BULLETIN
OF THE
SOUTH INDIAN MEDICAL ASSOCIATION.
MAY 1933.

GENERAL NOTES.

The old game of musical chairs has been reintroduced into the medical department. It was the fashion in days gone by and that not long ago. To-day a professor of midwifery, to-morrow of ophthalmology, the day after of jurisprudence the then occupants of the chairs were expected to and did turn their hands to any trade under the government from a mint-mastership to zoological survey. The condemnation it received then from all true lovers of medical relief and medical education is well known. And there were no stronger or more vehement opponents and critics of this than the members of the Provincial Medical Service.

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But then, the privilege of play was restricted to the members of the Indian Medical Service. When the entries were open or, better still, limited, to the local stipendiaries we hear a different tale. Experience in these manifold subjects only improves a person and makes him fit for other places. We have had to criticise these appointments on a former occasion a Professor of Materia Medica being appointed to a lectureship in Operative Surgery, an X-ray expert being posted to a lectureship in Lunacy and so on. Such changes are in no way conducive to improvement in medical education and we wonder whether it was the existence or fear of such moves which made the British Medical Council issue its ultimatum to the Government of India. We are extremely sorry that this has happened during the tenure of a vete an educationist like Major-General Sprawson.

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No one likes to say 'I told you so' but we are afraid we have to do it. We had mentioned before the hostility of the stipendiaries towards the honorary scheme, how they unwillingly bowed down to its inevitable extension and remained so as long as no replacement was contemplated and how the quiescent hostility would blaze forth into activity once such a proposition was before the public. This recent question before the Honorary Committee has justified our prophecy and warning. We understand that the Surgeon-General has invited the opinion of the superintendents of the various hospitals regarding this replacement. They in their turn have invited the opinions of their stipendiary subordinates. We shall not be surprised if the latter in their turn invite the opinions of their assistants and so on. We have not heard of anyone asking the opinion of the honorary officers. We are reminded in this case of the well known story of Aesop relating to the 'Lion and the Man.' We can well anticipate the views at least of some of the superintendents and the majority of their subordinates. For was it not a mad mullah who proclaimed that it was the considered opinion of himself and his staff that the entertainment of honoraries would demoralise the service.

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We do know that there are honorable exceptions. We have not to go far for instances of such men. To mention one, Coimbatore gives us a standing example of how a happy team under a sympathetic chief can work. We have another set who whilst outwardly expressing their acquiescence to the honorary scheme condemn it on its existing personnel. Anyhow, the reports would be interesting reading and we daresay that the Committee would call for them in original. It will be noticed then that the biggest opponents of the scheme are those who are conscious of their own professional weakness and ineptitude and who because of political turns of fortune have attained positions which in the ordinary course of events professional ability would not have enabled them to achieve.

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Anent these reports a little bird tells us, well, we will leave it for a future occasion. There is so much to say.

EDITORIAL.

The Honorary Committee.

"Men saw things in a new light; and knew not even whether it was the sunset or the dawn."—G. K. CHESTERTON.

We are glad to note that the profession is at last evincing some signs of mild interest in the Honorary scheme and the present Committee that is considering the question of extension of the scheme. The appointment of this Committee was in the air for well over a year and it is nearly six months since the Committee was originally constituted. We have been looking forward to considerable activity in the medical associations of the city and the mofussil in the way of mobilizing independent medical opinion about the defects in the existing scheme of medical relief and putting forward practicable suggestions for the improvement and extension of the honorary scheme. We have been greatly disappointed. We have not been able to understand the cause of this silence. It has been suggested that in the midst of the painful struggle for existence among the medical men, the majority of the practitioners have no time to think of the honorary scheme and is therefore indifferent about it. But from our experience of the number of young men who have approached us for information about the honorary scheme, we do not believe that the profession is indifferent. We are aware that it is held by some senior members of the profession that the honorary scheme should not be extended without further experience of its working. They take hold of a case here and an instance there where the honorary medical officer has not been said to be satisfactory. And while they admit that the honorary scheme has generally been successful, far more than anticipated by some, the few failures make them nervous about a rapid expansion of the scheme. They take this line not from lack of enthusiasm for the scheme, but because they desire that the honorary scheme should aim at a much higher level of conduct and efficiency than even what obtains in the *paid* services. There are others who believe that the government is not quite enthusiastic about the scheme and that any representations that the profession might make would be waste of time and thought. This might appear to be a defeatist idea. But we must recognize the existence of this idea among a large number of the practitioners of this province. We have referred to the different views somewhat fully, since we desire that the profession should be well aware of the various opinions held by the members on the question of extension of the honorary scheme, and since one or more of these causes might be responsible for the general silence of the profession on the objects of the Committee recently appointed to consider the question of the honorary scheme.

Whatever might have been responsible for the past indifference, we are indeed glad that the profession has at last begun to take some interest, We have had a few lectures, an article or two in journals and some correspondence in the lay papers and journals. We have carefully scanned these papers and letters. We confess that the profession gets no guidance from them as to what it needs from the government. There are appeals to the Committee, there are admonitions and even threats. But at the end of it all, there is nothing but vagueness. Some complain that those who are already in the honorary scheme are against getting more people into it. Such critics should be very ignorant of the history and the working of the scheme. Others find fault with the previous Committee for its omissions. The wrath of these critics seems to be specially reserved for some of the members of the independent profession who were on the Committee.

It is a common human trait to feel that one knows everything and that one would have done infinitely better than the others in similar circumstances. But it is hardly fair to find fault with people for omitting to do things which they were not called upon to do. The rules that have been framed by the last Committee have been much criticized, but we have yet to come across any suggestions which are real improvements. Some have questioned the representative character of the members of the independent profession on that Committee. Responsible members of the government have attempted to cover their lack of policy with blaming the Committee for not going into the question of substitution of paid honorary staff. If the government then required guidance on this subject there was nothing to prevent it from including it in its terms of reference to that Committee.

It is unnecessary to linger any more on the work of the former Committee. In spite of the criticisms of journals, in spite of the sayings of some public men who have one eye on easy popularity and the other on the safety of their office, and notwithstanding the sneers of ill-tempered anonymous correspondents, we have reasons to believe that the great bulk of the independent profession recognize that the rules are generally helpful to the healthy growth of the honorary scheme. We know well that the profession is dissatisfied with the rules in so far as they relate to the appointment of licentiates to the teaching hospitals. Means should certainly be found to rectify this defect.

It is vastly more important now to consider the work before the present Committee. This Committee has been set up to go into the question of extension of the honorary scheme and the feasibility of substitution of the paid staff by honorary workers. The Government and the Surgeon-General have both testified to the successful working of the scheme, and the honorary scheme has been shown to have saved to the government nearly two lakhs of rupees a year which it should otherwise have spent on increased medical staff. It is therefore assumed by many members of the profession that there is no hindrance now for the rapid extension of the honorary scheme and its utilization to reduce the paid staff. Nothing can be more mistaken than this impression. The profession would do well to remember that there is another party to this question. We refer to be various paid services. We shall mention briefly the known attitude of the various medical services to the honorary scheme. To begin with the Indian Medical service, from a realization of their part mistakes, from a truer insight into the needs of the sick population in the districts and from a better appreciation of what is due to the members of the independent medical profession, the officers of this service with a few regrettable exceptions, have generally been very helpful to the growth and success of this scheme. We are extremely sorry and greatly pained to note that the attitude of the provincial medical service has from the beginning been one of continuous and bitter hostility to the scheme. In the early days their objection to the scheme was in reference to the official rank of the honorary officers, and through various stages their hostility to the scheme has evolved now into one of self-interest. We do not hear from them any concern for the crowded out-patients, nor do they evince any sympathy for the rural sick population who have no centres of medical relief. They are not evidently worried about the need for augmenting the staff of teachers in hospitals and schools. They are

indifferent to the absence of laboratories and the understaffing of the few that exist. But they are anxious that the number of civil surgeons should continue to exist and to increase if possible. They do not seem to be very solicitous about the assistant surgeons who might sometimes be thrown to the wolves if thereby some civil surgeoncies could be saved.

