# BULLETIN

OF THE

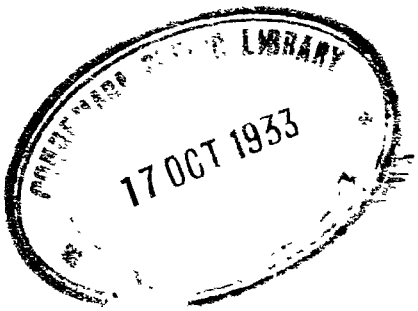
# SOUTH INDIAN MEDICAL ASSOCIATION.

OCTOBER 1933.

Due to uncontrollable circumstances the Bulletin has appeared rather late. We regret this very much and crave the indulgence of our readers. Rather than make this one a composite issue we have decided to omit those issues and have this as October's.

Certain changes have also occurred in the Publicity Section. **Dr. Subramania Iyer**, who has been in charge of it, has had to resign on account of other pressing business demanding his whole and undivided attention. The thanks of the Union and of his colleagues on the Publicity Section are due to him for his indefatigable zeal in his sphere. It is a pity that he finds it unable to be directly connected with the Bulletin but we are grateful for his assurances of all help and guidance whenever required.

Dr. Krishna Menon who had been connected with the Bulletin from its inception has been elected in his place. We are sure that under his guidance the Bulletin to continue to fight for the cause of the Independent Medical Profession and maintain the high standard which it did when under Dr. Subramania Iyer.




BULLETIN

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SOUTH INDIAN MEDICAL ASSOCIATION.

OCTOBER 1933.

## Some Arguments!

The insistent demand of the public for extension of medical relief by enlarging the scope of the *honorary scheme* and the increasing attention devoted to the scheme by the Government have together created a flutter among the local medical services. To these, Lt.-Col. Proctor's address at the Rotary Club of Calcutta has come as a godsend. The organ of the local stipendaries promptly published extracts from the speech which are supposed to be condemnatory of the honorary scheme. We therefore think it fair to state at the outset, that those who so read the speech are doing Col. Proctor a great injustice. Almost at the very beginning of this speech he lays it down that the public ideas about the appointment of an honorary staff are not impracticable, and that the Government of Bengal had anticipated the public by twenty years when they issued their *press communique* about the desirability of introducing an honorary scheme in Bengal. In another part of the speech he complains that there were not enough qualified men to take up the advertised appointments. We are therefore entitled to infer that his desire for expansion of the scheme is only tempered by the availability of suitable men.

But what Col. Proctor dislikes most is evidently the suggestion of substituting paid medical officers by honorary men, and the suggestion of appointment of non-official medical men as professors in the medical colleges and schools. Most of the statements he makes in this connection are not entirely correct. Nobody in Madras will disagree with him when he says that professors are always paid. He says that the physicians and surgeons on the staff of the hospitals are there by virtue of

their being professors in the colleges. Conditions in Calcutta might be different. But in Madras, men hold professorial appointments in the colleges by virtue of their being officers on the hospital staff. This is evidenced by the fact that the officers draw their basic pay for the hospital appointments and get an additional allowance for their professorial and teaching duties. Col. Proctor seems to lay particular emphasis on the fact that in some of the hospitals and medical schools of England, the professors and physicians or surgeons are whole-time paid men, and that where the seniors are honorary, they are provided with paid full-time assistants. But if he had cared to give the figures, it would clearly have shown what a negligible ratio these full-time officers bear to the very large number of honorary medical men and honorary assistants who staff the bulk of the first class institutions of England. It is certainly a fact that the professors on the continent are fully paid whole-time men. But these professors are employed by the universities and are not in any sense to be compared with the general run of professors in this country who are appointed to these places, not chiefly because they are specially eminent in their departments, but most certainly because they happen to be seniors in their particular services. Occasional exceptions to this practice does not affect the general truth of the statement.

As against the hope of the public that a greater utilization of the honorary scheme would render medical relief less expensive, Col. Proctor says that it actually entails greater expense, both initial and recurring, on account of the need for additional junior staff. This is contrary to experience elsewhere, and on closer scrutiny, we are sure it would be found that additional staff has been appointed because they were needed, and not because part of the staff is honorary. This contention of Col. Proctor brings out clearly the unsoundness of the policy of the Government of Bengal. The honorary scheme is evidently introduced there to provide opportunities for the members of the independent medical profession to work in hospitals and with this purpose they hope to create new hospitals and buildings. But really the object of the scheme should be to take advantage of the willing services of the honorary medical men to relieve the pressure of work in hospitals and to increase the speed and efficiency of medical advice and thus ensure a better standard of efficiency in the wards. If only people would compare the number of beds in charge of each physician or surgeon in England with those in this country, it would be easily seen that men here are expected to look after a much larger number of beds with equal efficiency. It is commonly argued by the men in the *services* here that they devote more hours for their hospital work. Indeed Col. Proctor mentions with obvious pride that the Surgeon-Superintendent and the Resident Medical Officers of Calcutta spend more than eight honrs a day in the hospitals. It is significant that he has chosen the officers with administrative duties. It would be of interest to know the amount of time taken by these officers for purposes of administration and the time actually spent in the wards and the theatre. We take it that Resident Officers have no definite ward work, and it is unfair to compare the time spent by them with that of the physicians and surgeons. We are familiar with this argument in Madras. It could be shown that no physician or surgeon generally spends more than three hours a day in the wards or the operating room. Many of them actually spend much less time.

Occasionally a surgeon might stay longer in the operating theatre, but that is not the routine.

On the whole, the impression that is left on one after going through the speech is that Col. Proctor is more concerned about defending the paid medical officers than condemning the honorary scheme. We have always maintained that high politics is generally out of place in the medical department. When one concentrates on the rights and privileges of particular classes or services, one generally sacrifices the good of the enormous sick public. What is required is not to waste time in attempting the fruitless task of assessing the relative worth of various groups of men, but to recognize the fact that sickness is rampant in this country and that the men to minister unto them are certainly few. It is time therefore to cry halt to these endless controversies and to concentrate our attention on how best to organize medical relief pressing into service all available medical talent. It would be well if people would recognize that no single method is perfect. What is good for one country is generally not so suitable for another situated differently as to climate, finance and general advancement. There is room in Indian medical organization for the most highly qualified as well as the most humble. There is need for honarary as well as for paid *full-time* officers. And we urgently need an agency which would skilfully utilize their services for appropriate spheres.

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## "The Vasko Case"

(Dr. U. D. Gopal Rao, Madras).

'May the State order an operation on a child if the parents object?' was the point which the supreme court of New York, had to decide in the following case.

Holen Vasko, a baby, 2 years old, was suffering from a malignant tumor of the retina. Her physician stated that she would probably die within a month unless operated on. The father refused to permit the operation. He said "I would rather have a dead baby than a mutilated one."

The physician thought it was his duty to apply to the judge of the children's court, for an order to perform the operation over the parents objection. The judge promptly gave the order.

John Vasko, the father of the child, being a fighter himself made an appeal to a higher court. The case thus went from court to court. The number of physicians and lawyers directly interested in the case grow. Meanwhile the baby's eye tumor also grew.

The delicate issue in the case hinged around the question of parental neglect. The Children's Court Act of New York, defines a neglected case as 'one whose parents, guardians, or custodians neglects or refuses when able to do so, to provide necessary medical, surgical, institutional or hospital care for such child'. Here a delicate situation arose in trying to decide whether the medical treatment because of its doubtful results could be called necessary. The case eventually reached its final destination, when the Supreme Court of New York appointed its own physicians to examine the child and as per their opinion 'it would be better to risk the operation than to avoid it', the court concluded that the surgical treatment of Helen was necessary and could be ordered by the State.

The Supreme court's decision which ordered doctors to perform the life saving operation over the objection of parents has a special significance for every conscientious physician. It

shows him that he has a clear duty in such cases to apply to the authorities, when necessary for the power to save a life.

The case also raises some other points of professional interest. If the Government of the country is empowered to force removal of a tumor for the purpose of saving life, is not the Government also empowered to enforce a tonsilectomy for the purpose of protecting health? Children need not be penalised for the ignorance of their fathers and mothers. Why should they be denied curative and ever preventive treatment such as diptheria antitoxin, because their parents have neglected or refused such treatment.

