliment

but can never replace collapse therapy. The lecture was followed by screening of 3 cinema films viz., (1) Tolserol Acid Hydrazide" reports say that drug resistant strains develop in 10% of cases during the first month, 50% of cases during the 2nd month and 70% of cases during the 3rd month. So this so-called wonder drug has definite limitations.

(2) Uses of Curare (3) Tropical Nutritional Anaemia provided by Messrs. Squibb and Sons.

Dr. M. N. Shenoy proposed a vote of thanks. Tea was provided by Dr. (Mrs.) A. D. Rajanayagam.

NILGIRIS BRANCH

President : Lt. Col. J. C. Bharucha
 Vice-Presidents : Dr. S. R. Pandit & Dr. C. Gopalan
 Hony. Secretary : „ P. V. Kurian

The monthly meeting of the Association was held at Aruvankadu Club, Cordite Factory, Aruvankadu at 3 P.M. on Saturday 15th November, 1952 with Lt. Col. J. C. Bharucha in the chair.

The Secretary read the minutes of the Annual Meeting and it was passed. He announced the starting of the circulation of the 'British Medical Journal', the increase in membership of this branch and about the meetings to be held in December and January.

Dr. C. K. Ramchandrar, of Messrs Barry & Co., Ranipet, and Secretary for the Madras State Branch of the Society for the Study of Industrial Medicine, India, spoke on the subject of 'Concept of Industrial Medicine.' After tracing the growth of Industrial Medicine in different parts of the world, he stated that Industrial Medicine and occupational health were blind spots with general practitioners and consultants. The Second World War demonstrated the great value of adequate medical care of industrial workers in stepping up production. Though we could get the broad principles and methods from highly industrialised western countries, we had to work out the details basing on our local conditions.

According to the speaker industrial medical care was very comprehensive.

It touched the physical, mental and moral outlook of the worker. Though it included good medical care and hygiene, it was much more than environmental hygiene. Besides pre-placement and periodical medical examination of all employees, it included regular analysis of industrial accidents and the application of necessary corrective measures. An industrial physician who respects the human rights of the worker and handles them with a human touch can often be an ambassador of good-will between management and labour. Great industries have found this a sound investment.

Continuing, the speaker traced the inauguration and growth of the Society for Study of Industrial Medicine in India and its Madras State Branch-He invited doctors in the Planting Industry to join this Society. Answering several questions he dealt with the records maintained by the Factory Medical Officer and the possibility of an allergen in tea leaves. Capt. DeLemose and Dr. H. C. Berlie spoke from their wide experience of Industrial Medicine.

The following films projected were:—
 1. "Medical uses of sulphonamides" showing the history of sulphonamides, their pharmacology and the clinical uses. (Through the courtesy of Messrs. May & Baker (India) Ltd., Madras.)

2. "Tuberculosis"—a good public health film for lay people. (Through the courtesy of the U.S.I.S., Madras) and 3. "We see them through" showing the excellent arrangements made in a State in U. S. A. for the care of children contracting rheumatism. Capt. DeLemose and medical officers of Cordite Factory were at home to those present. A cheque for Rs. 1000/- was handed over by the President to the Director, Pasteur Institute, Coonoor, being the amount collected for the projector fund

NAGAPATTINAM BRANCH

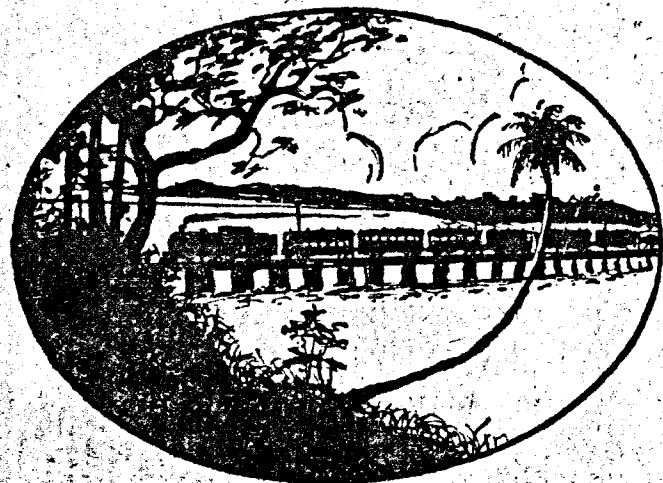
President: Dr. J. Y. Arthur, B.A.
Hony. Secretary: " S. Vijayaraghavan
Treasurer: " T. S. Varadachary

At the monthly meeting of the Nagapattinam Branch of the I. M. A., held at the Government Hospital, Nagapattinam, on 26-10-52 at 6 P.M. with Dr. J. Y. Arthur in the chair, 12 members attended. After tea provided by Dr. E. R. Menon, Dr. S. K. Pillay, Asst. Surgeon read a paper on "COMMON DISEASES OF THE NEW BORN" The speaker gave a lucid review of the varieties of Jaundice, and their differential diagnosis. He stressed that most of the ailments in infants, particularly those of the respiratory and gastro intestinal tract, were due to poor resistance and low adaptability of the infant to its environments.

This was followed by a lively discussion, in which many members took part.