A few years ago some of the senior officers in the provincial medical service were giving out that their opportunities for research work were wasted for want of a sufficient number of junior medical men to help them in the team work. They were suggesting splitting of subjects in the various medical schools and colleges to be handled by a larger number of civil surgeons and assistant surgeons. But now with the advent of the honorary scheme, when they are asked if they would need the services of honorary assistants, they are firm that there is not sufficient work for extra men in the wards. In their generosity these officers sometimes say that the out-patients departments of the general hospitals could usefully employ more medical men. But when medical men apply for honorary assistants, places in the out-patient clinics they would probably be told that there is not sufficient accommodation in these places for more medical men to work at a time!

We have said enough to give an idea of the attitude of the provincial medical service towards the independent profession. While they intensely dislike the scheme, they fear that with further increase in the number of honorary officers, they world gradually lose their position which they now fully utilize for self-aggrandisement. They are like the exploiters of forests who, drunk with the easy success from an yielding soil would splinter their tools against the rocks they encounter at the end of the clearing. They see the decline of their luck, but would not submit to the inevitable. Such men use all their resources, all the advantages they have gained, in tfying to disintegrate the rocks that stand in their way of self-aggrandizement and then finally end in obscurity.

These men in the provincial service are therefore likely to use all their energy and arts in an attempt to spread disunion among the ranks of the independent profession. They might appeal to the vanity of one to distrust the actions of another. They would tear from their context actions and opinions of the honorary medical officers to tell the unwary among them that the seniors are against encouraging younger men. They would say that the honorary scheme is the cause of a number of young men being discharged from service. But they would say nothing of the cupidity of the senior civil surgeons who refused to be retired to make room for the juniors in service. It is therefore necessary that the independent profession should be on its guard and not play into the hands of the members of its avowed opponents.

In these circumstances, the indedent profession should organize their resources and use their undoubted influence with the general public in educating them on the merits and advantages of the honorary system. They should educate the public out of the misconceptions which might have been sedulously instilled by the class of men, who are jealous of their perquisites. In this useful and immediate task, the various medical associations in the districts and taluks can render very get help.

BULLETIN

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Some Common Fungus Infections of the Skin.*

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This is too big a subject to deal with in detail in the period allotted for an evening's lecture. The heading will include many affections of the skin, like Pityriasis Versicolor, Erythrasma, Actinomycosis, Mycetoma, Blastomycetis dermatitis, yeast infections, Sporotrichosis, Pityriasis alba, etc. I am dealing fairly in detail only with conditions common in Madras. I am not dealing with the anatomy of the skin, or the different methods of culture and the different microscopical appearances of the different fungi or the systematic examination of a skin case.

Fungi, Tinea or Ringworm affection of the skin is the name given to certain inflammatory affections of the skin, caused by the implantation and growth of certain of the hyphomycetes or moulds. It is fairly common.

The varied manifestations of Tinea, the varied treatments adopted towards their cure, and the various cases which defy treatment justified Sir Norman Walker calling Tinea the 'Opprobium Dermatologicum.'

There are two distinct types of Ringworm fungus: (1) The small spored or microphytons and (2) The large spored or Trichophyton. Some varieties of microsporon e.g., microsporon Adounii affect only human beings, while others affect both human beings and animals. The large spored Ringworms occur in two groups:

(1) Endothrix group, where the fungus lies wholly within the hair,

(2) Ecto-Endothrix group in which the fungus is found both outside and within the hair.

The Endothrix group is a human type, while the Ecto-Endothrix is essentially an animal type but easily transmissible to man and produces lesions with a marked degree of inflammation and frequently suppuration. Both these cause the disease known as Ringworm. Chalmers and Castellani add two more types of fungus. (1) The Epidermophytons characterised by not attacking the hair and, (2) Favus, which is not quite included as a Ringworm—The fungus, belongs to the genus Achorion.

The Microsporons attack children in particular, the Epidermophytons is found more in the old and the Trichophyton attacks people of all ages.

The horny layer of the Epidermis is the main seat of affection of all ringworm fungus in the beginning, the deeper structures getting affected later on.

Starting to describe the different manifestations of the Fungus Infection it is best to classify them in the following three groups:

(1) Tinea of the hairy region.

(2) Tinea of the glabrous skin—non-hairy skin.

(3) Tinea of the nails or onychomycosis.

1. *Tinea of the hairy region.*—This will chiefly include Tinea of the Scalp, Beard Region, Axillae and Pubes.

* Delivered before the South Indian Medical Union.

2. *Tinea of the Scalp* is not a very common affection in Madras. The fungus involved is the Microsporon—Tinea Tonsurans. This is essentially a disease of childhood. Out of 6,000 cases only 1 or 2 were adults. The disease begins as a circular scaly patch on the head. Other similar patches appear and some of these coalesce to form larger patches. The margins of these patches are lined by greyish white hairs, some of them broken, others very brittle and snap easily when pulled and come off. Sir Norman Walker gives a nice analogy—A cow tethered in a rich meadow and then compelled to feed on a circular patch of grass. He compares the appearance of an early, untouched patch of Ringworm to the condition of that patch of meadow after the cow has finished grazing for the day. There are broken hairs, some of them bent and some twisted—the hair at the centre longer than those at the margin.

The fungus first attacks the mouth of the follicle reaching the hair shaft. Then descends beneath the cuticle of the hair and ends in a sort of fringe just above the expansion of the bulb. The hair easily fractures. One of these infected hairs pulled out, put on a slide, a drop or two of 8 per cent. KOH put over under a cover glass and examined the next day under a microscope show s athick mosaic sheath round the hair.

Scalp affected by the Endothrix variety of Trichophyton presents bald patches resembling Alopecia Areata but, on closer examination reveals small black dots. Hair pulled out from one of these dots with a suitable forceps and examined, reveals fungus. This is named by Aldersmith as ' The Black dot ' Ringworm.

Ectothrix variety of Trichophyton affects the scalp resulting in a more inflammatory type of lesion and the name " Kerion " is given to it. This is mostly a suppurative affection, the fungus, itself being responsible for the formation of the pus. The affected area is raised above the surface—inflammatory—sometimes really looking angry, and boggy to the feel. Pus oozes out through several pores. The hair over this swelling could be easily pulled out and when examined after soaking them in liquor potash, show chains of the Trichophyton along the length of the hair both within and without.

Ringworm of the beard region occurs as two types :

(1) The *scaly variety* where there is just a scaly dry patch with broken hair stumps.

(2) The *suppurative variety* where there are definite patches with secondary infection of the hair follicles. Pus oozes out through a number of points from this patch. The affected part is raised above the surface and soft and lumpy to the feel and resembles a 'kerion ' to some extent. The infection in either case is supposed to be, from the barber's shop. Hence it goes by the name of ' Tinea Barbae.' The fungus is of the Endothrix type in the case of the dry scaly variety and of the Ectothrix type in the suppurative variety.

Sycosis Barbæ or Coccogenic Sycosis—a follicular infection of the beard region is considered by some as caused by a fungus. But, there are not many adherents to this conception.

Tinea celiorum, i.e., Tinea of the eye lashes and Tinea in the pubic region are very rare occurrences.

Tinea of the Glabrous skin.—A very common affection, next to scabies and Impetigo—(a streptococcal infection of the skin)—it holds its place for frequency of occurrence. The common Tamil term ' ' applied to this

affection is in most cases correct. This is also called Tinea Circinata and Imbricata. Fungus infection of the glabrous skin, need not in all cases be circular, as the name implies but it is so in the majority of cases. It occurs as definite scaly patches, with a definite well marked margin. More commonly, there is no vesication or pustulation. The patches spread at the margin and the healing starts from the centre. It is very itchy in 99% of the cases. It may be taken for granted that most of these people have their groins affected. This forms a source for the infection to spread—and the spread is usually facilitated by indiscriminate scratching with dirty fingers.

Tinea affecting the Groin goes by a special name—Eczema marginatum or Dhobies' itch. It is to a good extent correct that the Dhoby causes the spread of the infection. The name Eczema marginatum is to some extent a misnomer. It refers to the characteristic appearance of the affection over this region but the patch may not look like an eczematous patch. Fungus of the groin or Tinea cruris appears as a scaly patch with a definite border, very itchy. Neglected for some time it spreads to the scrotum and adjoining buttock regions. It has got a great tendency to get sodden due to the natural extra moisture present in the region. The wide prevalence of the affection is mainly due to neglect of the proper cleanliness of the part and to overlooking the early itchy symptoms. The affection is easily and very completely treated. There have been cases neglected so far that they reached the stage of Eczematisation and Impatiginisation—the part looking red, sodden and almost messy. Some view this as due to the fungus Epidermophyton. There is not much concensus of opinion. This affection occurs in Epidemic form.