The Doctors who brought "The Vasko Case" to court have set a precedent. This requires serious consideration by the medical professions at large. 'It is the duty of every practitioner confronted with such a case of parental stubbornness or neglect, to focus public attention on the matter bring legal pressure to bear and give the child involved a fair chance in its fight for health and life'.

It is not uncommon to find many many cases of parental neglect in this country where illiteracy, ignorance and susperstition reign supreme It is the duty of the Government and the public to bring in the necessary legislation for the formation of Children's Court, just on the lines of the civilised countries of the west. This would save indeed, many child falling victims to barber midwives and charlatans and quacks.

*Reference.*—Medical Economics, Vol. 10, No. 10, July 1933.

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## Specialist—Concerning Use of the Term.

During the deliberations of the Vienna chamber of physicians, last year, Doctor Sonnenfeld presented a communication in which he explained the present regulations concerning the assumption by physicians in Austria of the title of "specialist." At present there are no legal regulations bearing on the right to assume and use the title of specialist in the republic of Austria. Only with regard to the admission of physicians to the *krankenkassen* having free choice of physician has any regulation of the specialist problem been attempted. As affecting the contracts between the organization of the medical profession and the *kranken kassen*, the following regulation obtains. "Only such physicians who, following a special course of training, confine their practice to a special branch of medicine are entitled, in principle, to announce themselves as specialists. Such physicians are recognised by the economic organization of physicians as specialists and are announced to the *krankenkassen* expressly as specialists for a certain branch of medicine. They are not permitted to serve, at the same time, as general practitioners. Every specialist must be a member of the Verband der Facharzte (league of specialists) in Vienna if he wishes to practise in Vienna. In the provinces, outside Vienna the title "specialist" is approved, by the chamber of pysicians having jurisdiction, only after the applicant has furnished evidence of his special training. The special training required has been standardized by the Verband der Facharzte in the following manner: A specialist can practise in only one of the following fields: surgery, dermatology, gynæcology (including obstetrics), internal medicine, respiratory organs, neurology and psychiatry, ophthalmology, orthopedics, otorhinolaryngology, pediatrics, physical therapy, roentgenology, urology and medical laboratories, or a total of fourteen specialties. That holds for Vienna; in the provinces the three specialties, orthopedics, urology

and medical laboratories drop out. In case of need, the chamber of physicians has the right to combine two or more specialties (internal medicine and pediatrics, and respiratory organs, or ophthalmology and otorhinolaryngology, or surgery with gynæcology and radiology). Every specialist in Vienna or in the provinces must first request admission to the narrower group and furnish proof that he has fulfilled the conditions for admission as specialist, which, for the non-operative branches, are at least four years of training in a clinic or hospital service dealing with his specialty, and, for the operative specialties, five years of training and experience in such an institution. The applicant must also furnish proof that, for at least two years of the four to five-year period, he served as assistant to the department head and was thus compelled to work more or less independently. The applicant is not recognized by the Verband der Facharzte until the group of specialists concerned has admitted him; he can then enter into contracts with the health insurance societies (*krankenkassen*). But in case a physician does not seek service with the *krankenkassen*, he can select any specialty he desires, specialize in that branch of medicine, and announce himself as a specialist in that branch; and, if he desires, he can practise also general medicine, which the members of the specialist groups are strictly prohibited from doing, as has already been mentioned. But he cannot be admitted to membership in the Verband der Facharzte. It should be noted, however, that the general public has become so used to regard and patronize only the members of the Verband der Facharzte as specialists that the other specialists receive little consideration. The only specialist title that is protected by law in Austria is that of *zahnarzt*, (physician-dentist), since the study of dentistry is regulated by law and only doctors of general medicine who devote themselves exclusively to dentistry may call themselves *zahnarzt*, other persons ("dentisten," technicians, and others) not being permitted to refer to themselves as *zahnarzte*. In Vienna there are something over 4,000 registered physicians, for a population of 1,810,000. Of that number, 800 are hospital physicians, 1,220 specialists, 650 physician-dentists (*zahnarzte*), and the remainder (about 1,400) general practitioners, 290 of whom are women. Among the specialists and physician-dentists there are 110 women. In Austria, outside Vienna, there are about 2,600 registered physicians, with about 600 specialists and physician-dentists.

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## UNION NOTES.

### The South Indian Medical Union.

Annual Report for the year ending March 1933. Officers for the year 1932-33.

*President.*

Dr. S. Rangachari.

*Vice-Presidents.*

Dr. U. Rama Rao.
„ E. V. Srinivasan.

*Members of the Governing Body.*

Dr. T. Satakopan.
„ K. Srinivasa Rau.
„ G. Zachariah.
„ U. Venkata Rau.
„ Mr. L. Jacob.
„ M. R. Grandhi.
„ K. C. Paul.
„ M. Sanjiva Rao.
„ V. D. Nimbkar.
„ P. Mitchell.
„ M. Subramania Iyer.
„ P. Rama Rau.

*Hony. Secretaries.*

Dr. C. R. Krishnaswami.
„ U. K. L. Narayana Rau.

*Publicity Section*

Dr. S. Rangachari.
„ U. Rama Rau.
„ T. Satakopan.
„ M. Subramania Iyer.
(*Publisher of the Bulletin.*)

The Annual meeting of the Union was held on the 18th July 1933 at 32, Broadway, at 6-30 p.m. More than 40 members were present at tea prior to the meeting.

Dr. E. V. Srinivasan, one of the Vice-Presidents took the chair.

The Secretary submitted the following report for adoption :—

The membership of the Union continues as before. The financial statement as certified by the auditor is herewith appended.

*Work.*—The following papers were read before the Union :—

(1) 22nd August 1932. "Bronchography" By Dr P. Rama Rau.

(2) 12th September 1932. "Otitic Media" By Dr. M. Sanjiva Rao, Dr. C. V. C. Rao and Dr. M. R. Bail.

(3) 10th October 1932. "The Vegetative Nervous System in Surgery" By Dr. C. R. Krishnaswami.

(4) 21st November 1932. "Proprietary foods and their abuse" By Dr. C. Ranganathan.

(5) 21st February 1933. "High Frequency Currents in General Practice" By Dr. C. V. Sudarsanam.

(6) 21st March 1933. "The Rational use of Digitalis" By Dr. T. Krishna Menon.

(7) 22nd May 1933. "Some common Fungus Infections of the Skin" By Dr. S. Rajagopalan.

*Governing Body Meeting.*—The governing body of the Union met four times during the year and the thanks of the Union are due to those of the members who were regular in their attendance and who guided the affairs of the Union by their wise counsel.

*General Meetings.*—Two General Meetings were held during the year.

*Social.*—There were four socials held during the year. The Secretaries feel proud to state that these were unqualified successes and that no encroachment on the finance of the Union were made

Dr. E. V. Srinivasan has once again placed the Union under a deep debt of obligation to him by allowing the use of his premises for all the various activities of the Union.

*Bulletin.*—The Bulletin, the official organ of the Union, is maintaining its circulation and its usefulness to the profession and the public. The thanks of the Union are due to the members of the Editorial Board for their untiring efforts in maintaining its high standard of efficiency and public usefulness.

The income from advertisement having fallen off considerably owing to financial stringency in the business world, it is a matter for congratulation that there has not been much encroachment on the general funds.

*General.*—The Union is pleased to note that its suggestions for the improvement and extension of the Honorary Scheme have found favour with the Government and resulted in the appointment of a fresh Committee to consider the questions. We hope that the report will embody most of the principles we have been agitating for.

# THE SOUTH INDIAN MEDICAL UNION, MADRAS.

*Statement of receipts and disbursements for the year ending 31st March 1933.*

| RECEIPTS. | Rs. A. P. | Rs. A. P. | PAYMENTS. | Rs. A. A. | Rs. A. P. |
|---|---|---|---|---|---|
| To Balance | | | By Establishment ... | | 315 0 0 |
| With the Indian Bank Ltd : | | | ,, Postage ... | | 4 12 3 |
| Current Account ... | 466 0 1 | | ,, Bank Commission ... | | 4 14 0 |
| Savings Bank Deposit a/c ... | 1,804 5 3 | | ,, Bulletin Account ... | | 1,615 12 6 |
| On hand ... | 105 11 3 | | ,, Balance : | | |
| | | 2,376 0 7 | With the Indian Bank Ltd : | | |
| ,, Subscriptions ... | | 770 0 0 | Current a/c ... | 395 6 1 | |
| ,, Interest on Bank Deposits ... | | 92 15 5 | Savings Bank Deposits ... | 1,885 3 8 | |
| ,, Bulletin a/c : | | | On hand ... | 60 15 6 | |
| Amount received on account of Advertisements ... | | 1,044 0 0 | | | 2,342 9 3 |
| Total ... | | 4,283 0 0 | Total ... | | 4,283 0 0 |

Examined and found correct.