As most of the cases of diarrhoea and vomiting in infants were caused by irregular and mixed feeding, it was felt that every nursing mother should be properly educated on right feeding habits in their children. The desirability of instilling a week solution of Argyrol or preferably 1 in 1000 penicillin into the conjunctive of the *new born* in the prevention of ophthalmia neonatorum was adequately stressed.

After a vote of thanks proposed by the Secretary to the host of the evening, Dr. E. R. Menon, and the speaker, the meeting terminated.



INDIAN MEDICAL ASSOCIATION

RAMANATHAPURAM DT. BRANCH

TWENTY SECOND ANNUAL REPORT

Ladies & Gentlemen,

It is with great pleasure. I am presenting you the annual report for the year 1951-52. Though I have been a member of the Association for the past ten years the working of the Association was entirely new to me till I became the Secretary last December.

It is regrettable to note that there were only twenty one members for this year. At the last annual meeting Dr. S. Sundaresan the then Secretary had appealed to the members of the profession to join the association. Unfortunately many have not responded. Once again I request those of you who are not already members, to join immediately. Wherever possible please ask your friends also to become members. Further I appeal to the members of the association to take more active part in the proceedings of the association.

Finance

The balance at the end of the year under review is Rs. 566-8-3 as against Rs. 648-11-0 at the end of the previous year. The only way to improve the finance is to increase the number of members and ask the members occasionally to contribute more money. Members must pay the subscription at the beginning of every year to the treasurer and notify the secretary about any change in address, so that the journals may be sent to the correct address. Any default in the payment of the subscription fee will seriously affect the finance of the association.

Meetings

We had only four clinical meetings. The details of the meetings are given

in an appendix at the end of the report. In this connection I thank Dr. M. G. Jones, our President, Dr. T. S. Kalkura and Dr. G. Subramaniam of Aruppukottai, Dr. M. Samuel and Dr. D. K. Jayabalaraj of Sivakasi for all the arrangements they had made in their places to conduct the meetings.

It is gratifying to note that many of the members of the association attended the Provincial Conference at Palamcottah and I hope that they will continue to attend all the Provincial Conferences with the same enthusiasm.

This year the British Medical Association has been kind enough to supply our branch through the Provincial Branch, a free copy of the journal. I have made arrangements to circulate the journals to the members, along with Provincial Office and Central Office Circulars regularly. I request the members to pass on the journal to the next member without unnecessary delay.

As the Secretary of the association I have found the members very obliging and they have co-operated with me in all the work. I thank Dr. S. N. Ganapathi, Dr. R. Venkatachari and Dr. T. S. Kalkura for their valuable suggestions from time to time.

To-day we are fortunate enough to have in our midst two eminent men of our profession Dr. U. Sripathi Rao of Madras and Dr. M. N. Rajan of Madura as speakers. On behalf of the members I thank them for accepting our invitation.

Messrs. Imperial Chemical Industries (India) Ltd., and Messrs. Lederle Labora-

tories Ltd., were kind enough to arrange a film-show this evening and I thank them on behalf of the association.

Lastly our thanks are due, to the Chairman and Commissioner of Virudhunagar Municipality for lending the

Council Hall from time to time to have our meetings.

Once again I thank all the members for their kind co-operation.

Virudhunagar. } **T. Muthusamy.**
22-11-52. } *Honorary Secretary & Treasurer.*

APPENDIX I

List of Meetings held in the Year 1951-52.

No.	Date	Venue	Topic	Speaker
1	16-2-52	Aruppukottai	Abdominal Tuberculosis.	Dr. P. Vadamalyan, M.B.B.S. Hony. Surgeon, Madurai.
2	19-4-52	Virudhunagar	Leprosy.	Capt. S. N. Ganapathi, M.B.B.S. Virudhunagar.
3	19-7-52	Sivakasi	The progress of Medicine and Surgery in China	Dr. G. W. Milledge, L.R.C.P. & S. D. T. M. & H., Neyoor.
			Ascitis	Dr. R. Venkatachari, M.B.B.S. Virudhunagar.
4	31-8-52	Ramnad	Neglected Labour and its Consequences.	Dr. S. Subbalakshmi, M.B.B.S., D.G.O., D.M.O. Ramnad.

RAMANATHAPURAM BRANCH

President : Dr. M. G. Jones
Vice-President : „ R. Venkatachary
Hony. Secretary & Treasurer : „ T. Muthusamy

The twenty-Second annual meeting of the Ramanathapuram District branch of the I. M. A. was held in the premises of the Kshatrya Vidhya Sala High School, Virudhunagar, at 4 P. M. on 22-11-52.

The speakers, members and the visitors were entertained to tea by the association.

Dr. M. G. Jones, president of the association presided over the function. Dr. T. Muthusamy, Secretary of the association read the annual report (published herewith) with statement of accounts. The annual report was adopted

by the members. The secretary appealed to the members of the profession to join the association. Then messages of greetings for the meeting were read.

Dr. S. N. Ganapathy explained to the members about the difficulties of having the clinical meetings in many places owing to the paucity of members in certain parts of the district.

Then the members elected unanimously Dr. R. Venkatachari as President and Dr. T. Muthusamy as Secretary for the next year.

Later Dr. M. G. Jones explained to the members about the need for having

rules for the association for the proper functioning of the branch. Members accepting her suggestion resolved that a committee, consisting of the following, be empowered to frame the rules of the association and place it before the general body of the association before 1-1-53.