Tinea Versicolor caused by the fungus—Microsporon furfur. This is a very common affection, sometimes itchy sometimes not. There are patients coming for treatment who are bothered by just the look of it. This occurs as depigmented scaly patches of varying sizes. The scales may not be visible to the naked eye but are easily seen under a magnifying glass. The patches are very largely situated in regions most liable to sweat—chest, neck, interscapular region. It is scrapings from these patches of Tinea Versicolor that show beautiful specil mens of the fungus in almost cent per cent of cases.

The condition *Epidermophytosis*, goes by the name of 'சொறிசிரங்கு' in-Tamil. As you all know it is a thing present in almost every house. It is a very chronic affection resisting treatment to a great extent. Water seems to play a great part in the starting and keeping on of the disease. It occurs mostly between the little and the fourth toes. The other toes get affected by and by. The affected part is white and sodden. It is itchy to a great extent. Sometimes it gets inflamed when pain and burning happen to be predominent symptoms. It may extend to the dorsum of the foot and also to the sole. In the latter place it manifests itself sometimes as deep furrows. The hands and the palms get affected in some cases. The causative fungus is an Epidermophyton. The condition occurs in epidemic form. Fungus affection of the palms manifests itself as patches of thickened areas, scaly, hyperpigmented. Sometimes, the thickening is advanced enough to produce a sort of contracture. The affection may be acute in which case it may pass off as Eczema. Dermatitis of the palms and soles owes its character to the anatomical structure of the skin in those regions. The horny layer is specially developed and conse-

quently the exudation does not readily find its way out but diffuses itself through the thick layers which are, later on, separated in large thick patches.

Fungus of the nails or onychomycosis is one of the most intractable diseases known in Dermatology. It is caused by Ecto or Endo thrix fungus. One will quite agree with Sir Norman Walker when he says that you will not wish the disease even in your worst enemy. It is just the case to be magnanimously sent on to your rival practitioner opposite or adjacent! Heredity seems to play a part in the causation. Toe nails are more rarely affected perhaps due to the better protection afforded to them. The disease commences underneath the free end of the nail and travels slowly upwards. The nail gets thickened and the nail-bed sodden. The latter could be scraped. The nail gets discolored, striated and distorted, breaks and falls out leaving the nail bed exposed. The condition is hereditary.

Tinea is quite *generalised* in a certain number of cases. Practically the whole body being affected. Usually these cases are pretty much neglected and there is plenty of secondary infection and there is Scabies and Impetigo superadded. You really can't say which came first. From experience in the out-patient practice I should say that one must try and exclude leprosy in every case of generalised fungus infection. Almost 9.. per cent of such people are lepers.

Other rarer varieties of Fungus Infection, I will just mention.

Erythrasma. The organism is microsporon minutissimum—very rare. We have had just two cases.

Things like Favus, Blastomycosis, Sporotrichosis and Actinomycosis I am not going to say anything about.

Deep Trichophytic Infections manifest themselves as various forms of Rashes—Erythematoid, papular, vesicular and pustular, etc. Patient is out of sorts, glands swollen, rise of temperature.

Lepothrix alias Trichomycosis axillaris flava rubra et nigra according to Castellani is an affection caused by a bacillus like fungus with a special predilection for the axillary hair. We have had a few doubtful cases but they seemed mere ordinary follicular infections.

Diagnosis.—Accuracy of diagnosis can only be acquired by a wide knowledge of the various diseases affecting the skin and by ample use of the experience gained in each and every department of medicine. Every portion of the eruption must be seen before a diagnosis is given.

Certain appliances made use of in the diagnosis of skin affections:—

Wood's glass or Filter.—This is composed of glass containing nickel oxide.

Correx Filter may be used instead. It may be of blue or purple glass. Vigne was the first to demonstrate the detection of Ringworm by this. In an infected hair the fungus is seen as brilliant beads along the length of the hair. Wood's light helps us to know the location and extent of Ringworm. It also helps us to know the hairs left out after the action Thallium acetate and X-ray.

Diagnosis of Fungus of Hairy Region

Fungus Scalp.—Apart from the general appearance of the patch and the nature of the affected hair the point to clinch the diagnosis in a case of Tinea of the Head is by microscopical examination of any loose hair. This

hair taken out, put on a slide, a drop or two of KOH put on under a cover slip and examined after twelve hours, reveals the fungus in a very characteristic manner. In any affection of the head in a patient below twelve years of age, one must take care to first exclude fungus. Fungus after the age of 14 years is rare enough to be almost unknown. Things to consider in the diagnosis are (1) Impetigo, (2) Alopecia Areata, (3) Seborrhoea, (4) Psoriasis.

In *Impetigo* the hair is unaffected. No marked scaliness. The definite isolated crusted impetiginised spots are characteristic enough.

From *Alopecia Areata* by the absence of the proverbial billiard ball smoothness, absence of mark of exclamation hairs at the margins, and the presence of scales and broken and loose hairs. Of course, microscopical examination of a loosened hair clinches the diagnosis.

The scurfy head of *Seborrhoea* is characteristic. The hair is not affected. There are no broken or loose hairs. We get fine dry and greasy scales. When dry, they are bran-like and not adherent to the scalp, but "flake off", and when greasy, they are adherent. There is no pustulation.

The *Black dot Ringworm* is characterised by the black-dots on the Alopecia like patch.

Fungus of the beard region has to be differentiated mainly from three conditions:—(1) Sycosis Barbae, (2) Impetigo, (3) Group Eczema.

Sycosis Barbae is a follicular infection, each hair follicle being affected. It is more wide spread than the fungus infection and the hair in the affected region is neither broken nor loose. The solitary crusted *Impetigo* spots with no particular follicular relation is characteristic.

Grouped Eczema of the beard region has just one thing to differentiate it from Tinea The hair is unaffected. A group of Impetigo looks very similar to a patch of eczema and is almost indistinguishable.

The silvery scales of *Psoriasis* cannot be missed. Patches of Psoriasis in other parts of the body like the elbow and knee help. In every case diagnosis is always made certain by examining any loose hair under the microscope.

Diagnosis of Fungus of glabrous skin.—A specimen slide from any fungus is taken by means of scrapings from the patch. The part is scraped with a special scraper, scrapings received over a slide. To this is added a drop or two of Liquor Potash 20 per cent. and the cover slip put on. It is always good to let the slide with KOH stay on from 12 to 24 hours before examining it. The soaking helps the fat to be dissolved and the fungus brought into greater prominence. Whenever there is a doubt about the diagnosis a microscopic examination will help to decide.

The diseases to be considered in the differential diagnosis of Tinea marginata and versicolor are—Leprosy, Psoriasis, Eczema, Seborrheic Dermatitis, Superficial serpigenous tertiary syphilide and a patch of lupus.

It may seem slightly far fetched to mistake a patch of Leprosy for Tinea or the other way. But it is a mistake very liable to happen and it is worth all your while to avoid it. I am referring only to those cases where you have a definite patch, circular or otherwise, with a definite margin, Erythematous and even seeming to be scaly at the first glance. Such a

patch you make out to be Leprosy by the look of it mostly. It is a non-scaly depigmented patch—not itchy. It is anaesthetic—but this is not always the case. The vague look about it is impressive enough. In the case of such a patch there is always a very long history. There may be other signs helping like thickened ulnars.

Though far-fetched again, patches of Tinea Versicolor should not be mistaken for the non-pigmented patch of Leprosy. The fungus has a definite margin, shows scales under a magnifying glass, is itchy and a scraping reveals fungus. We have had two or three cases in the out-patient where the whole of the back and chest were spotted with a number of depigmented patches. They are not as definite as Tinea Versicolor or as vague as Leprosy. Scraping negative, other signs were not manyto help us in diagnosis. Such cases one can never say. One of such cases I have taken to be leprosy and the patient is getting Alepol. He had about 16 injections. Very slight improvement. Another affection which may be mistaken for Tinea Versicolor is *cutaneous leishmaniasis*. This is a rare affection indeed. We have had one or two cases with a motley of depigmented patches.