K. GOPALAKRISHNA RAO, B.A.,
*Accountant and Auditor.*

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

With a modification that the words "Editorial Board" in the last but two paragraphs in the report be changed into "Publicity Section" the report was passed.

Dr T. Krishna Menon proposed that a vote of thanks be passed for the services rendered by the auditor. Having been duly passed, the Secretaries were asked to communicate the same to Mr. K. Gopalakrishna Rao, the auditor.

The following office-bearers were elected for the year 1933-34:—

*Council*, 1933-34.

*President.*

Dr. S. Rangachari.

*Vice-Presidents.*

Dr. U. Rama Rao.
,, E. V. Srinivasan.

*Members of Council.*

Dr. C. R. Krishnaswami.
,, U. K. L. Narayana Rao.
,, T. Satakopan.
,, T. Krishna Menon.
,, George Zachariah.
,, K. Srinivasa Rao.
,, V. D. Nimbkar.
,, P. Govinda Rao.
,, Mrs. L. Jacob.
,, U. D. Gopal Rao.
,, M. Sanjiva Rao.
,, U. Venkata Rao.

*Honorary Secretaries.*

Dr. P. Rama Rao
(*Joint Secretary*).

Dr. K. C. Paul
(*General Secretary*).

As it was already 8-30 p.m. the meeting was adjourned to 24th July.

At the adjourned meeting held on 24th July 1933 at 32, Broadway, Dr. U. Rama Rau, one of the Vice-Presidents of the Union took the chair.

The following resolutions of which due notice had been given by Dr. U. K. L. Narayana Rau came up for consideration:

1. That the Policy of the Bulletin of the South Indian Medical Union be more clearly defined, so that more attention might be given to propaganda work on behalf of the Independent Medical Profession.

2. That the publicity section of the Union be requested to furnish a report of its activities and an account of the Bulletin to the Executive Committee once every three months.

3. That any vacancy arising in the Publicity Section shall be filled by the Executive Committee till the next elections.

4. The clause in the Union Rules, regarding Election of a Treasurer be abolished, and one of the Secretaries shall function as Treasurer also

5. That one of the Secretaries shall be in sole charge of the clinical and social meetings of the Union.

6. That the Bulletin be converted into a quarterly.

7. That the South Indian Medical Union desires to bring to the notice of the Government, the large number of well to do classes, getting medical relief in the various Government Hospitals, thereby depriving the really deserving poor and needy.

8. The Union requests the Government to put an end to the chit system of admission into the Hospitals, in the

interest of the Independent Medical Profession.

9. That the Government be requested to disallow private practice to members of the paid service in view of the adequate number of well qualified independent medical practitioners.

Dr. U. K. L. Narayana Rau in commending his resolutions complain that there was not a definite policy for the guidance of the Bulletin and no definite rules stating the relationship between the Governing body of the Union and the Publicity Section and suggested that the Bulletin should do more of Propaganda work than the publication of Extracts.

Dr. C. R. Krishnaswami. "There is no purpose gained by passing the resolution. As the welfare of the Independent Medical Practitioner is intimately bound with the Honorarization of various Hospitals, the Bulletin was already doing sufficient propaganda work in that direction. Furthermore a rigid system of rules defining the policy of the Bulletin would hamper the Editorial Board in their effort to tackle the various problems as they arose."

Dr. K. C. Paul: "I propose that the resolutions 1, 2, 3 and 6 be taken up together and the different resolutions be considered as clauses of a single resolution. Dr. P. Rama Rau seconded.

Dr. K. C. Paul's resolution having been passed the chairman proceeded to put clause by clause to vote.

Dr. Sanjiva Rau: The 1st clause was then thrown out.

The 2nd, 3rd and 6th clauses were then withdrawn by the mover as he felt that his purpose was served when he had initiated a discussion on these clauses.

No. 4 of the resolutions that the post of the Treasurer be abolished and that one of the Secretaries shall carry on the work was unanimously passed.

No. 5 of the resolutions that one of the Secretaries shall be in sole charge of the clinical and social activities of the Union was withdrawn by the mover on his being informed that there was already a specific rule to that effect and was that was actually obtaining in practice.

Resolution 7. "That the South Indian Medical Union desires to bring to the notice of the Government, the large number of well-to-do classes getting relief in various Government Hospitals, thereby depriving the really deserving poor and needy."

Resolution 8. "That the Union requests the Government to put an end to the chit system of admission into the Hospitals in the interests of the Independant Medical Profession."

Resolution 9. "That the Government be requested to disallow private practice to the members of the paid service in view of the adequate number of well-qualified independent medical practitioners."

During the consideration of the above three resolutions, it was brought about that the concession granted to the service men to practice led to their taking a fee privately from patients prior to admission into Hospitals and the correct income of patients not given out to the Hospital authorities.

All the above resolutions having been unanimously passed, the Secretaries were asked to communicate the same to the Government.

## ASSOCIATION NOTES.

### Godavari District Medical Association.

An ordinary meeting of the East Godavari District Medical Association was held at Ramachandrapuram at 4-30 p.m. on the 8th July 1933 in the premises of the Local Fund Travellers' Bungalow. A large number of members of the medical profession from all over the district, attended the meeting. Major T. S. Sastri, L.M.S., District Medical Officer, East Godavari and President of the Association, presided on the occasion.

After a few remarks from the President, Dr. V. Kamaraju, L.M.S., of Cocanada, one of the secretaries of the Association read the minutes of the last meeting of the Association held at Polavaram. Dr. T. Kanakaraju, L.M S., of Ramachandrapuram, then delivered an address on some interesting cases, both medical and surgical, treated by him, accompanied by demonstration of apparatus used by him and the patients treated by him.

Dr. T. Chelapathi Rao, L.M.P., next read an interesting paper on "Birth control and contraceptive methods." He discussed the arguments for and against birth control by artificial mothods, and gave short accounts of the various means adopted in various countries in this connection and exhibited some of the pessaries now sold in the market. Dr. Chelapathi Rao said, however that none of the so-called contraceptives could be considered effective in actual practice. A short discussion ensued in which one doctor condemned birth control as immoral and unethical and positively harmful to the health of the parties practising it.

Major Sastri, in his concluding address, referring to the question of birth control and the use of contraceptives, declared that while these might be advantageously taken to by those who wanted to do so, they had also to warn them that most contraceptives now in the market might prove ineffective. As an alternative Major Sastri put forward the suggestion that facilities should be afforded for the practice of abortion to prevent the birth of unwanted children and that for that purpose abortion should be legalised. Finally he said that while prevention of child birth might be resorted to as a necessity under present day conditions, still most women who were eagar to do so in their youth, would find the absence of children in their old age a tremendous drawback.

There might come about a shattering of nerves and a general break down which were but a poor compensation for thier early attempt at avoiding child-bearing.

Major Sastri, next referred to the leprosy relief work that had been decided to be organised by the Government and exhorted all medical practitioners especially those in Government employ to take to it cheerfully.

The next meeting of the Association was then fixed to be held at Rajahmundry. The meeting then came to a close.

At 8-30 p.m. all the members were treated to dinner and later were entertained by the local Bhajana Party.

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### Malabar Medical Association.

"Our duty to our country as members of a noble fraternity cannot end in merely criticising the Government. We should come forward and put before the public and the Government a suitable and most congenial scheme of medical relief which, while serving the purpose for which it is meant, will help the medical profession to grow a contented band ever ready for sacrifice and service," declared Dr. Rama Kamath, of Madras, addrssing a meeting of medical men of Malabar, held in the Calicut Town Hall on the 9th July in

connection with the celebration of the second anniversary of the Malabar Medical Association. Major A. J. Cox, I.M.S., District Medical Officer, Malabar, presided.