1. Dr. R. Venkatachari
2. Dr. T. Muthusamy
3. Dr. M. G. Jones
4. Dr. S. Meenakshisundaram
5. Dr. G. Subramaniam

Then Dr. U. Sripathi Rau of Madras gave a very interesting lecture on "Acute Diarrhoea and Dehydration in Infants" with illustrative cases. He explained the differential diagnosis in various diarrhoea and their treatment.

Dr. M. N. Rajan of Madura spoke on "Some Aspects of Cardiac Pain". He

explained the various diseases where cardiac pain is a prominent symptom. Many members took part in the discussion following the speech.

At 7 P.M. there was a film-show on Aureomycin and Filariasis by Leaderle Laboratories (India) Ltd., and Ether Anesthesia and stages of Anesthesia by Imperial Chemical Industries (India) Ltd.

The Secretary proposed a vote of thanks to the speakers, members and visitors. The Secretary on behalf of the association thanked the Secretary of K. V. Sala for lending the hall, Mr. P. Thangarajan B. Sc. (Hons.) for lending the projector and the proprietor, South Indian Manufacturing Co., for printing the annual report.

The meeting terminated after a sumptuous dinner.

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TIRUCHY BRANCH

ANNUAL REPORT

Ladies & Gentlemen,

I have very great pleasure in presenting to you, on behalf of the Managing Committee, the annual report for the year 1951-52. We had our last annual meeting on 18th November 1951 when Drs. Y. P. Vasudevan, R. Subramanyam, N. Vaidyanathan, K. N. Rao, D. Damodar Dass, C. Raghavachary and V. S. Subramanyam addressed our association on various subjects under the presidency of Dr. R. Kalamegham. After the lectures we had film shows on Modern Sanatorium and Surgical Treatment of Pulmonary Tuberculosis, Nutritional Dystrophy among children in Madras, the working of the Pasteur Institute, Coonoor, Larynx, Extra Pleural Pneumothorax, and Anaemia.

Before reviewing our activities during the year, I must bring to your notice a very painful fact. Dr. D. Srinivasan one of our Life Members and a former Editor of the Miscellany had been snatched away from our midst in January 1952 while in harness. We who have known him, especially his valuable record of services to our association will always cherish grateful memories about him.

Eight meetings of the managing committee which were well attended, were held and the work of the association was directed from time to time. We held 12 clinical meetings during the year. For our meetings we had lecturers of outstanding merit and renown and a wide variety of subjects were dealt with in these lectures. This year we had the honour of meeting Dr. U. Krishna Rao, M.B.B.S., M.L.A., Minister

for Industries, Labour and Motor Transport, Madras Govt., Dr. M. V. Krishna Rao, B.A., M.B.B.S., M.L.C. Minister for Education, Madras Govt., and Dr. Stoll from Switzerland who is known internationally for his work on Chlorophyll and plant Glucosides. The South Indian Provincial Medical Conference was held at Tirunelveli and many of our members attended the same. During this period some of our members were invited to deliver lectures at Mathurai and Salem District Medical Associations.

This year, we are happy to record some very noteworthy features. It was an unique honour that one of our members Dr. E. P. Mathuram has been elected as an M.P., and Dr. G. Joseph Gnanadickam as a Councillor of the Tiruchy Municipality. We have to congratulate Dr. T. S. Balasubramanyam, M.B.B.S., on his 61st Birthday which falls tomorrow. Long live Dr. Balasubramanyam for his Sathabishekam too. We share with Dr. Ramamurthy and Dr. Indira Ramamurthy the ecstasy which is their's tomorrow.

The work of the District Health Association is carried on energetically by Dr. P. A. S. Raghavan who also takes an active part in the work of the Hind Kusht Nivaran Sangh and the Indian Red Cross Society as its Secretary. I would also like to say that the Miscellany is still run by Dr. P. A. S. Raghavan on behalf of the South Indian Provincial Branch and he hopes that he would be able to make a contribution to our branch if the journal is run on a more profitable basis.

association have undertaken a campaign of blind relief and propaganda on care of the eyes in the district. They have within a year visited 34 camps, serving a total number of 1107 villages. The total number of cases seen by them are 6822. Their report stresses the need for medical attention and education of the public on elementary care of the eyes. For example out of 1750 blind eyes seen by them, so many as 659 need not have gone blind at all, if the eyes had been properly protected or if people knew what should be done in early cases of a simple disease or accident. The ophthalmologists have also undertaken the examination of the eyes of the high school children in the city year after year, so that the deterioration in any eye is noticed early and steps are taken to prevent it. Their statistics reveal information which must draw our attention towards the care of the eyes of our children. Among 1595 boys examined in 1951, so many as 552, had vision which is below normal. That is one fourth of our children between the ages of 9 and 19 do not have full normal vision. During the second year of examination they noted 38 boys who had normal vision in 1951, had a lower vision, after a year. On the other hand with necessary treatment and injections, they noted improvement in the vision of 95 boys. Complaint is frequently made that no doctor is available for rural dispensaries and they are closed down on that account. Our President has offered the free services of doctors in the city who could go to the villages on particular days and run the dispensaries for the benefit of the villagers. His proposal is under the consideration of the authorities concerned.