A patch of *Psoriasis* is always made out by its situation on the elbow or knee—by the silvery white scales, and, after the removal of these scales with a glass slide, by the appearance of 'Bulkleys' membrane with those red papillary dots about them. Psoriasis is more commonly not itchy.

Things like *Leucoderma*, *Addison's disease and Arsenical pigmentations* have to be eliminated.

In *Eczematous eruptions* there are almost always outlying red papules pushing out a little way beyond the main area affected, into the neighbouring healthy skin. Regarding Eczema the diagnosis is always never easy. Straightforward cases give no trouble. Some cases, such as patches on the dorsum of the foot or sides of the leg, usually years old, one can never say what it is. A specimen slide may reveal nothing. Of course, taken to a specialist, he has to say it is only one thing. But there is nothing definite to go by to help the diagnosis. It always pays to examine a scraping of an obstinate dermatitis for fungus.

Seborrhaeic Dermatitis, mith its favourite place of election on the back of the neck and the middle line of body, with its characteristic greasy appearance and a negative slide result speaks for itself.

Streptococcal Scaly eruptions are eliminated by examining the scales.

Superficial serpigenous tertiary syphilide is more indurated and reddish and very rarely itches.

Epithelioma Erythematoidis Benignum, though very rare may simulate a fungus patch. Patches are of varying sizes—reddish, sharply defined margined and tallengiectatic masses in the centre. Surface rough and atrophic and covered with minute scales.

Lupus Erythematoses.—cannot be easily mistaken. A long history and a symmerical distribution and a negative slide result help in the diagnosis. Von Pirquet may be sometimes positive. The ready response to Whitfield, tendency to ring formation and asymmetric distribution help diagnosis of Ringworm.

We have had two or three cases of generalised skin affection. They looked lichen planus at places, a sort of melanodermia at other places and doubtful fungus at other places. These we put down as general fungus infections.

Another handful of cases that elicited interest and attention were cases where the palm was affected. In one or two there was Tylosis; the skin of the palm was thickened, hyperpigmented, hyperkeratiuised and at places scaly. First it was taken as Leprosy, then Tinea given a chance and then it was by pure luck we happened to send the blood for Wasserman. It was strongly positive. A course of Anti Syphititic treatment improved the case a very good bit.

Keratolysis Plantaris.—Though no text-books mention about it, looks a definite fungus infection of the sole of the feet. It manifests itself as definite pits and depressions forming sometimes a very beautiful picture. We have tried to cultivate the fungus, I mean, send them on to Guindy every time we got a patient but it has not been successful till now.

There must be no difficulty in diagnosing Epidermophytosis and Tinea Cruris. They are almost definite entities by themselves. Repeated scraping examinations are necessary in the case of Epidermophytosis. Scales from the advancing edge must be examined.

Eczema Rimosmu occurring in sole of feet as furrows, may easily pass off as Epidermophytosis but it makes little difference.

Tinea cruris is supposed to resemble the rare affection Erythrasma. The latter occurs as superficial reddish patches more or less symmetrical.

Chieropompholyx of the palm may be easily mistaken for fungus specially if inflamed. There is no itching, no definite scaling and microscopical examination will decide diagnosis.

A Late Scaly Syphilide sometimes attacks the palm. This occurring unilaterally is in favour of being syphilis.

Ichthyosis and xerodermia.—Limited affections of these, may simulate Tinea infection. But the former a birth anomoly has a long history and does not itch.

Fungus infection of Nails have to be diagnosed from 3 conditions. (1) Syphilis (2) Psoriasis and (3) Eczema. Repeated microscopical examinations and cultures are necessary. History helps.

Regarding some of these skin affections which could not be classed as fungus definitely—They may be a sort of reaction secondary to some superficial fungus infection.

C. White and S. J. Taube have recorded the cases of four females in whom superficial fungus infection was followed by some sort of secondary sensitization dermatitis of non-fungus nature. It looks as if that the skin in these cases gets to a supersensitive state after the fungus attack and you don't know which exactly starts the reaction; may be from some food or external irritation. If this is spotted and removed the patient gets the necessary cure. The complete cure of the original fungus affection does not prevent the patient from getting on to this surpersensitive state. Asking for the previous history certainly throws plenty of light on the nature of the affection and mode of action thereafter.

Treatment.—It was doubted whether diseases of skin should be treated at all But absurd as this is, the doctrine was driven from the profession by Heba's scathing satire on those who unable to cure the disease, took refuge behind the theory that harm might result from interference. And, there is no more common fallacy than the

statement. 'If it does him no good it will do him no harm'. There was no remedy powerful for good, which is not capable of harm. The question must be how much harm can I afford to incur in this experiment in helping the patient. If it is none, the remedy under question must be left out of the programme.

Fresh air, food, water, sleep and elimination—of these certainly it could be said that they would do no harm, and with equal certainly that they would do good.

There is plenty of scope for the exercise of common sense in treatment in Dermatology.

In Ringworm, prevention is much easier than cure The drugs used are legion. The method of application and the form in which the drugs are applied are more important. The stage of the infection must be noted but this isn't as essential in fungus infections as in eczema.

Soaps used moderately and in selected cases are useful. In certain cases they are best avoided. Soap mixed with water sets free a certain amount of alkali and emulsifies the greasy matter on skin and removes it. Alkaline soaps emulsify better. The so called neutral soaps sold in bozaars are really rarely neutral. Alkaline soaps clean the skin slightly too thoroughly. The alkaly acts on horny cells softening them and dissolves them and thus helps thinning of the skin. The Saponis Mollis of textbooks is made from potash and olive oil. Soaps are added on to ointments on account of their softening power.

Treatment of an affection resolves itself into general and local. It is the proper care of the general treatment that makes the local treatment more successful. Attention must generally be paid to proper sleep, exercise, fresh air, daily baths, simple food slowly eaten. If one has to avoid head infections he must take care not to lean against sofas and chairs unless one knows them to be clean. The pillow case should be washed every day and if the patient is in the habit of wearing a hat, his hat-band should be clean and always protected with a clean bit of gauze when trying on hats. Particular attention paid to the cleanliness of combs and brushes and their promiscuous use should be avoided. Bowels should be kept scrupulously clean. Treatment of dyspepsia, diabetes or anaemia does increase the patient's resistance.

Treatment of fungus in hairy Regions.

Ringworm of head in children cures spontaneously after 14 years and this must be remembered before adopting the severer methods of treatment. The one method of treatment is by epilation and this is effected by means of X-rays.

Ringworm of beard gets cured in 6 to 8 weeks.

I am not going into the details of the X-ray treatment. X-ray, it must be remembered, as Norman Walker 'who has been through the mills' says, is a potent agency for good as well as evil. In proper hands it is bound to do a lot of good and is about the best method to employ. X ray has stood the test of time, one of the first things they employed it for. after its first installation in St. Barthalomeo's Hospital under Dr. Adamson was for the treatment of Ringworm.

Thallium acetate has been used more recently to effect epilation. It has been advocated for children who can't keep steady during the X-ray exposures. Halden Davis advises Thallium acetate for very young

children. This drug has been in vogue since as early as 1918 and the Mexican Dermatologists seem to be the exponent of it. The original method of giving small doses is now given up and one large dose is given. 8·5 m gm. to the kl. gm. of body weight—nude. Babies weighing 30 to 35 lbs. seem to be the most suitable. It is given dissolved in 20 oz. of water flavoured to taste. Solution must be always freshly prepared. The substance should be weighed very carefully. The drug is rather avoided in case of older people owing to the large dose they have to take. The maximum dose that could be given with impunity is 300 m. gms. After—treatment of cases is important. Patient must be in bed for four days. Toxic symptoms that may appear are—Diarrhoea, pain in joints, Pyrexia and unconsiousness lasting for a few days. After 9 to 15 days hairs begin to loosen and fall off. The epilation could be assisted by mechanical means. The treatment if unsuccessful should not be repeated within 3 months. Thallium acetate has a cumulative effect. It is excreted by the kidneys and hence contraindicated in albuminuria. The action is not directly on the hair papillae but through the sympathetic nerves.