The President, in the course of his introductory remarks, reiterated the value of medical associations. Dr. V. Krishna Menon, Secretary of the Association, then read the annual report which showed steady progress. Dr. Rama Kamath of Madras then delivered an interesting and instructive lecture on " Medical Relief."

The election of office-bearers for the coming year was then held. Major A. J. Cox, I. M. S , was re-elected as President and Dr. V. Krishna Menon as Secretary.

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**Trichinopoly Medical Association.**

A monthly meeting of the above Association was held on 24th June 1933, in the Government Head Quarters Hospital, Trichy. About 50 members attended. Dr. T. K. Ranganathan, B.A. , L.M.S., was " At Home " to the members of the Association. Dr. P. A. S. Raghavan, the Secretary of the Association read the minutes of the last meeting and it was unanimously carried. Dr. S. Padmanabah Sarma who presided on the occasion demonstrated the following cases :—

(1) Talipes Equino Varus and explained that if the case was brought immediately after birth the deformity could easily be corrected by simple plastering. But if the child was brought little later, tenotomy should be tried, but if there was gross lesion resection of one of the Tarsalbones, might become necessary ;

(2) Tubercular disease of the hip joint;

(3) Advanced hook-worm disease which was resistant treatment;

(4) A tumour in the abdomen with Ascitis and in which there was lot of speculation as to its origin whether from the ovary, tubes or elsewhere ;

(5) Intestinal obstruction which was relieved by operation ; and

(6) A case of Valulus which was improving under Turpentine-stupes, high-enemata and Atropine injections.

In the unavoidable absence of Dr. T. S. S. Rajan, his assistant Dr. Jambunathan demonstrated a Sarcoma of the rectum recently removed from a patient and a case of Ventral Hernia which similated an abdominal tumour.

With a vote of thanks proposed by the Secretary, to the host, the lecturers, and the President of the meeting, the meeting terminated.

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A monthly meeting of the above Association was held on 26th August 1933 at 5. P. M. in the Government Headquarters Hospital, Trichinopoly, when about 35 members were present. Dr. R. Kalamegham, B.A., M B.B.S., was " At Home".

Dr. S. Balavelayuthan Pillay, Ag. District Medical Officer, proposed Dr. T. S. S. Rajan to the chair and Dr P. A. S. Raghavan, seconded.

Dr. T. K. Ranganathan, B A., L.M.S., demonstrated three clinical cases of Syphillis.

Dr. Rajan introduced, Dr. T. S. Shetty of the S. A. Hospital, Kanadukathan, Chettynad, as an energetic young man who had enriched his knowledge by a recent visit to the west and called upon him to deliver his lecture.

Dr. Shetty delivered an interesting lecture on Gonorrhoea and its treatment, at the end of which there was an interesting discussion in which about half a dozen doctors took part.

With the concluding remarks of the Chairman and with a vote of thanks proposed by the Secretary, Dr. P. A. S. Raghavan, to the Chairnan, Lecturer and the Host, the meeting terminated.

**BULLETIN**
OF THE
**SOUTH INDIAN MEDICAL ASSOCIATION.**

OCTOBER 1933.

# Modern Treatment of Thermal Burns.*

Lt. Col. V. Mahadevan, M.R.C.P., F.R.C.S. (E.), I.M.S.,

*Surgical Unit, Royapuram Medical School.*

Burns may be caused by : heat, dry and moist, alkalies, acids, X-ray, radium and electricity.

Rational treatment of any disease consists in correcting and combating the pathological processes at work. I shall therefore start with a short description of the pathological changes found locally and show how they produce the various clinical stages of burns. It is convenient, customary and scientific to divide the *clinical manifestations into four stages.* Each has its own pathology.

1. Primary shock.
2. Secondary shock or acute toxæmia.
3. Septic toxæmia.
4. Healing. (Wilson)

Local changes produced by the cooking of the tissues by heat are, by Dupuytren, divided into six degrees. They are

1. Hyperæmia or Erythema.

2. Destruction of epidermis, blister formation and œdema of the subcutaneous tissues.

3. Partial destruction of true skin with exposure of papillary nerve endings—(very painful).

4. Total destruction of true skin down to subcutaneous tissue and including that tissue. This is due to prolonged action of heat. Since the process extends deeply, healing is slow. As a great amount of granulation tissue formation is necessary, scarring and subsequent contraction are very common.

5. Destruction involves muscles.

6. Deeper type involves bone.

The treatment of the 5th and 6th degrees are generally the surgical treatment of bad lacerated wounds.

*Primary shock* is due to excessive and abnormal stimulation of afferent nerves by the injury and inhibition of the vital centres. This produces a dilatation of the capillaries, and stagnation of blood and thus lowers the blood pressure. Duration up to six hours. It comes on directly after the injury. Hence the term primary shock. It is usually recovered from.

*Secondary shock*—Duration 24 hours. It manifests itself about six hours after the injury but may be delayed up to 24 hours. It is most serious and accounts for 75 per cent of deaths due to burns. The Post-mortem findings are (1) General hyperæmia of all the internal organs, (2) Marked leucocytosis with destruction of R. B. C. and setting free of hæmoglobin which lodges in the epithelium of the tubules of the kidney, (3) Minute thrombi and extravasation throughout the tissues of the body, (4) Degeneration of the ganglion cells of the solar plexus, (5) Oedema and degeneration of the lymphoid tissues throughout the body (6) Cloudy swellings of the liver, kidney and spleen.

As these changes are also found in cases of death due to a definite toxin it is suggested that the cause here is

* Address delivered before the South Indian Medical Union, Madras

most probably a poison produced in the tissues and the proteins of the blood by the action of heat, most probably a proteose. In this connection it is very interesting to note that the snake venom which is one of the deadly poisons known is a proteose and the post-mortem findings in deaths due to snake poisons are also similar. On the other hand it is a definite fact that the blood of these patients does not show the presence of any poison when injected into experimental animals. The clinical manifestations can all be explained by the changes in the blood such as dehydration, concentration and deprivation of the chlorides of the blood. As this will not explain the post-mortem findings a septic toxæmia is brought forward for the explanation of the findings. Streptococci are present in cases of burns even as early as 6 to 12 hours after the accident. The truth most probably is that both factors combine to produce these changes.

*Stage of septic toxæmia* varies. It requires little explanation and it varies with the extent of burns and effective treatment.

*Stage of healing*—This is the natural result of healing and varies with the treatment adopted. Greater or less degrees of fibrosis and contracture and chronic ulcers requiring skin grafting will be present.

*Treatment.*—From the above pathology it is evident that the main factors to be combated are (1) abnormal impulses to the brain, (2) dehydration and low blood pressure, (3) tissue toxins, (4) acidosis, present in all cases of toxæmias, (5) septic infection (6) excessive fibrosis and contraction deformities.

It has been suggested that blister formation can be prevented by gently rubbing vinegar or spirits over the burnt part immediately after the accident. I have tried them both and found them not satisfactory. A tablet of $\frac{1}{4}$ grain of morphia, if handy, should be given by the mouth at once. It allays pain and prevents shock.

In cases of 1st degree of burns, in addition to morphia, cleaning the part well and dusting with powder is all that is necessary. I have already mentioned that 5th and 6th degrees of burns are big lacerated wounds and are to be treated on general surgical principles, leaving us with 2nd, 3rd and 4th degrees of burns and it is the treatment of these that is dealt with here. The majority of these cases are extensive and require hospitalisation.