During the year 13 newmembers joi-

ned our association and I regret to say that the name of Dr. N. A. Subaroyan had to be deleted from the membership of the association due to the long outstanding arrears. It is however gratifying to note that the arrears of subscription outstanding from members are considerably less this year.

Our efforts to build a building for our association have not been attended with success since the town planning scheme has not yet been finalised. At this juncture I must point out that we were able to get Rs. 8,400/- from the Govt. for the sale of our lands to them. The building fund account amounting to Rs. 16,000/- is invested in National Saving Certificate and Fixed Deposit. The Certified statement of accounts show a net increase of Rs. 197-8-10. It is hoped that at least next year we will have a building of our own.

Finally, I thank all the lecturers who had responded to our invitations and addressed us on various occasions, to Lt. Col. T. H. Morris of Messrs. T. J. Smith and Nephew for the film show, to the authorities of the Bishop Heber High School, the Superintendent of the Govt. Hd. Qrs. Hospital, to the Secretary, District Health Association and to the President of the District Board for allowing their premises for our meetings, to the various members who came forward on every occasion to stand as hosts, to the various companies who stood as hosts and who exhibited medical films, and to the members of the managing committee for the very valuable support they have given me. Thank you ladies and gentlemen.

JAI HIND.

A. Dharmarajan,

Hony. Secretary.



Summary of Meetings held During the Year 1951-52

DATE	PRESIDENT	LECTURER	SUBJECTS	HOST	PLACE
18-11-51	Dr. R. Kalamegham	Dr. Y.P. Vasudevan	Prevention of Tuberculosis	Chemists & Drug-gists of Tiruchy	Bishop Heber High School
		Dr. R. Subramanyan	Random Reflections	M/s. Pharmaceu-tical & Research Labs., Madras	
		Dr. N. Vaidyanathan	Coronary Insuffici-ency	M/s. Sarabhai Chemicals, Baroda	
		Dr. K.N. Rao " D. Damodar Dass }	Recent trends in control & treat-ment of Tuber-culosis	M/s. W. T. Suren & Co., Ltd., Bombay	
		Dr. C. Raghavachary	Diseases of Rectum and Anal canal in General prac-tice		
		Dr. V. S. Subramanyam	Diseases of Larynx		
10-12-52	do	Dr. P. Arunachalam	Rheumatic Fever	Dr. R. Kalamegham	Govt. Hd. Qrs. Hospital
9-1-52	do	Dr. C. V. Ramchandani	W. H. O.	Dr. Vepa Ramamoorthy	Aerodrome, Tiruchy
17-2-52	do	Dr. S.T. Narasimhan	Epilepsy & Electro Encephalography	Dr. R. Seshadri	Govt. Hd. Qrs. Hospital
5-3-52	do	Dr. N. Vaidyanathan	Dyspepsia	Dr. C. R. Chari & " A. Dharmarajan	do
27-4-52	do	Dr. B. S. Viswanathan	Medical treatment of Pulmonary Tuberculosis.	Dr. V.N. Lakshmi-narayanan & Dr. M.V.A. Iswaran	Govt. Hd. Qrs. Hospital
4-5-52	do	Dr. T.V. Venkatesan	Some recent drugs and their clinical uses	Dr. V.V.S. Krishnamoorthy	do
1-6-52	do	Dr. N. Chandrasekaran	Local Anaesthesia	Dr. T. R. Rajagopalan	Dist. Health Association
3-6-52	do	Dr. M.G. Kini	Rehabilitation of crippled children	Dr. K. P. Chidambaram	do
5-7-52	do	Dr. P. Govinda Rau	Diseases of the prostate & their treatment	Dr. M. R. Bhat	Bishop Heber High School
12-7-52	Dr. T.V. Srinivasan	Dr. P. Natesan	Recent develop-ments in Vene-reology	Dr. T.V. Sundaram	Dist. Health Association
3-9-52	Dr. R. Kalamegham	Dr. B. Ramamurthy	Spinal cord lesions	Dr. T. V. Ranga-nathan & Dr. T. M. Krishna-moorthy	District Board Meeting Hall
25-10-52	do	Dr. R.E.S. Muthaiah	Headaches in rela-tion to Onthal-	Dr. A.N. Subbaraman	do

December 1952

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INDIAN MEDICAL ASSOCIATION TIRUCHY BRANCH

The 23rd Annual Meeting of the Association was held on Saturday the 22nd, November 1952 at 10 A.M. in the premises of the Bishop Heber High School, Teppakulam, Tiruchirapalli. About 125 members including some visitors from sister associations and press representatives were present. Dr. R. Kalamegham the President was in the chair. After breakfast kindly given by Messrs. Fine Pharmaceuticals, Kumbakonam, the President opened a discussion on "Three Year Medical Course". Drs. T. S. Balasubramanyam, P. A. S. Raghavan, T. V. Srinivasan, L. S. Ramachandran, S. Venkatachari and Dr. Y. P. Vasudevan from Coimbatore took part in the discussion. Then the following resolution was passed unanimously.

"The Tiruchy Branch of the Indian Medical Association disapproves the suggestion of the Govt. of Madras to start a Three Year Medical Course to be conducted in the Dist. Head Quarters Hospitals with the idea of carrying medical relief to rural areas. This association is of opinion that the products of the Three Year Medical Course cannot acquire sufficient knowledge to give medical relief nor were they likely to settle in villages.