The best method seems to be a sort of via media using both X-ray and Thallium acetate. The evil effects of this combination, seem to be less than the evil effects of either of them alone.

Kerion Is best treated by just leaving it alone with only fomentations to allay the pain. As Norman Walker would put it " the essence of treatment is an attitude of masterly inactivity ". Stimulants do harm. The hair should be cut close. The part may be given just one paint of iodine. I know a case of an Anglo-Indian boy of about 12 years who got completely cured of his kerion by keeping the part clean, fomentations three times a day and application of iodine once a day. He took about a week. Incision in these cases does more harm than good.

In regard to almost all other fungus infections Unguentum Whitefield forms the sheet anchor of the doctor. It is a mild clean and effective ointment which never fails. It contains—

R.

Acid Salicylic gr. 30
Acid Benzoic ℥i
Vaseline ℥i

Time and custom were the tests of all things remedies among them and as Thomas Horder will put it " like good wine, good medicine needs no bush"; and most certainly Unguentum Whitefield with necessary slight alterations answers all requirements. This could be mixed with cocoanut oil to make it thinner. True economy consists in prescribing adequately and not small amounts. It is very essential that this ointment should be very gently rubbed in—mere application doing no good. The patient does the rubbing, in the night before going to bed. The ointment is kept on over night and washed in the morning. Soaps are best avoided. The soaps that are useful and effective are : ' Afridol ' soap, Margosa, soap and the German soap 'Nyke'.

Certain additions could be made to the ointment according as the particular condition warrants. Ichthyol m X—XX to an ounceof the ointment could be used in the more chronic forms of Tinia. Ichthyol is a good anti-pruritic and a mild keratolytic. Two cases of extensive chronic Tinea yielded very good results with this combination. In chronic cases again-Chrysarobin-grs. X to an ounce of the ointment could be used. But chrysarobin is not a very desirable thing to use in that it stains clothes very badly and, it causes a

very bad conjunctivitis if, by chance, it gets into the eye. It should be completely avoided in affections in the neighbourhood of the eye. *Cignolin* a more recent product—a derivative of chrysarobin, *i.e.*, chrysarobin minus the CH_3 radical forms a good substitute It has not the ill effects of chrysarobin. Whitefield's ointment itself could be used in half or double strengths. Cure effected in 6 to 10 days.

The treatment has to be modified in the case of fungus with Eczematisation and Impetiginisation. In these cases removal of the crusts and allaying the inflammation if necessary must be the first step towards treatment. The best way is by a Boric Starch poultice—i of acid Boric in ¸i of starch, is cooked into an uniform thin paste adding sufficient amount of water. This is spread on a bit of lint and put over the part and bandaged up. This is repeated twice or thrice a day. The inflammation and the exudation are put a stop to very effctively by this process, and the crusts get cleaned leaving a clean surface.

Varying doses of *staphylococcal vaccines* also help at this stage. Doses varying from 20 to 200 millions may be given.

'*Eczemine*' a special mixed vaccine has been used with effect. The injection given intramuscularly twice a week. The other general remedies like collosal Manganese, Magnesium butyrate and stannoxyl may also be tried. Of these last three collosal Manganese seems to be the best for staphylococcal infections.

In the case of generalised Tinea, apart from Whitefield ointment with Ichthyol and Chrysarobin, a few drug have been tried and I think with not bad results.

3. gm. of *N. A. B.* undoubtedly helps. But, one should think twice before repeating it. '*Enesol,*' a combination of mercury, Arsenic and sodim salicylate, given intravenously twice a week had very good results. 'Mercury and Arsenic' A. F. D. intravenous weekly injections.

Injections intended to give a general shake up, by way of protein shock have been tried. 'Aolan' intramuscular proved effective T. A. B. vaccines, curative, starting from 10 millions up to 50 millions have been given intravenous with almost satisfactory results.

It was in a doubtful case of generalised fungus infection we tried *Tricho Yatren.* There was no reaction at all after the injections. The patient improved after almost finishing 2 or 3 boxes. I don't know whether to attribute the good results to the injections or to the ointment he has been using all the time. Of course from the patient's point of view it was the injections that worked the magic. *Collosal Chrysarobin* does some good in chronic fungus infections. Given intravenously, biweekly. From the experience gathered, the results are not uniform. One thing which has not been tried and which will be doing some good is the injection of Proteose from patients urine. Perhaps some have tried this with salubrious effects. In case of fungus manifisting itself as Erythematous scaly patches only a few days old, the condition may be too inflammatory for the use of an ointment. The best thing to use in this case is a *Cold cream.* Cold cream acts in virtue of the water it contains. It normally contains the following drugs :—

R.

Calaminae ʒi.
Zinc oxide ʒiii.
Adepis Lanae ʒi.
Ol. olivae
Aqua Calcis. } aa ʒss.

The constant evaporation of the water produces the soothing effect. They needn't be rubbed in, mere smearing being enough. Adepis Lanae or Lanoline has great capacity for water and excellent cream made with it. To a cream like this a small amount of Sulphur Precip. or γ naphthol added has very good effect. About X—XX grs. of sulphur may be added.

Treatment of Epidermophytosis tries one's patience indeed. I have adopted the following treatment with effect. (For this affection, Unna's compound chrysarobin ointment may be used:

Composition:—

Acid salicylic	15 gr.
Chrysarobin	25 gr.
Ichthyol	25 m.
Vaseline	one ounce

The part is first dried completely with a clean bit of gauze. Then cleaned thoroughly with bits of lint soaked in methylated spirit—giving the toe intervals a good rub. Then bits of cotton soaked in 20 per cent. KOH are placed between the affected toes. The bits are removed when it just starts to smart This is important because delay may cause the part to get very tender and even to ulcerate. Then the parts are very gently scraped with a scraper or a blunt scalpel. As much of the sodden material as could be got is removed. Then the ointment is put on and left over till the next morning.

Kerolysin, a patent ointment of Up John & Co, containing acid salicylic, acid benzoic and about 1 per cent of thymol, seems to be the favourite to-day for this particular affection. It could be used for any fungus infection. It is always safe to make sure that it is tolerated as it is; otherwise it should be diluted with Vaseline or Lanoline to the necessary extent. A dusting powder composed of acid salicylic 3 per cent., acid Boric 3 per cent. in an ounce of talc could be used for the part when the ointment is not applied. The powder could be put inside the socks or a pair of meshy socks may be first put on, the dusting done thereon and the usual socks worn over it.

Collosal Chrysarobin was given to these epidermophytosis cases.

Gould-Adrian G and Carter Edna —in Archives of Dermatology and Syphilology (International Medical Digest)—advocate 2 per cent. mercurochrome 220 and Liquor Hexyl resorcinolis 1 in 1000. This is recommended by many. The latter drug claims its place by virtue of its relation to resorcin. It is as active as salicylic acid (1 : 30,000 restrains growth). Mercurochrome is comparatively less active. Trichophytons of the toes and feet grow in 1 : 6000 mercurochrome but not in others. As a blood antiseptic it is the ideal one as Sir Thomas Horder stated in his talk about Chemotherapy.

The very chronic, hyperpigmented sometimes scaly, almost lichenified itchy patches occurring on the dorsum of feet or sides of leg are a set of incorrigible things to deal with. It is taken for granted that they are fungus. For sometimes one never knows whether it is Eczema or Tinea and goes ahead with a sort of via media treatment These patches are best treated in the following manner. The patch is first wiped clean; then constantly rubbed with bits of cotton soaked in 20 per cent. KOH. This is continued till the patient just starts to feel the burning sensation. Then the part is rubbed in with bits of cotton with soap. The Keratolytic action of soap is supposed to play its part and the KOH is also removed. Then the ointment, either

chrysarobin or kerolysin is put over as a very thin smear and the part bandaged. The process is repeated the next day. It requires some patience to complete the cure.

Another good drug that could be used is Liquor C carbonas Detergens. The part is given one good smear with a swab of this and the ointment put over.

Tar acetone.—One drachm of tar to an ounce of acetone—it is well worth one's while to give this a trial.