As soon as the patient is brought in, he is given an injection of morphia ($\frac{1}{4}$ to $\frac{1}{3}$ gr.) with atropine (1/150 gr.). This allays shock and eases pain. A prophylactic dose of antitetanus serum—500 units is also given. The following doses of opium or its preparations according to age, extracted from a recent journal will be a safe guide.

| | | |
|---|---|---|
| Child | 1 month | $\frac{1}{6}$ m. Tr. Opium or 2 to 3 m. Tr. Camphor Co. |
| ,, | 6 months | $\frac{3}{4}$ m. Do, |
| ,, | 1 year | 2 m. Do. |
| ,, | 3 years | 8 m. Do. |
| ,, | 12 years | $\frac{1}{6}$ gr. morphia. |
| Adults | | $\frac{1}{4}$ to $\frac{1}{2}$ gr. morphia. |

The patient is now put to bed, with sterile sheets, clothes removed preferrably by cutting. A cage provided with 3 to 4 electric bulbs and covered by blankets is placed over the patient. Plenty of fluids are given by the mouth and rectum to replace the water lost and this is continued throughout the active phases of treatment. If this is not possible, subcutaneous infusion is given. Lastly, in bad cases intravenous administration is resorted to. By the mouth, rectum, or subcutaneous route the following solution is used. Soda bicarb $\frac{1}{2}$ per cent with glucose 1 per cent, in normal

saline. For intravenous administration Roger's hypertonic solution with 2 per cent glucose is usually given—dose 1 pint. Intravenous injections may have to be repeated. Dehydration and depletion of the chlorides are thus met.

When by these methods the shock is combated and the systolic blood pressure is raised at least above 90 mm. of Hg., the surgical treatment of the wound is begun. If any active surgical treatment is instituted without this precaution one is asking for trouble and disappointment.

Under light anæsthesia debridement of the burnt area is carried out, *i e.*, the blisters are cut; dead and damaged tissues are removed. The part is *cleaned and dried with ether or rectified spirits.* It is on the completeness of this purifying process that the success of the treatment depends.

*Spray treatment*—We owe to Davidson the gift of tannic acid spray in the treatment of burns. The strength of solution he recommended was ·5 per cent, which is generally used everywhere. We use a solution of tannic acid 5 per cent and picric acid $\frac{1}{8}$ per cent in double distilled water and prepared fresh. An ordinary spray is used. The spray we use is the simple cheap spray, one sees with the barbers and costs only about Re. 1-8. The spraying is repeated every hour till it forms a dry crust over the raw surface. This crust falls off in 10 to 15 days, the deeper the wound the more time it takes. Once the crust is formed no further local treatment is necessary except covering with a sterile towel. When in some 3rd and 4th degree burns the crust cracks, the exposed areas are covered over with ointment of the same strength. When the face is burnt the same ointment is employed, as with the spray there is the danger of some of the solution getting into the eye and irritating it. If the original cleansing process is not thorough, suppuration occurs under the crust, this is treated by incision, purifying with Eusol and dry sterile dressing. The debridement should be thorough without increasing the shock. When the crust falls off, or is cut off in the 2nd and 3rd degrees of burns the surface exposed is nicely epithelialised, but in the 4th degree a raw healthy granulating surface is exposed which has to be skin grafted. If there are deep ulcers they may be filled up with ambrine. In this stage movements of various joints are carried out to prevent stiffness. Contractions are treated on general principles, but with this treatment contractions are very rare.

Advantages claimed for this treatment are (1) by debridement, the infected burn is made as nearly aseptic as possible. (2) tannic and picric acids fix the proteose forming tannate of albumin, thus preventing absorption of this toxic product. (3) Any organisms left behind are acted upon by the picric acid. (4) The crust acts as a new skin, preventing dehydration, and heat is conserved. (5) The electric bulb in the cage give warmth, dry up secretions and the crust. (6) Depletion of water and salts are substituted by the fluids and salts given by different channels. (7) The glucose acts as an anti-toxic and alkalinising agent. (8) Lastly there is the phylactic action of $CHCl_3$ as in tetanus and eclampsia.

By this treatment the stage of septic toxæmia and complications connected with it are prevented. Contractures seldom occur. Tannic acid alone did not give in our hands as satisfactory a result as the tannic picric combination of ours. The 5 per cent solution gives a crust much quicker than the weak $2\frac{1}{2}$ per cent

solution. In our solution the crust is formed in six hours whereas with 2½ per cent solution it takes 12 hours.

A mild diuretic consisting of Pot. acetate grs. X, Pot. citras dram 1, Aqua chloroform oz. 1, is always given three times a day. For Citras acts as an alkaliniser of the blood preventing acidosis. A dose of Mist. Alba. ozs. 3 with m. 3 of Tr. Nux vomica on the 1st day acts as a cleanser of the bowels. Subsequently liquid paraffin in any form or castor oil, a teaspoonful at night, keeps the bowels regular.

*Diet* consists mainly of diluted and citrated milk, glucose water, sugar and fruit juices. When the patient's condition improves a more generous diet is prescribed. We are against giving whole milk to any of the toxic cases.

If there is hyperpyrexia an ice bag is applied to the head.

Hæmaturia, we have met with in many of our severe cases. This does not require any further treatment than what is detailed above. Ulcer of the duodenum or stomach was seen in one case. The usual treatment for this condition is glucose and saline per rectum, nothing by the mouth for the first 24 hours as in our post-operative treatment of gastric cases. In our series respiratory, meningeal or cardiac complications were seldom seen.

This is the treatment carried out in the surgical unit of the Government Royapurm Hospital for the last 9 months. Before this, tannic acid 2½ per cent alone and for some months tannic acid 2½ per cent with acriflavine 1 per cent were used. The latter mixture produced a precipitate and was given up for the tannic and picric acid mixture and six months ago the strength of the tannic acid was increased to 5 per cent. I have collected figures for the 9 months during which we adopted the mixture treatment and of similar period previous to it where tannic acid alone was employed. :—

| | | | |
|---|---|---|---|
| Tannic picric | admissions 60 | deaths 6 | (10 %) |
| Tannic alone | ,, 46 | ,, 7 | (15 2 %) |

The figures speak for themselves. I was unable to classify them according to severity, age, part affected and state on admission. They were all severe enough to be admitted into hospitals and safe enough for a rough comparison of the results of different treatments adopted. This tannic picric acid treatment is not suitable in cases of burns which seek treatment after 48 hours. They have become septic and are to be treated on general principles. This treatment is also exceedingly useful in superficial wounds produced by the surgeon in skin grafting.

*The gentian violet treatment* is to use 5 per cent gentian violet instead of our mixture.

It gives equally good result and is in use in John Hopkins University Hospital.

If a spray is not available, especially when treating cases at home, compresses lightly wrung out in the picric tannic solution may be applied over the cleaned area and kept soaked by the solution till a coagulum forms.

Carron oil and carbolic oil makes the part greasy, and difficult to clean afterwards and do not allow the free flow of secretions and should never be used.

*Prognosis.*—" The highest accomplishment of medical practice is *Prognosis.*" Its foundation is proper diagnosis and efficient treatment. Pathological anatomy is a sub-structure of diagnosis and treatment.

It is very difficult to say at the first visit whether a patient is going to die or survive. But the following may be taken as a guide:—1 Age: children very easily succumb to shock; but they stand suppuration much better. Our treatment has prevented this suppuration stage. 2. The extent of the burn; the superficial area being more important than the depth. 3. The site of the burn is over the three important cavities as the skull, thorax or abdomen the case becomes very serious.

I have to thank my colleagues Drs. Sabhesan, M. S, Atchayya Naidu, F. R. C S., and Nataraja Ayyar, L. M. P. for their valuable assistance in planning out this treatment, and watching the various stages of our cases during treatment as also for their valuable advice and criticisms.

DISCUSSION

Dr. V. D. Nimbkar remarked that a mixture of kerosene oil and salt was an old household remedy for burns in his native place and that he had used it on himself often for minor burns with considerable benefit.

Dr. C. R. Krishnaswamy believed that in the causation of secondary shock in cases of burns the absorption of toxins from the burnt area was an important factor, as was suggested by Wilson in his report (1929), who cited experiments by Dale and others in support of this view. He suggested the utility of ex-sanguination and transfusion of blood in properly selected cases of burns for the relief of shock and toxæmia.

Dr. P Govinda Rau wished to know whether a solution of corrosive sublimate and tannic acid, as suggested in a recent number of the British Medical Journal, could not be used in case of burns instead of picric acid and tannic acid.

Dr. K. Srinivasa Rau asked whether chloroform could be administrated in cases of burns as it dilates the blood vessels and lowers the blood pressure, thereby tending to increase the shock. He wished to know whether some other form of anæsthesia could not be given with advantage. He observed that administration of chloroform may bring about atrophy of the liver. He stated that the use of spray may lead to pressure gangrene in burns involving the whole circumference of the finger and should therefore be made with care.