This association recommends to the Govt. and the Universities to adopt the suggestion for the Indian Medical Council to introduce the shift system in Medical Colleges and increase admissions into medical colleges by at least 25% more."

Then Dr. A. Dharmarajan, the Secretary presented the Annual Report for the year 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 from the Chair Dr. T. S. Balasubramanyam was elected as President and Dr. T. V. Srinivasan was elected as Vice-President and approved unanimously by the members. The following office-bearers were elected for the year 1952-1953.

Secretary: Dr. A. Dharmarajan

Treasurer & Jt. Secretary: " S. Venkatesan

Committee Members: " P. A. S. Raghavan
" V. Enok
" V. K. Ranganathan
" T. M. Krishnamoorthy
" T. V. Sundaram

Provincial Council: " T. S. Balasubramanyam
" R. Sambasivam
" V. Iravatham

Central Council: „ T. S. Balasubramanyam
 „ R. Sambasivam
 „ V. Iravatham

Then the members adjourned to Lunch kindly provided by Messrs. East India Pharmaceutical Works Ltd., Calcutta. The afternoon session commenced at 2 P.M. with Dr. T. S. Balasubramanyam in the chair. The President introduced Dr. K. R. Doraiswamy, M.A.R.S. Madras to the members and requested him to give his talk on Tomography in relation to Pulmonary Tuberculosis. After the lecture there was a discussion in which many members took part. Then the President introduced Lt. Col. V. R. Thayumanavaswamy, M.S., MCh., F.R.C.S., Madras to the members and requested him to give his talk on "Fracture Neck of Femur." After the lecture and discussion the members were entertained to Tea given by Dr. B. Ramurthy, M.S., F.R.C.S.E., Madras and Mr. B. Krishnamurthy, B.Sc., M.S., Calcutta on the eve of the 61st Birthday of their father Dr. T. S. Balasubramanyam to be held on Sunday the 23rd November 1952. The evening session commenced at 4-30 P.M. when Drs. R. Subramanyam, B.Sc., M.D., M.R.C.P., and U. Mohan Rau, M.S., F.R.C.S. gave lectures on Pulmonary Amoebiasis and Dysuria in the elderly male. 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. Then 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, Tiruchy for kindly placing the hall at our disposal for the meeting. After the vote of thanks two films were shown by Messrs. May & Baker Ltd., Madras and were appreciated by the members. After a dinner provided by Messrs. Alembic Chemical Works Ltd., Baroda to the members, the grand function came to a close at 9-30 P.M.

TANJORE BRANCH

President: Dr. N. R. Subramanyam
 Vice-President: „ T. M. Pillai
 Hony. Secy. & Treasurer: „ S. Narayanan.

The monthly meeting of the Association was held at 4-30 p.m. on 26-10-52 at the Medical School Buildings, R. M. Hospital, Tanjore. Dr. T. M. Pillay, the Vice-President of the Association was in the chair. Twenty-six members were present.

After tea provided by Dr. T. R. Seshadri M.B.B.S., Tanjore, the minutes of the last meeting were read and adopted. Correspondence and communications from the Provincial Secretary and the Central office were read out to the members.

Captain V. S. Nedungadi L.M.P. (Mad.) L.M. (Dublin) Z.C.D. (wien) then spoke about his one hundred

cases of labour. He described the routine followed in his hospital in cases of normal labour. He gave the case history of a number of complicated cases and how they were managed. The general poverty of the people and the lack of proper equipment and services of an anaesthetist were great handicaps in the management of difficult labour. He said that regular antenatal attention was necessary in all cases to prevent complications during labour.

The lecture was followed by a discussion after which the meeting terminated with a vote of thanks to the lecturer and the host of the evening.

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 BARODA 3

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

CORONARY THROMBOSIS — *The Journal, June, 1952.*

TO THE EDITOR—A patient was treated for coronary thrombosis. He was kept at rest for a long time and has been advised to exercise moderately all this year. He went to a heart specialist in another city, who said there was no evidence of his ever having had coronary occlusion. He went to another city and had another heart specialist examine him. This heart specialist said there was no trouble at this time and doubted that there ever had been a coronary occlusion; however, after looking at the electrocardiogram which the first internal medicine specialist had made, he said that he felt there was some evidence on the electrocardiogram that there had been a coronary occlusion. This left the patient confused, so he went to still another heart specialist, who stated that there was no evidence of coronary occlusion and there never had been. His "attack" occurred in February 1949.

1. Does a normal electrocardiogram at this time preclude any possibility of there ever having been a coronary occlusion?
2. If an electrocardiogram taken at this time shows no evidence of there ever having been a coronary occlusion, can he safely assume that he is completely out of danger and forget that he may ever have had heart trouble? Each of these so-called heart specialists has a good reputation in his own locality.

ANSWER.—A normal electrocardiogram does not preclude the possibility of there having been coronary occlusion in the past. This is not an unusual occurrence. It is necessary, therefore, to have adequate information, preferably by direct comparison of the electrocardiograms in the past at the time of the episode that might have been thought to have been coronary occlusion with the newer record before definite conclusions are made. Second, if there is no other evidence of heart disease and the present electrocardiogram is normal, a fairly good prognosis may be given even though coronary occlusion may have occurred in the past. This prognosis, however, cannot be given without qualifications, for recurrence of coronary heart disease is common. One should in this

instance follow the middle line of common sense measures, periodic examinations (probably once a year would suffice), careful review of family history and possibly studies of metabolic nature, including content of cholesterol in the blood.