Bacteropyophag almost cured one of these patches. Many treatments have been tried on that particular patch with no effect. It was a chronic patch on the dorsum of the foot at the usual hairy spot. One box of bacteropyophag cured it; but it is regrettable to have to say that the effect is far from uniform and is unreliable. Before the application of the phag the part should be cleaned with distilled water. Then a clean bit of moistened gauze well squeezed out, is drenched with an ampoule of the phag and put over the patch. This is covered with an oil paper and bandaged. This is left over for 24 hours and then a second ampoule is used in the same fashion, No kind of antiseptic should be used.

It is very good plan to touch the advancing vesicular margin of a Tinea patch with Ag NO_3 (20 grs. in one ounce of spirits etheris nitrosi). This arrests the spread and stops the oozing very effectively. In some cases the patch may be given one good sweep with the Ag NO_3 solution—just one —with very good result.

Fungus of the nails is best left alone. The treatment is very prolonged, very painful and when all is said and done there is no knowing at all that the new-growing nail is going to be free from fungus infection.

The treatment in vogue—(I have not seen any case treated)—skin of finger is covered with vaseline or zinc galetine—only the nail is exposed, a piece of lint soaked in Fheling's solution is applied to the nail and the whole coverd with a rubber finger stall. In 24 to 48 hours the nail is soft enough to be removed.

A more drastic method was by the combination of Potassium Iodide, Liquor Potash and Hyd. Perchloride. The resulting mercury iodide is supposed to do the softening. Very painful. Modern method advocates soaking the nail in Liquor Potassæ and applying Iodine.

It is mildly surprising that there are not many advocates for the use of Ultra Violet light treatment. Dr. George M. Mckee of New York and Dr. C. B. Herald have found Ultra Violet light not having much scope in Dermatology in general and Tineasis in particular. This agency used with some effect for such varied things as Erysipelas, various Tuberculides, many other cutaneous affections and lastly removal of portwine stains, has no therapeutic value at all in fungus infections.

Venereal Disease.*

By Major A. K. Murti B.A., M.B., C.M., L.A.R.O.

The subject of Venereal Disease is a very ancient one and we are particularly concerned about the incidents of the disease among communities in India. Books of all lands, Egyptian, Greek, Arabic and ancient Indian Medical books, *e.g.*, Susruta, mention signs and symptoms of syphilis and gonorrhoea. Syphilis was known in China in 3000 B.C. Bible has its record

* Delivered before the Trichinopoly Medical Association.

of venereal complaints. Pharoah contracted the disease from Serai, Abram's wife. David's lamentations in the Psalms were due to venereal disease contracted from Bathshelva. The Israelites who began to commit whoredom with the daughters of Moab contracted the disease from them, because the Moabites, worshippers of Baalpeor, had its attractions in all sorts of venereal excesses and debauchery (Chatterjea). Moses said, "Slay ye every one, his men that have joined the Baalpeor" A splendid preventive indeed for the spread of venereal disease.

Venereal disease was introduced into Europe after the return of Columbus from Haiti to Spain. The Spaniards carried it to Naples. It soon spread all over Italy and France, being brought to the latter country, by the troops of Charles VIII of France, who had a contingent of about 900 women, chiefly prostitutes. The disease was probably syphilis. Each infected country considered itself innocent and attributed the infection to the other country, *e.g.*, British called syphilis, Mal Francais (French disease); French called it Mal Anglia, and both called it sometimes Mal-Nepolitan, after its first incidence in Italy.

It is difficult to give the exact date of the introduction of venereal disease into India. Symptoms of local syphilis are described in Susruta, but the correct syndrome of syphilis was described by Bhavamisra in his Bhavaprakasa about 1550 A. D. He calls it Ferrangi roga, and describes three aspects, Bahya (external), Abhyantara (internal) and Bahurantra (internal and external). Bone lesions and mercurial treatment are mentioned in this work. This is about 50 years after Vasco de gama left India and it is obvious that the Portuguese were the donors of the disease to this country. There is also the possibility of the introduction of venereal disease by Mahomedan invaders and by the Chinese, who got their religion, Buddhism from India. The Buddhists of India gave a good religion to China, and brought syphilis from China where the disease had existed centuries before the birth of Christ.

To the student and practitioner of medicine, the importance of the study of venereal disease can hardly be exaggerated, when it is pointed out that it has become part and parcel of civilised life. The rapid introduction of venereal disease into society has made it a menace to public health, a peril, to the family, and suffering, intermittance throughout life, to the infected individual. Thus the study of venereal disease presents many aspects for study. From the point of view of the state, the efficiency of man power becomes much below par. From the social point of view, venereal disease is a demoralising agent. From the public health point, it is one of the largest plagues to be prevented. For the medical man, it is a disease which demands the most thorough and efficient diagnosis, treatment and a standard of cure. For the patient, it is a malady, which makes him miserable for life and makes him anxious for the future, as there is a chance of his offspring inheriting the disease. The parent eats the forbidden fruit and his children inherit the bad teeth.

There are three venereal diseases :— syphilis, gonorrhoea and chancroid or soft sore. A fourth also may be mentioned, *i.e*, infective granuloma. Of these, syphilis, and gonorrhoea are very prevalent and they are very serious infections with grave consequences. Gonorrhoea is the great preventor and syphilis is the great destroyer of life.

Syphilis : is a specific infectious disease, chronic in evolution, inter-

mittent in manifestation, and indefinite in duration, caused by a parasite, the treponoma pallida, discovered by Schaudin in 1905,—usually the result of sexual intercourse with infected persons and occasionally caused by abraded parts of the body coming into contact with infection. Thus, dressers, midwives and surgeons get the infection by careless handling of infected persons. The point of infection in these cases is extra-genital. The infection shows itself as a sore with peculiar characteristics. The infection is probably a local one but soon becomes generalised being absorbed by lymph and blood streams. The earliest stage at which the patient seeks the advice of a medical man is when he notices a sore on his penis. The ideal one, called hard sore, hard chancre or Hunterian chancre is very characteristic. It is a hard popular sore, round, well-demarcated and painlessInflammation is absent and the draining glands enlarge and present the typical hard feel—Shotty feel or the *India rubber feel.* The sore appears long after sexual access, one to six weeks; the text-book stages of syphilis are arbitrary and have no meaning. Syphilis is an infection which quickly gets into the blood stream ; at this stage it ought to be called generalised syphilis. The so-called secondary stage is early generalised syphilis where the lesions heal with a no scarring The late secondary and tertiary lesions in which tissues is destroyed, and the healed lesions show scarring, may be classified as late, generalised syphilis (or recurrent syphilis). Tabes and G. P. I. come under Neuro Syphilis. So the classification ought to be:—

(*i*) Local syphilis,

(*ii*) Early generalised syphilis,

(*iii*) Late generalised syphilis or recurrent syphilis and

(*iv*) Neuro syphilis.

The complement fixation test (Wasserman test) should be negative in local syphilis, spirochoetes being found only in the sore with a negative Wasserman reaction; but experience shows that even the sore stage is generalised syphilis. This test is generally positive in all stages. It is strongly positive in the early generalised stage. The pathology of syphilis is simple. It is a presistent and continuous inflammation of arteries, veins and lymphatics.

Periarteritis
Arteritis
Endarteritis
Periphlebitis
Phlebitis
Endophlebitis
Peri-lymphangitis
Lymphangitis

This leads to sclerosis of vessels and narrowed lumen making tissues avascular. The end results are either sclerosis or necrobiosis, sclerosed arteries, cirrhosed livers and kidneys. Sclerosis of the brain and spinal chord are examples of the former and gummatous inflammations are examples of the latter type. I may also mention that the treponema pallidum is fond of epiblastic tissues (skin and nervous systems). Early generalised syphilis shows itself in lesion of the skin and the latest stage is neuro-syphilis. Mercury has been the sheet anchor in the treatment of syphilis in all climes and all ages. In India mercury, arsenic, sulphur (Rasa, Visha and Gandaha) have been freely used.

" Half hour of Venus, one hour of a Bachus and a life-time of Mercury " a favourite saying of an old Professor of mine. "

In the present day treatment a metal and a non metal are employed.

Bismuth and Arsenic.—Bismuth is given as an emulsion of the metal

and arsenic as Neo-Salvarsen. The treatment has to be done for over 2 years, off and on, if real good results are to be obtained.