Lt.-Col Mahadevan, I.M.S. (replying) said that he will try the treatment suggested by Dr. Nimbkar in such cases as are suitable. As regards chloroform, in his hands it has not so far given any trouble in cases of burns; he employed only light anæsthesia. Regarding the spray producing a constricting crust when applied to encircling burns on fingers and thereby causing gangrene, he said that an ointment may be used instead of the solution in such cases. The experiments referred to by Dr. C. R, Krishnaswamy were old ones and more recent ones have been performed by Blalock and others (1933) which question even the existence of toxæmia in cases of burns. As for Dr. Govinda Rau's querry, the solution of corrosive sublimate and tannic acid was probably as efficient as the solution of picric acid and tannic acid; but he believed that when we have found a good thing it was wiser to stick to it. About the statistics he said that formerly many cases of burns were reported to have been admitted into the Royapuram Hospital and died; but that at the present day such reports are not in the papers, as all cases of burns are treated with the new solution and sent out cured. Anyhow as the statistics given were based on the total number of admitted cases and not on selected ones it may be accepted as satisfactory.

Dr. U. Rama Rau (Chairman) remarked that when he was a student he used to treat cases of burns with carron oil; later he began the use of picric acid; and now he is using the tannic picric solution In his experience the last mentioned acts much better than the others. He has found that a paste of bi-carbonate of soda if applied over the burnt area relieves the pain immediately. The common treatment of burns known to the lay people of Madras is to apply ink to the burnt part; and the success attending this treatment is probably due to the tannic acid contained in the ink used.

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## X-ray Evidences of Pathological Appendix.*

By Dr. P. Rama Rao, D.M.R. (Vienna),
*X-ray Institute, Poonamallee Road, Madras.*

I should apologise for asking you here, on an apparently small subject, as the usual tendency is to mention a few salient features on diseased appendix in a general treatise on X-ray examination of the gastro-intestinal tract. In diagnosis—clinical and radiological—fallacies are not very rare; and it is not uncommon that the surgeon finds a normal appendix in some of his "appendix" cases. The radiological signs of a pathological appendix are simple; but to obtain them the appendix must be first made visible. With an ordinary barium meal,

* Read at a clinical meeting of the South Indian Medical Union, Madras.

the appendix fills in only 40 to 50 per cent of cases, so that it is doubtful whether non-filling of the appendix is to be considered evidence of disease. In acute cases, no radiographic examination is necessary. It is in the subacute and chronic cases, with intermittent or unusual symptoms that X-rays come in as an ideal method for accurate diagnosis, specially as the techniques of procedure have improved considerably of recent years; and the purpose of this paper is to dilate on these recent advances.

The grossly pathological appendices as revealed by surgical exploration show a wide range of conditions:— There may be enlargement with edema; inflammatory exudates in the appendix substance or within the lumen, and denudation of the mucosa; or we may find merely vascular congestion, with or without some tissue oedema. There may be swellings separated by areas of sclerotic scars and denudation; general or partial obliteration of the lumen; or the distal end may be distended and even closed off from the remainder of the appendix and contain cellular debris or even sterile muscus. The appendix wall may be greatly thickened and adherent to adjacent structures due to inflammatory process or we may have a bulbous appendix with marked thinning of the wall from pressure. There may be foecaliths of varying size and consistency; masses of thread-worms or a round worm in the appendix may also produce symptoms. All such when filled with barium throw a variety of shadows on the skiagram, which when liberally interpreted and considered with the findings of a flouroscopic examination with definite deep palpation give us salient points in discovering diseased conditions.

Enumerated in the order of their relative value the signs are:

1. *Tenderness and muscular rigidity.*—This sign is produced by pressure directly over the appendix; it can be elicited only by palpation sufficiently deep to permit satisfactory exploration of the cecum, and it is the most important of all signs in this examination. While pain may be produced by pressure applied at a distance from the appendix, its point of maximum intensity should coincide with the viscus, and this localization must be definite and constant. If the appendix is mobile, the tender point changes with the altered position of the organ.

2. *Fixation of the appendix*—The normal appendix is freely movable and can easily be displaced by the palpating hand. When its position cannot be altered, it is indicative of inflammatory process, either primary or secondary, active or quiescent. If fixation is accompanied by tenderness, unquestionably the process is either acute or subacute. Either the entire length of the viscus may be fixed or the process may be confined to the tip. When the appendix is situated in the pelvis, there may be difficulty in separating it from the pelvic viscera; palpation with the patient in Trendelen berg position will usually overcome this difficulty unless true fixation is present. A long appendix gives more reliable information than a short one, as a short mesentery often might not allow much mobility of an otherwise normal free appendix.

3. *Pain referred to the appendix, produced by pressure over other parts of the abdomen.*—This sign is based on the well known clinical principle of referred pain. The visualization and knowledge of exact position of the appendix is much more accurate.

4. *Abnormal position of the appendix.*—While normally situated on the mesial aspect of the cecum, the appendix is found not uncommonly in various other locations chiefly among which may be mentioned the retrocecal appendix, the subphrenic appendix as found in an undescended cecum, the left sided appendix in cases of non-

rotation of the cecum, and the appendix that arises in the normal position but lies parallel to the cecum, either on its lateral or on its mesial aspects. Quite obviously, inflammation in an abnormally situated appendix will not produce pain or tenderness over Mcburney's point and may simulate disease in other innocent organs. Especially is this true of an appendix located in the upper right quadrant. It may give the classic picture of gall bladder disease. The post cecal appendix may closely imitate the symptoms of renal or perinephric disease. In acute inflammatory processes, especially when an abscess is present, a knowledge of the exact position of appendix is of the greatest aid to the surgeon in selecting the avenue of approach, and may prove to be a life-saving measure.

5. *Spasticity of the cecum.*—Diseased conditions of the appendix quite commonly produce a reflex spasm of the cecum which, when accompanied by other signs, is of diagnostic importance. Quite often the first clue to cecal spasticity is a residue in the terminal ileum at the end of eight hours. This, in the absence of stenotic conditions, is most suggestive. Especially is this spasticity suggestive in cases in which the appendix cannot be visualized but in which tenderness is elicited by pressure over the caput coli. The semicircular filling defect of the cecum caused by chronic appendicular abscess is characteristic. The position of this defect depends on the situation of the appendix.

6. *Pain referred to other parts of the abdomen, produced or increased by pressure over the appendix.*—That the appendix may occasionally cause pain which is referred to other part of the abdomen is well-known. When this pain is produced by pressure over visualised appendix or is increased by pressure, it is of considerable diagnostic importance, especially if associated with any of the aforementioned signs.

7. *Appendiceal stagnation* as determined by the retention of barium is a subject of considerable dispute. In the first place, barium retentions cannot be proven when the cecum retains free barium, as the appendix may empty and refill giving the impression of stagnation. Appendiceal stasis cannot be considered as a probable cause for symptoms, although we do frequently find this association especially when the appendix retains barium for a period of several days after the cecum has cleared. For example retention of barium in the appendix 24 hours after cecum is emptied is more significant than at 72 hours with cecum and right colon filled. The ability of an appendix to empty would, however, indicate a free lumen in most cases, and would contraindicate appendiceal surgery. With a closed off bulbous tip we may find the proximal end filling and emptying with apparent normality, and if this sign were the only one observed, we should miss the true appendiceal condition. The detail of definition of barium in the appendix has some significance. An appendix containing mucopurulent exudate may receive the barium but it will show hazy indistinct outlines.

To sum up, the location of the tip of the cecum whether high or low, fixed or movable, the coincidence of a point of localised pain on pressure over the tip of cecum, the presence of appendiceal retention especially when persisting for several days, after emptying of the cecum, the presence of concretions or foreign bodies in the appendix, the existence of partial obliteration of the proximal part of the appendix with clubbing and distension of the distal half, kinking and demonstration of definite adhesions of disturbing character are some reliable X-ray signs of value in diagnosing appendiceal disease.

The question arises if following an opaque meal, the appendix is not

visualized by the usual methods, is it normal or pathologic ? This question is frequently discussed by radiologists and there is no general agreement as to the significance of the X-ray non-visualized appendix. Many claim that the failure of appendix to become visualized is without significance, and that non-visualized appendix may or may not be pathologic and that the same statement also applies to the visualized appendix. In other words the mere presence or absence of the appendicular shadow on the skiagram is not the basis of making a diagnosis of appendicitis. On the other hand, there are not a few radiologists who believe that the failure of the appendix to visualize is a symptom of pathology. In view of the general disagreements as to the significance of non-visualized appendix, it is interesting to know the teachings of the Holzknecht School of Vienna, representing as it does the views of one of the leading radiologic teaching institutes.