* * *

TREATMENT OF PNEUMONIA IN CHILDREN WITH A SINGLE INJECTION OF REPOSITORY PENICILLIN—*John F. Grigler, Jr., M.D., J. Neil Lysaught, M.D. and Elizebeth G. Fisher, Ph. D.—The Journal, June, 1950.*

The use of penicillin in the treatment of pneumonia in outpatients was made practical by its suspension in oil and beeswax. Although the use of such a preparation in children was satisfactory, daily injections were necessary and in adults reactions were frequent. Therefore, following the report of Tillett, Cambier and McCormack, and later the experimental work of several investigators, a twelve hour schedule of aqueous penicillin intramuscularly was chosen for use in the pediatric outpatient department of this hospital. For the past two years such a schedule has been used successfully. It has, however, posed a twofold problem: first, the inconvenience to the parents and possible harm to the patient of repeated dispensary visits; second, the increased burden on the nursing and administrative facilities of the outpatient department. For these reasons, a study of the effectiveness of a new repository penicillin giving therapeutic levels for several days was undertaken.

Material and Method of Study

A preparation of crystalline penicillin G procaine suspended in peanut oil containing 2 per cent aluminum monostearate was used. This preparation was supplied in 10 c.c. vials containing 300,000 units per cubic centimeter. The peanut oil used as a vehicle was deprotenized, and the penicillin particle size was less than 5 microns.

Between Jan. 1 and May 15, 1949, in 106 consecutive cases diagnosed as pneumonia on the first dispensary visit the patients received the repository penicillin. Ninety-one of these cases are reviewed

here, the other 15 being excluded from this study because of mistaken diagnosis, inadequate follow-up or inclusion through error of additional penicillin therapy. All cases admitted to this study were seen and followed by the two senior authors. Only cases of clearcut lobar or bronchial pneumonia were included, the selection being based on a characteristic history and physical observations and fluoroscopic and roentgenographic evidence of pulmonary consolidation or infiltration. Nasopharyngeal and blood cultures were performed routinely before the injection of penicillin. All patients had tuberculin tests. A blood leukocyte count and a hemoglobin determination were obtained in 87 of the 91 cases. Tests for cold agglutinins and agglutinations of the MG strain of streptococcus were made on patients whose clinical course of laboratory data suggested the diagnosis of primary atypical pneumonia.

The dosage of the repository preparation of penicillin (table 1) was based on previous experience with aqueous penicillin given every twelve hours. A maximum dose of 1,200,000 units was established.

TABLE 1.—Dosage of Repository Type of Penicillin

Weight of Patient (Lb)	Units
Up to 10	300,000 (1.0 c.c.)
10 to 15	450,000 (1.5 c.c.)
15 to 20	600,000 (2.0 c.c.)
20 to 30	900,000 (3.0 c.c.)
30 and over	1,200,000 (4.0 c.c.)

This is approximately one quarter of the total amount of aqueous penicillin given in discontinuous therapy of pneumonia in adults. After the vial was thoroughly shaken, the preparation was withdrawn in a dry syringe through a no. 19 needle and injected intramuscularly in the buttocks through a no. 20 needle. No more than 2 c.c. was deposited at one site.

For the most part, these children were treated as outpatients, the follow-up consisting of four consecutive daily visits after the day of injection and later visits on the seventh and fourteenth postinjection days. The patients were admitted to the hospital only when the treatment of their

disease had to be supplemented by therapeutic measures not available at home, i.e., parenterally given fluids and oxygen. Physical examinations were made on each visit and fluoroscopic examinations on the first, fourth, seventh and fourteenth days. Initial roentgenograms were made, with few exceptions, on the day after injection. Further roentgenograms were made as deemed necessary. At varying intervals after the injection of the repository penicillin and on each return visit up to the seventh day, blood was drawn for assay of serum penicillin levels. Orders for care of the patients consisted of complete bed rest, except for daily dispensary visit, for forty-eight hours with provisions for fluid intake sedation and diet as indicated. No other antibiotics or chemotherapeutic agents were used at any time.

In the present study 74 patients were Negro and 17 were white. The ages of the patients ranged between 1 month and 12½ years. For the purpose of clinical classification, in patients whose lungs showed a

TABLE 2.—Distribution of Patients according to Age and Type of Pneumonia

Age	Broncho-pneumonia	Lobar Pneumonia	Total
Under 2 years	13	32	45 (49%)
Under 1 year	(4)	(18)	(22) (24%)
Over 2 years	11	35	46 (51%)
Total	24	67	91 (100%)

localized homogeneous consolidation the diagnosis was lobar pneumonia, while in those whose lungs showed a diffuse, patchy infiltration the disease was designated bronchopneumonia. The distribution according to age and type of pneumonia is shown in table 2.