The question of marriage is involved in the syphilitic problem. Shall a syphilitic marry? Better not, as it is so difficult to sterilise the person of spirochœtes. But in common with others everyone efficient or inefficient, syphilitic or otherwise has to be allowed his quota of sexual life and the syphilitic should not be denied his pleasures of life. Thorough treatment for 2 years, with absence of symptoms for another 2 years, with the negative Wasserman tests and absence of all nervous signs may make the syphilitic eligible for the marriage.

Syphilology made rapid progress in the 20th century. Schaudin discovered the parasite, Wasserman modified the reaction (compliment fixation text devised by Bordet and Gengou) and Erlich put in the market his " 606 and 914." Schaudin, Wasserman and Erlich form the syphilitic trinity of the 20th century. McDonagh studied the evolution of the parasite and results of treatment by arsenic, bismuth and sulphur.

Syphilis is a very good example of a disease which is uncontrollable, though we have a perfect knowledge of the causes because the intermediate host is one of the ourselves. It is easy to stamp out a disease where the intermediate host is an animal or plant over whom we have perfect control. We have a certain amount of control over our surroundings and we have dominion over the lower animals but the control of man requires the consent of the governed. The civilisation has been syphilisation; at the present day syphilis is supposed to be less prevalent among civilised than among uncivilised people and this is promising. As civilised nations, we must not rest until we stamp out syphilis. Civilised Europe has put its foot on leprosy, small pox, typhoid and many other communicable diseases. A sincere and persistent effort must be made to eradicate syphilis from society, though it is a very uphill work.

From the economic point of view, early generalised syphilis is not so serious, as the late stages which produce tabes, G. P. I. para-syphilitic affections and congenital syphilis. Crime and insanity go with syphilis. Syphilis is one of two of the causes which give society its insanes and criminals, the other two being alcohcl and heredity.

Gonorrhoea.—The next venereal disease is as serious and intractable a disease as syphilis, though some regard it as trivial as a common cold. One cannot afford to neglect either, as a common cold might extend to the lungs and kill by giving pneumonia and neglected attack of gonorrhoea end the patient by attacking the heart and giving gonorrohoeal endocarditis.

The gonococcus is a diplo-coccus with a morphology and culture peculiar to itself, and having characteristic staining reactions It is a blood thirsty organism, and grows best on human serum agar.

Infection is by sexual intercourse, though production of disease by contaminated towels, lavatory seats, etc., has also been reported. The organism attacks the urethra in the male and the cervix in the female. The chief symptom in gonorrhoea is a discharge, catarrhal at first, later on becoming thick and purulent, and finally becoming thin and gleety, from the urethra in the male, and from the vagina in the female derived from urethra and cervix. Neglected, the disease becomes chronic and intractable.

The complicated anatomy of the male urethra, and the large number of organs connected with the Os Uteri and urethra in the female, are the hiding places for the gonococci which makes it difficult for it to be attacked locally by antiseptics. It is indeed very difficult to dislodge the gonococcus once it leaves the lining epithelium and gets its home in the sub-mucous tissue of the urethra.

Complications.—Persistence of inflammation, leads to formation of fibrous tissue, which contracts and gives rise to stricture, the most common complication. Other complications are due to extension of inflammation owing to continuity of tissue, *e.g.*, balanitis, vasiculitis, epidemitis, orchitis, cystitis, pyelitis, etc. The gonoccocus gets into the blood stream, and fatal complications like gonorrhoeal septicaemia, gonorrhoeal endocarditis, ensue. The usual complication is arthritis—single or multiple. Contact complications, *e g.*, gonorrhoeal ophthalmia, ophthalmia neonatorum and gonorrhoeal proctitis and stomatitis are not uncommon.

Treatment.—At the earliest stage, *i e.*, within 48 hours, rest, low diet diuretics, are indicated. After 48 hours systematic lavage of anterior and posterior urethra must be practised, until the urethra is normal. Internally, none of the old drugs like cubebs, copaiba, sandal wood oil, etc, should be given. Mild diuretics and plenty of water or barley water may be given by the mouth. Stricture must be dilated and other complications treated symptomatically and by vaccines. Many cases of arthritis derive benefit by intravenous injections of sodium iodide.

Instrumentation of the urethra for diagnosis by the urethroscope or treatment by Clapp's suction bell ionic treatment, etc., require only mention. No doctor has used them for himself or his friends. They are quite good things to experiment with on his enemies. Verdict is unanimous from medical men engaged in the practice of gynaecology, that their practice is made up of the consequences of gonorrhoea. Sterility in male and female in one of the consequeuces of gonorrhœa.

Soft sore, Chancroid.—The third venereal disease is a purely local lesion caused by a strepto bacillus discovered by Ducrey and named after him, Ducrey's bacillus. It is auto-inoculable and shows the infection as multiple sores on the penis. Frequently septic organisms, the staphylococcus and the streptococcus, gain access and the sores become phagadenic and intractable to treatment. The draining area becomes inflamed to the point of suppuration, producing the so-called "Bubo." There have been occasional instances of the septic process becoming generalised and the patient dying of septicemia.

The disease is preventable, if thorough cleanliness is exercised during sexual intercourse; perfect cleaning with soap and water before and after sexual intercourse is the best prophylactic for the disease.

Venereal Prophylaxis.—The principles on which we prevent venereal disease do not in any way differ from those we adopt for the prevention of other communicable diseases. The complicating factor in the prevention of venereal disease is its close association with such problems as those of sex, prostitution and alcoholism. The question of prevention of venereal disease pervades the whole texture of society.

There are 3 primitive appetites of man. Hunger, thirst and the sexual appetite. Of these the first two

continue throughout life. The sexual appetite (Libido) appears at the age of puberty (though in some sexual manifestations are present even before), grown stronger during the period of adolescence and adult age and becomes less and less marked with advancing age. In preventing venereal incidents all legislators, public health workers and medical men must sincerely feel and recognise the most essential fact, that this appetite, is as natural as any other appetite, *e.g.*, hunger and thirst. The failure to recognise this simple natural fact in the framing of laws for the proper evolution of society's free from this evil will not lead to success. Venereal disease enters largely into the daily life of humanity and is the chief cause for the largest amount of domestic unhappiness. It is very difficult to estimate the incidence of venereal disease as we lack statistics for any civil population on earth. Hospital figures are not true figures as the rich, and middle classes, the backbone of any population, do not seek hospital relief. Army figures show an incidence of over 50 per thousand.

Attitude towards Venereal Disease.—It is uufortunate that society has a natural aversion for these diseases. The sanitarian should view all preventive diseases in the same light and in the same impartial spirit. His attitude toward syphilis (great-pox) must be the same as his attitude towards small-pox. The treatment of venereal diseases should be done as carefully as that of any other disease and sufficient accommodation should be provided for in all state and private hospitals. The venereal patient must not be made to feel that he is ostracised from the rest of the hospital population. His diet, nursing and other hospital attendance must be given in the same human spirit in which it is given to other patients. So one method of preventing venereal disease is by giving suitable hospital accommodation and free treatment for all classes of people and treat them until we get at the standard of cure. The local government has taken the right step in sanctioning free treatment. The proper hospital accommodation has yet to be sanctioned.

Notification.—As society place a ban on the person acquiring venereal disease, the principle of prevention by notification becomes difficult. Notification and compilation of correct figures are the first requisites for preventing any epidemic.

To be effective, compulsory notification must, in the judgment of the National council for combating veneral diseases, include as the first and most measures :—

(*i*) the provision in every area, of adequate facilities for prompt diagnosis and efficient treatment free of charge.

(*ii*) The prohibition of quack treatment.

(*iii*) Granting of privilege, to any communication made in good faith by a medical man in order to prevent spread of infection.

The above are calculated to give the government proper figures of the incidence of venereal disease. If these measures are persisted in, though complete figures may not be obtained at the start the popularity of efficient diagnosis and treatment is bound to produce correct figures eventually. Moreover, every venereal case thoroughly treated, is a focus of infection neutralised.

Isolation.—Is compulsory in the acute and active stages of Gonorrhoea and Syphilis. This can be accomplished if good facilities for free and human hospital treatment are available.