The Holzknecht school claims that 100 per cent of normal appendices can be visualized by the X-ray method and repeated failure of the appendix to visualize is pathologic, but the examination must be made with the special technic of Czepa. The essential feature of the technic is to maintain a fluid opaque media in the cecum and ascending colon which will cause sufficient retroperistalsis to permit the filling of the appendix. The basis of the examination is the use of magnesium sulphate and the following is the technic.

The patient reports to the clinic in the morning (about 8-0 A M.) and is given 2 ounces of pure barium sulphate dissolved in 4 ounces of water, to which is added three teaspoonfuls of magnesium sulphate. Later in the afternoon (about 6-0 P.M.) the patient is examined fluoroscopically, and if the appendix is not visualized, is given additional water and barium as above but without the magnesium sulphate. The following morning the patient is again observed with the fluoroscope and if the appendix is not visualised, the barium-magnesium, sulphate mixture is again repeated. That afternoon if the appendix has not yet been visualised, the second administration of barium water mixture is given. On the third morning and afternoon additional fluoroscopic examinations are made and if these too fail to visualise the organ, it is considered pathologic, the lumen being narrowed or obliterated by inflammation. It will be noted that with the above technic, five negative screen observations are necessary before calling the appendix pathologic.

The magnesium sulphate should produce mild diarrhoea; if this does not occur, the dose must be increased; while on the other hand, if too frequent bowel movements occur, it should be reduced. This method possesses the great advantage that the appendix is seen unobscured by other parts of the bowel; indeed, it is the only method by which a proper examination of a retro cecal appendix can be made. Acutely inflammed conditions are of course a contraindication to this mag-sulph. method.

SKIAGRAMS * SHOWN ·

1. Normal appendix depicting also terminal ileum and normal cecum and haustrations.
2. Appendix with short mesentery.
3. Appendix is a case of visceroptosis.
4. Appendix involved in pelvic inflammation in female.
5. Stomach (hypertonic and transverse) and appendix in a case of subacute appendicitis.
6. Chronic appendicitis with adhesions; after barium enema and barium-meal.
7. Normal appendices visualised by the mag-sulphate method (these were not visualised by the ordinary barium meal.
8. Appendiceal retention (of barium.)
9. Appendiceal abscess (different situations and defects caused.)
10. Appendix visualised on the 3rd morning following the barium and magnesium sulphate technic. X-ray finding: a long appendix with a very much thinned lumen, bent on itself. The barium was found in a thin streak along the whole length of the appendix and was considered to be due to narrowing of the lumen due to inflammatory swelling. Operative finding: a round worm was found inside the appendix.

(* Skiagrams by Dr. P. Rama Rao, the Madras Radiological Institute.)

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## THE SOUTH INDIAN MEDICAL UNION

IS

## AN INDEPENDENT MEDICAL PRACTITIONER ORGANISATION

### *OBJECTS.*

To foster and develop *esprit de corps* and camaraderie among the members of the Medical Profession in the Madras Presidency, Hyderabad, Mysore, Travancore, Cochin and other States of Southern India.

To watch, protect and extend the rights and privileges of members of the Independent Medical Profession,

To supply its members a centre of information and advice.

To afford its members, as far as may be practicable, support and defence of their rights.

To watch the local administration of all laws and regulations affecting the Independent Medical Profession.

To negotiate with Local Authorities on all matters affecting the Independent Medical Profession.

To cultivate reciprocal relations with kindred institutions elsewhere in India and abroad.

### WHY YOU SHOULD JOIN THE SOUTH INDIAN MEDICAL UNION.

1. Because you require somebody to see that your rights and privileges as a Member of the Independent Medical Profession are watched, protected and extended.

2. Because you are bound at some time or other to require information and advice on matters pertaining to Medical, Medico-political, Educational, etc., matter

3. Because no man is infallible and you are likely to be involved in any professional dispute requiring advice or assistance.

4. Because you are bound to travel at some time or other and will want to enjoy the benefits of affiliation with kindred institutions.

5. Because, unless you do join, you will be regarded by Legislative Councils, District Boards and similar bodies, as opposing the policy and principles of the S.I.M.U. and registering your vote against any representations it may put forward.

6. Because you can make a substantial saving on your annual insurance premium and obtain better benefits.

7. Because you are a practitioner and wish to add strength to the arm of the S.I.M.U. when fighting for equity and justice and all the amenities which on account of pressure by the *paid* Service, Government is so loath to grant or recognise the necessity for.

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**TO**

*The General Secretary.*

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**South Indian Medical Union,**

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**Membership Fee.**

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Qualifications..... .....Year.....

Colleges in which studied.....

Permanent Address..... .....

.....

.....

## Articles and Bye-laws of the Union.

### CONSTITUTION.

*Article 1. Title.*

The name and title of this organisation shall be "The South Indian Medical Union."

*Article 2. Objects.*

The objects of this Union shall be :—

(*a*) The promotion of the science and art of medicine in South India.

(*b*) The union of the Medical profession of South India into one common organisation.

(*c*) The development and diffusion of scientific knowledge.

(*d*) The promotion of friendly intercourse between persons engaged in the pursuit of scientific knowledge.

(*e*) The elevation of the standard of medical education.

(*f*) The enlightenment of public opinion in regard to the prevention of disease.

(*g*) The publication of the results of scientific investigations.

(*h*) To concert such measures as to bring about mutual good will, better understanding, co-operation and a spirit of brotherhood amongst members of the medical profession.

*Article 3. Composition of the Union.*

The Union shall consist of ordinary members, associate members, and honorary members.

*Article 4. Membership.*

(*a*) The ordinary and associate members of the Union shall be Medical Practitioners and Dentists licensed by their Home Governments. They shall hold a qualification registrable in the Madras Presidency.

(*b*) Honorary members shall be those who have done meritorious service in furthering the objects of the Union and Scientists working in the sphere connected with medicine and hygiene. They need not necessarily be Medical men and shall be elected unanimously by the Council of the Union.

(*c*) Ordinary members alone shall be competent to hold offices, attend or vote at any business meeting.

*Article 5. Council.*

The Union, subject to the terms of this constitution, shall be governed by the Council.

The Council shall consist of the President, two Vice-Presidents, two Secretaries [a General Secretary who shall be in-charge of the general work of the Union and the other, a Secretary in-charge of the Scientific Section], and twelve Members elected at an annual meeting, of whom at least one half shall be members of the out-going Council.

*Article 6. The Officers.*

The officers of the Union shall be the President or in his absence one of the Vice-Presidents and the General Secretary.

All correspondence in the name of the Union shall be conducted only by the General Secretary.

*Article 7. Office.*

There shall be an office of the Union under direction of the General Secretary, who shall take care of the archives and conduct the general business of the Union.

*Article 8. Funds and Expenses.*

*Section 1.* The expenses of the office of the Union shall be met from the subscriptions. These funds shall be collected by one of the Secretaries who shall also be a Treasurer.

*Section 2.* Funds for meeting other expenses of the Union shall be raised either by voluntary gifts from individuals, medical and other organisations or by special grants authorised for the purpose by the Council from the general funds.

*Section 3.* Membership subscriptions shall be Rs. 10 and 3 per annum for ordinary and associate members respectively, payable yearly or in half yearly instalments of Rs. 5 and 1-8 respectively.

*Section 4.* Subscriptions are due before the fifteenth day of April and October. All subscriptions are payable in advance.

*Article 9. Amendment.*

*Section 1.* The Council may recommend any amendment of any article of this Union for consideration at any special meeting of the Union provided that three-fourths of the total members of the Council vote in favour of such a change or amendment.

*Section 2.* The Union may amend, repeal or alter any part of this constitution at any special or annual meeting provided that three-fourths of the members attending such meeting vote in favour of such amendment, repeal or alteration, and same is confirmed by a simple majority of the members present at a meeting to be summoned not earlier than 30 days after passing of the first resolution and that the amendment, repeal or alteration shall not take effect till and after the succeeding annual meeting.