Results

The results of treatment were classified as good or as failures. The result was considered good when the patient made an uneventful recovery in a reasonable length of time, without complications or use of further specific therapy. This group was further subdivided into very rapid, rapid

and slow responses. A very rapid response was one in which the patient was afebrile within twenty-four hours and asymptomatic within four days. The response was considered rapid when the patient was afebrile within forty-eight hours and asymptomatic after four days. Those patients whose fever fell by lysis but who were completely asymptomatic within two weeks and required no further treatment were classified as having a slow response. The patients who did not have an uneventful recovery with a single injection of the repository penicillin preparation were considered failures. There were no deaths in this group of cases. Six patients required hospitalization.

The results of treatment in the 91 cases studied are recorded in table 3.

Of the 87 patients showing good responses, 8 had previously been treated with sulfadiazine and had failed to improve. Six of these had received usually effective

TABLE 3.—Results of Treatment with Repository Penicillin in 91 Cases

Results	No. of Cases
Good	87 (96%)
Very rapid (afebrile within 24 hr.) (65)	
Rapid (afebrile within 48 hr.) . . (18)	
Slow	(4)
Failures	4 (4%)
Total cases	91 (100%)

doses of sulfadiazine for two to eight days. The other 2 had received sulfadiazine for five day periods, four and five days before admission to the study.

Four cases were considered failures.

CASE 1.—A Negro infant aged 15 months had a three day history of rhinorrhea, cough, fever and vomiting. The temperature was 105.4 F. (rectal). The child was acutely ill with physical and fluoroscopic evidence of pneumonia of the upper lobe of the right lung. A type 14 pneumococcus was cultured from the nasopharynx. The blood was sterile. Repository penicillin, 600,000 units, was given intramuscularly. The patient was afebrile in fifteen hours and considered well on the seventh day, with a slight residual infiltration in the lower portion of the upper lobe of the right lung. He returned on the fourteenth day with fever and slight cough of one day's duration. His temperature was 104 F. (rectal) and he had bilateral otitis media. The small patch of infiltration in the lower portion of the upper lobe of the right lung was

still apparent with fluoroscopic examination. He was treated with aqueous penicillin every twelve hours and made a rapid recovery.

TABLE 4.—Pathogenic Organisms Recovered from Patients Treated

Organisms	Nasopharyngeal Culture	Blood Culture
Pneumococcus		
Type 14	17	...
Type 19	10	...
Type 4	8	2
Type 6	8	...
Type 23	8	81% 1
Type 1	4	1
Type 15	4	...
All other types	19	1
	(Type 17)	
Hemolytic Staph. aureus and albus	5	...
H. Influenzae (negative quelling types A-B with or without pneumococcus)	5	...
H. Influenzae B	3	1
Beta hemolytic streptococcus with and without pneumococcus	2	...
B. mesentericus with beta hemolytic streptococcus	1	...
Negative cultures	3	...
Unsatisfactory cultures	5	...

CASE 2.—A Negro boy aged 5 years had measles with cough, fever and rapid breathing of one week's duration. Temperature was 103.2 F. (rectal). Physically and radiologically, he had a pneumonia of the lower lobe of the right lung. A nasopharyngeal culture was negative. Repository penicillin, 1,200,000 units, was given. The patient was afebrile in twenty-one hours, and physical and fluoroscopic examinations of the chest revealed essentially normal conditions by the fourth day. He returned on the thirteenth day with cough and harsh breathing of two day's duration. Bronchopneumonia of the middle and lower lobes of the right lung and of the lower lobe of the left lung was demonstrated physically and radiologically. A nasopharyngeal culture grew alpha streptococci. He was again given 1,200,000 units of the repository penicillin, with subsidence of fever in forty-six hours and an uneventful recovery within one week.

CASE 3.—A Negro boy aged 10 years had fever of four days' duration and chills, cough and pain in the right lower portion of the chest for three days. The temperature was 102.6 F. (rectal). There was physical and fluoroscopic evidence of massive consolidation in the middle third of the right lung, confirmed by roentgen examination. A nasopharyngeal culture was negative. Sixteen hours after the injection of 1,200,000 units of the repository penicillin the child was afebrile, although he continued

TABLE 5.—Number of Assays Done at the Various Time Intervals After Infection

Up to 1 hour	52
1 to 24 hours	88
24 to 48 hours	85
48 to 72 hours	81
72 to 96 hours	79
96 to 144 hours	87
144 to 168 hours	53

to complain of pain in the right side of the chest. Forty-eight hours later he returned with a temperature of 103.2 F. (rectal) and increased pain with respiration. Repeated nasopharyngeal and blood cultures were negative. A second injection of 1,200,000 units of penicillin was given. Twenty-four hours later he was afebrile, and in four days he made a completely uneventful recovery with clearing of the pneumonia apparent clinically and fluoroscopically.

CASE 4.—A Negro boy aged 2½ years had had measles three weeks before this illness, which began two days before admission with fever and cough. The respiratory rate was 50 per minute, and breathing was somewhat labored. The temperature was 104 F. (rectal). Pneumonia of the lower lobe of the right lung was demonstrated physically and radiologically. A type 14 pneumococcus was cultured from the nasopharynx. Blood culture was sterile. Fourteen hours after treatment with 900,000 units of repository penicillin the boy was afebrile, and he remained so for one week, although he continued to cough. On the eight post-treatment day he returned with a temperature of 104 F. (rectal). Pneumonia of the lower lobe of the left lung was now demonstrated radiologically. A type 14 pneumococcus was again cultured from the nasopharynx. After six days of treatment with aqueous penicillin given every twelve hours, he made an uneventful recovery.