Medical Prophylaxis.—The careful use of Metchnikoff's ointment (33·3 per cent. and Calomel in Lanolin containing about 30 per cent of water) within 6 hours after exposure is a sure preventive. The application is successful only in the case of individuals who can understand and act up to instructions by the Doctor and in the case of people who are prepared by trained assistants.

Method of using the Prophylactic.—Before intercourse lubricate genitals with liberal supplies of vaseline. This prevents abrasions and access of infection. Immediately after the intercourse.

(1) Thoroughly wash the genitals with a liberal supply of soap and water.

(2) Wash with in 1000 HgCl 2 lotion if the prophylaxis is done by an intelligent man or a trained hand. It is not advisible to ask the laymen to carry tablets of HgCl 2 which is highly poisonous.

(3) Dry and rub Metchninoff's ointment for about 10 minutes on the glans, corona, body of penis, and the anterior scrotum. This must be very thoroughly done.

Mechanical Prophilaxis. A condom is a sure preventive ; opinions vary as to the advisabilities of wearing a condom—Gonorrhoea is prevented by injecting solution of Agryol 10 per cent or Protargol 2 per cent into the urethra and retaining it for 10 to 15 minutes.

As already stated specific treatment of infected cases in proper hospitals come under prohylaxis, and once more it may be stated that proper venereal hospitals giving free treatment to all cases is a desideratum in all civilized countries.

Prostitution.—As all know this is the chief source of venereal infection and any law to prevent infection and any law to prevent venereal diseases, which does not recognise prostitutes and when we recognise this as a normal appetite, the presence of the prostitute is a blessing, in that it keeps the lusty man away from the sin of adultery.

"So long as there is lust in the hearts of men, there will be some method of expression. Until the hearts of men changed we cannot hope for the removal of this social evil".

To prevent venereal incidence from prostitutes, it must be made distant and inaccessible. Accessibility of a prostitute is tempting to the lusty.

Suppression of prostitution is well neigh impossible. Regulation, by medical inspection and compulsory treatment, may prove a good method of preventing. Pure inspection without treatment and passing of protitutes has proved to be of no avail as this does not include clandestine prostitutes and the so called respectable family women—a fairly big population whose census, it is not possible to take. It makes success easy and gives a sense of false support.

Summary.

Venereal disease is of great antiquity and seems likely to continue indefinitely. A large number of the population is affected and the disease is spreading. The existing means of treatment among the poor and needy are very scanty. The common mode of propagation is irregular and illicit intercourse. "Prostitution arose in response to the strongest instincts and passions in the human breast and the prostitutes themselves need protection and have claims on the humanity of the law." The prostitute is ultimately the efficient guardian of virtue :—

To reduce the venereal infection we require :—

1. Education of the public.
2. Notification.
3. Laboratory facilities for diagnosis.
4. Proper Hospitals and Dispensaries.
5. Public Health Nurses, Social service and good laws actively administrated.
6. Medical Schools should give more training as to early diagnosis and reeognization of venereal diseases.
7. Strict supervision over all places of public resort.
8. Supervision and treatment of prostitutes.
9. Use of prophylactic ointment by trained hands or intelligent persons and observance of good personal hygiene or cleanliness.

If these measures are adopted, there is bound to be slow but sure progress.

General.

It is a long established fact that the instincts of sex begin from the very birth of the infant and become pronounced at puberty. It is well admitted on all hands that plain talks are necessary in households and educational institutions on sex matters. Training must be such that it bulids a good strong character, which moulds the desire to live according to the laws of nature. " Instructions should be individual, not collective, positive rather than negative and constructive than destructive." The essential qualifications of the teacher whoever it may be, parent, school teacher, doctor or friends should be :—

1. A thorough knowledge of facts and
2. An impressive personality.

Much can be achieved by attention to personal hygiene, mental and physical, and full value must be given to the facts that sex instinct is a primal impulse and the most natural of all passions. A successful life requires normal and temperate habits. Abnormal impulses should be curbed normal intutive impluses strengthened. Slavery to passion requires control.

Shakespeare makes Hamlet tell his best friend " Give me that man, that is not passions slave and I will wear him. In my heart's core, ay, in my heart of heart. That I do thee. "

Alcohol.

A word must be said in this connection about Alcohol which has a close affinity to sex questions. The strongest indictment against Alcohol is that it excites passions and diminished will power. Alcohol diminishes moral tone. It is more to be prohibited on this score, than on account of its distructive effect on human tissues, *e.g.*, Cirrhosed liver and inflamed stomachs, etc. Alcohol is not a stimulant, but it depresses the higher functions from the beginning. It reduces the inherent resisting powers of the organism against disease and parasites and bacteria find suitable soil in the drunkard.

" Mens Sana in Corpora sano " A sound mind can dwell only in a sound body.

A full development of will power will conquer all passions. The power to conquer comes to one who trains his mind, appreciates the correct value of his own powers and is able to control himself when he knows he is transgressing the law of nature or state. This training of the mind to obedience to state law, moral laws andnatural laws, is real mental hygiene and the personality and superior will power of good teachers in our high schools should be utilised in building up the body and

mind of the young pupils entrusted their care.

Educational and moral prophylaxis should aim at the development of an instinctive self control and self decline which will build up the character of the individual from his childhood onwards.

"Self reverence, self knowledge, self control, these three alone lead life to sovereign power. Yet not for power alone. Power of herself would come uncalled for but to live by the law, the law we live by without fear, were wisdom in the score of consequence."

ASSOCIATION NOTES.

Trichinopoly District Medical Association.

A monthly meeting of the above Association was held on Saturday the 13th May 1933, at 5 p.m. in the E. R. High School, Trichinopoly. Dr. S Padmanabha Sarma, M B, C.M, District Medical Officer, Trichinopoly, was "At Home" to the members. Nearly 45 members and 5 visitors from other districts attended. After "Tea" the Secretary of the Association proposed Dr. T. S. S. Rajan to the chair and it was unanimously carried.

Dr. T. S S. Rajan demonstrated the case of a boy aged about 8 years who developed Talipis—Equino Varus, about 2 years after an attack of Infantile Paralysis and on whom he had recently performed tenotomy and resection of os calcis.

He also demonstrated a Melanotic Sarcoma from the rectum which he had removed from an old man that morning. Dr. R. Sambhasivam demonstrated a child aged about 8 years which showed trouble in the lungs and abdomen. There was a lot of discussion as to its diagnosis.

Dr. T. S. S. Rajan then introduced Major A. Krishnamurthy B A., M B., C.M, District Medical Officer, Ramnad, and called him to deliver his Lecture on Venereal Disease.

Then Mr. K G. Sivaswamy Ayyer, Secretary of the Servants of India Society, Trichinopoly, gave a lecture on Rural Scheme and requested the Doctors to give as much help as they could for the Rural Scheme.

After the lecture there was a dinner at 8 p.m.

With a vote of thanks proposed by the Secretary, to the President of the Meeting and the Lecturer of the evening the meeting terminated.

The Chettinad Medical Association.

There was a monthly meeting of the above Association at Karaikudi on Saturday 20th May when a large number of medical men from all over Ramnad District and Pudukotah State were present. The meeting commenced at 5 p. m. with Major Krishnamoorthy B.A, M B C.M, A.I R.O., in the chair.

Dr. T. S. Shetty, Secretary of the Association who has recently returned from Vienna after a study of 1½ years, delivered a very interesting and instructive lecture on "Modern Methods of Treatment in Pulmonary Tuberculosis" as practised in the various clinics of Europe. He also showed interesting cases.

Nellore District Medical Association.

At the monthly meeting of the Nellore District Medical Association held in the District Board Hall on the 25th May Dr. M. K. Rajagopalachari read a paper on 'Pyorrhoea alveolaris.' Mr. K. Krishna Rao, District Medical Officer presided.

The South Indian Medical Union.

NOTICE.

The Annual General Meeting of the above Union will be held on Monday, the 10th of July 1933, at 32 Broadway, Madras. Members desirous of moving any resolution at that meeting are requested to give notice in writing to the Secretaries on or before the 3rd of July.

The members are requested to be present at the meeting.

C. R. KRISHNASWAMI,
U. K. L. NARAYANA RAO,
Secretaries.

[21-6-'33.]