*Bye-Laws.*

*Chapter 1.*

*Section 1.* Any person who is desirous of becoming a member of the Association shall present to the Council of the Union.

(*a*) A written application for membership on the prescribed form.

(*b*) Satisfactory evidence of the necessary qualification.

(*c*) And on his admission being approved by the Council, the payment of such dues as may for the time being be leviable;

Provided that a member once elected shall remain a member as long as he conforms to the rules of the Union and irrespective of his place of residence or of honourable withdrawal from the Union.

Honorary members shall be elected by the Council and shall be entitled to retain their membership for the period mentioned in the resolution electing them.

(*d*) Any ordinary or associate member of the Union shall be entitled to retain his membership so long as he pays his dues and otherwise conforms to the provisions of the constitution and the Bye-laws.

*Section 2.* Any member shall be suspended from the roll of members.

(*a*) for failing to pay his dues to the Union, provided that due notice shall previously be given to the member by the President.

(*b*) for conduct prejudicial to the interests of the Union, provided that due notice shall be previously given to the member by the Council.

*Section 3.* When a member is suspended or has forfeited his membership it shall be the duty of the General Secretary to make the necessary entries against the name of that member or to remove the name of such person from the roll of membership and to notify him of the action taken together with the reasons therefor.

*Section 4.* (*a*) Any member who has been suspended for non-payment of dues shall be restored only when all his dues have been paid.

(*b*) Any person who has forfeited his membership shall be re-instated at his request, if approved by the Council on such terms as the Council may decide.

(*c*) Members who are suspended or are in arrears for a period of 6 months or more are not entitled to attend or vote at any business meeting.

1. The Council shall meet at least once every month.

The quorum for any meeting of the Council shall be 5.

*Chapter 2.*

The President of the Union and the General Secretary shall be ex-officio members of any committee formed by the Association. The *Official* minutes of such committees shall be forwarded to the General Secretary by the *Conveners* of such meetings.

*Chapter 3.*

Nomination of officers shall be made by members and a majority of members present shall elect such officers. Nomination and election shall take place at the annual general meeting. Any post left unfilled at the annual general meeting or falling vacant later shall be filled by appointment of an officer by the Council of the Union at the next meeting of the Council.

Any member of the Council who is absent for 3 consecutive Council meeting shall " *ipso facto* " cease to be a member of the Council but is eligible for re-instatement.

*Chapter 4. Meetings.*

The General Secretary shall use all reasonable means to give due notice of the meetings to the members of the Association. Evidence of posting to the last address given by the members shall be considered as service.

2. *Annual General Meeting* shall be held in the month of April every year or soon after convenient, for the consideration of the annual report which shall include an audited statement of accounts, to elect the officers for the ensuing year, and to transact any other business that is considered expedient.

Members desirous of bringing forward any proposition before the annual general meeting shall send the same in writing to the General Secretary to reach him not later than the 1st day of March preceding the annual general meeting. For annual general meetings a notice of at last 15 days shall ordinarily be given. Members requiring information at the annual general meetings shall give at least 7 days' notice in writing to the General Secretary, stating the nature of the information required.

3. *Extraordinary General Meetings.*—On requisition in writing of not less than 15 members, stating the purpose of the meeting, the President shall have a meeting of the Association convened with one month of the receipt of the requisition. If the President does not convene the meeting, the

requisitionists themselves can convene the meeting. Quorum for such shall be 30. Notice of at least 15 days shall be given to the members.

4. *Ordinary General Meetings.*— The president may at any time convene a meeting of the Association for any general or special purpose. For ordinary general meetings a notice of three days shall be deemed sufficient.

5. The President shall preside at all business meetings of the Union. In his absence the members present shall elect one of the Vice-Presidents, or when no Vice-President is available, one from among themselves as Chairman of the meeting.

*Chapter 5.*

The minutes of all business meetings shall be recorded in a book kept for the purpose by the General Secretary and submitted to the Council at its next meeting.

2. The Council at their first meeting shall provide for the publication of the proceedings of the general meetings and one copy shall be presented to each member and such others that the Council may decide.

*Chapter 6*

(*a*) The Secretary Treasurer shall be the custodian of such funds as are collected from membership fees or otherwise and shall render to the Council a report of all funds passing through his hands at each meeting of the Council. All moneys of the Union shall be deposited in the Bank Account of the Union. The General Secretary shall be permitted to keep an Imprest account of not more than Rs. 10. All payments of any sum of Rs. 5 or more shall be only by cheques. Cheques shall be signed jointly by the President and the Secretary-Treasurer.

(*b*) The Secretary-Treasurer shall bring to the notice of the General Secretary the names of all members who are in arrears on the 1st of July and 1st January respectively.

*Chapter 7.*

(*a*) No address or paper before the Union excepting the inaugural or any special address shall occupy more than 30 minutes in delivery and no member shall speak longer than five minutes nor more than once on any subject except by unanimous consent.

(*b*) All papers read before the Union shall become its property and shall be deposited with the Secretary in charge, Scientific Section.

*Chapter 8.*

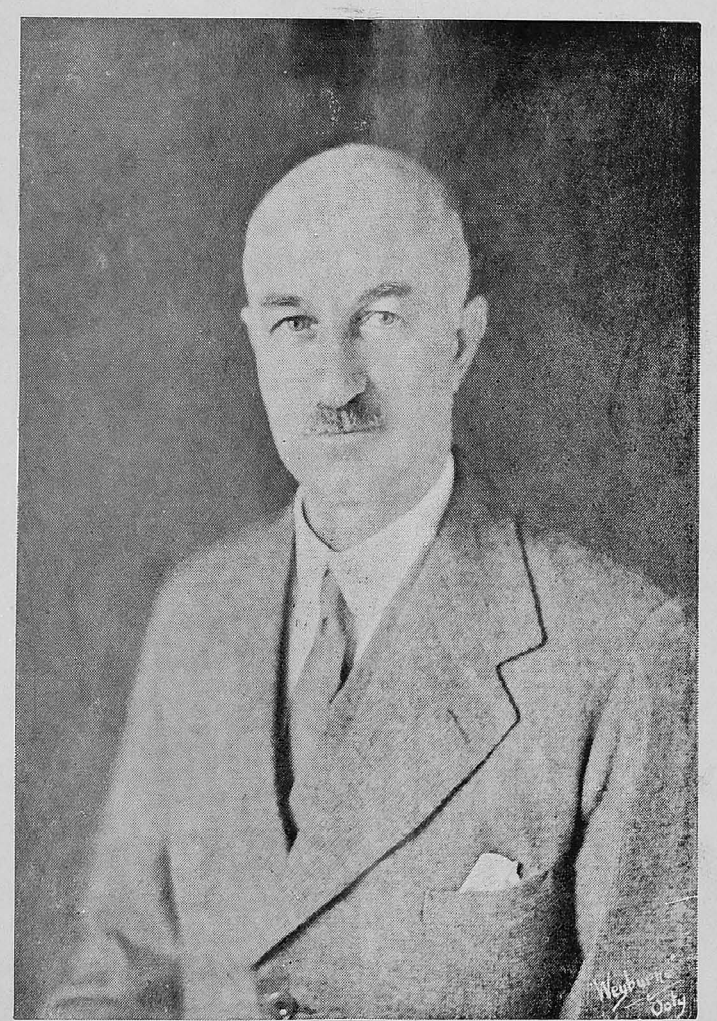
These Bye-laws may be amended by a majority vote of all the members present at any general meeting provided that at least 30 days' notice of the amendment has been given to the members and provided that the amendment shall be in force only till the next annual general meeting.

*Chapter 9.*

The deliberations of this Union shall be governed by standard rules of Parliamentary Procedure such as contained in Robert's RULE OF ORDER when these are not to conflict with the constitution and bye-laws.

*Chapter 10.*

An emblem shall be deposited at the Office of the Union and shall be used at all meetings of the Union. A Badge to be worn by all members at *Official Functions* of the Union shall be designed and issued to each member on admission at a price fixed by the Council.



MAJOR GENERAL C. A. SPRAWSON,

C.I.E., K.H.P., M D., F.R.C.P., I.M.S.,

*Director-General, Indian Medical Service.*