A summary of the results of the nasopharyngeal and blood cultures on the 91 patients in the present study is shown in table 4.

Eighty-one per cent of the patients had pneumococci in their nasopharynx. It should be mentioned that 4 patients had two types of pneumococci simultaneously and others had various combinations of pathogenic organisms. Six patients had positive blood cultures, the same organism being present in the nasopharynx in all cases. Nasopharyngeal cultures were taken in 33 of these cases on the seventh and/or fourteenth post-treatment days. On the seventh post-treatment day, cultures from 11 of 18 patients showed the same organisms. On the fourteenth post-treatment day, original organisms were present in cultures from 15 of 24 patients. However,

all these patients made uneventful recoveries. Since most of these patients were from the lower economic strata, where overcrowded living conditions prevail, they may have been reinfected by other members of the household.

Reactions

None of the patients receiving the repository penicillin had any allergic reactions. Local reactions or persistent oleomas were not observed. Twenty-eight of these patients had previously received aqueous penicillin for other illnesses. Eight of the earlier patients have subsequently received aqueous penicillin. None of these patients has shown any sensitivity reactions to intramuscularly given penicillin. Specific studies were not made to determine sensitivity to any component of the repository penicillin preparation used. In the medical clinics of the John Hopkins Hospital over 3,300 injections of the preparation used in this study have been given to adults without any untoward reactions. This observation is in agreement with the low incidence of sensitivity reactions reported by other investigators working with procaine penicillin G in peanut and sesame oils.

Serum Penicillin Assays

The serum penicillin assay method used was that originally described by Rammelkamp with modifications by Eagle. A total of 475 levels was determined (table 5), only 32 of which were done after administration of the two lowest dosages. Since there was a striking similarity among the high, low and average curves in all dosage groups, a composite chart adequately shows the range and average of levels. The levels taken within the first hour were unexpectedly high. Without exception, following any of the dosages used, the serum penicillin level was greater than 0.14 units per cubic centimeter for four days after injection. The apparent inconsistency in these two observations suggested the possibility of delayed excretion of the absorbed penicillin. This has not been the case, however, with procaine penicillin G, which has the same renal clearance as sodium penicillin G. Although the range of levels in all groups was great, the consistency of the rise and fall of serum levels in individual cases was striking.

Similar results have been reported by others.

Summary and Conclusions

1. The treatment of 91 cases of pneumonia in children by a single injection of a repository preparation of crystalline penicillin G procaine suspended in peanut oil containing 2 per cent aluminum monostearate is reported.

2. A Dosage schedule considered suitable for this method of treatment is presented.

3. Good results were obtained in 87 (96 per cent) of the patients treated. Of the 4 patients considered therapeutic failures, 2 recovered uneventfully after a second injection of the repository preparation.

4. Generalized or local sensitivity reactions or persistent oleomas were not observed after the one hundred and eight injections given.

5. Four hundred and seventy-five serum penicillin assays were performed. Unexpectedly high levels were found in the first hour following the injection. Accepted therapeutic levels for pneumococci were universally present for four days.

6. It is concluded that with the dosage schedule outlined, the single injection treatment with a repository penicillin in pneumonia in children is at least as effective as any other schedule of therapy. In outpatient clinic practice, considerations of economy and convenience makes this the treatment of choice.



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ODDS & ENDS

The next All India Ophthalmological Conference will be held in Poona during the first week of March.

♡ ♡ ♡

According to a U. S. Govt. report in 1948, 261 cases of syphilis were reported in a civilian population of 100,000. In 1951 there were only 132.

♡ ♡ ♡

There is a "Body Donors Association" in Japan. After death, their bodies are available for dissection and research by medical students.

♡ ♡ ♡

A bill in the Massachusetts Legislature proposes to prohibit the performance of any labotomy, tapectomy or transorbital operation or any brain operation designed to alleviate a functional disorder, unless the hospital staff has, by a two-thirds vote, approved the reasons for performing such an operation.

♡ ♡ ♡

From Newark Star Ledger, Thursday, August 28, 1952.

Despite Mrs. Stevenson's public diplomacy, the relationship between her and her husband had not improved. Good reason.
J.A.M.A.

♡ ♡ ♡

Beggar: "The lady next door gave me an Idli. Won't you give me something too?"

Lady: "I shall give some pills for its digestion."

♡ ♡ ♡

All aches, all pains demand the heading knife,
To seek a cause engenders only strife,
Why try to make a diagnosis blind?
The open belly suits the empty mind.

—Med. Bulletin.

76
LM 21192, NS 5M3
NS 21192

168209

DON'T'S

FOR DIAGNOSTICIANS

DO'S

1. DON'T be too clever.
2. DON'T diagnose rarities.
3. DON'T be in a hurry.
4. DON'T be faddy.
5. DON'T mistake a label for a diagnosis.
6. DON'T diagnose two diseases simultaneously in the same patient.
7. DON'T be too cock-sure.
8. DON'T be biased.
9. DON'T hesitate to revise your diagnosis from time to time in a chronic case.

B. M. J. 1928.

