

# The Bulletin

## OF THE

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## Medical Organizations and Public Health.

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“.....Organiaztion means, then, more disease prevented, more lives saved, a more scientific and a more fraternal and a more prosperous medical profession; in fact, the very things which are the ideals for which we should and do stand.”

GEORGE H. KRESS.

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

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**AUGUST 1932.**

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**Conference of Medical Inspectors  
of School.**

It was a very happy idea of the Health Propaganda Board to convene a conference of those who have been engaged in medical inspection of schools in this province. Those who had witnessed the Health Conference held under its auspices last year would bear ample testimony to the interest that the Board creates among the public and the enthusiasm with which well known workers respond to its call to read papers and take part in the discussions at these conferences.

It is within the last ten years that medical inspection of schools has been in working. There is disappointment in certain quarters that the institution has not come up to expectations. But one should remember that less than ten years is too limited a period to show tangible results. And the little that could have been achieved in the short period has been thwarted by the environment of scanty finances of the country. Medical inspection of schools has to its credit that it has drawn the attention of the public to the existence of a great deal of morbidity among the school population of which the public had no suspicion hitherto. In view of such widespread poor health of the children the public has recently demanded that provision should be made for the proper treatment of such children. It is much to be regretted that the Government should at this juncture curtail even the little

that they have been spending on this useful institution. The Health Propaganda Board has done a very useful thing by holding this conference. It has focussed the attention of the public and the Government on the need for encouraging and extending medical inspection of schools. It has enabled those actively interested in the scheme to put forth their considered suggestions for rectifying existing defects and for finding ways and means to develop the scheme on more useful lines.

A number of prominent men, medical and lay, took part in the Conference by contributing very useful and instructive papers. It must have been something of a shock to the public when Dr. Baxter told them of the high incidence of leprosy in this country. Early discovery and treatment of this one condition alone would more than justify all the money that is spent by the State on medical inspection of schools. The great prevalence of ear diseases and bad teeth deserve attention. They are recognised by the parents and teachers easily enough. But the poverty of the people is chiefly responsible for their neglect. If arrangements could be devised to have these children treated in their schools or in clinics nearby, much of this unsatisfactory state would vanish.

“The mind of the teacher and the taught” is the caption of an interesting paper by the assistant radiologist of the General Hospital. We are afraid that it would be difficult to find medical inspectors of schools who would be willing to undertake such arduous duties as “preparing the mind of the taught to be receptive and then allow the mind to cogitate and evolve out into larger spheres of human activity.” Whatever this may mean, “the youth of the nation is guided”.

better by the practice which their parents hold forth in their homes.

Another interesting paper that was read at the conference was "a plea for the introduction of psychiatric service in schools" by Dr. Venkatasubba Rao of the Royapuram Hospital. It is a plea for the appointment of one or more medical men specially trained in psychiatry to the staff of the schools to look after the mental hygiene of school children. Dr. V. D. Nimbkar's paper on the eye in relation to the health supervision of school deals in great detail about the various types of eye defects met with in school children and the proper method of lighting arrangements of the school. He discusses the qualification necessary for one who undertakes medical inspection of schools and rightly emphasises the need for a system of "follow up" of these children and the legislative duties of the State.

The broadcast talk of the Surgeon-General in connection with the Conference and the Welcome address of Dr. C. Natesa Mudaliar are instructive and useful addresses. We hope the suggestion of the Surgeon-General for the formation of voluntary committees to help in medical inspection would be taken up by public spirited persons with leisure. As Dr. Natesa Mudaliar puts it, the parents associations in the various divisions of the city ought to take a lead in these and kindred useful matters.

### **Interchange of Professors.**

We have heard some senior teachers of the Vizagapatam Medical College complain that it does not attract the best students of the Telugu districts. And this lends colour to the persistent complaint from the public of the Andhra districts that their Medical College has not been fairly treated by the Government. One can easily understand the reasons which prevail with

students when they prefer to have their education in Madras.

The Vizagapatam Medical College is young and it lacks tradition. These are unavoidable disadvantages. But if the institution hopes to be more popular, it should offer other inducements to counter these initial defects. If the institution were provided with a brilliant staff of professors and investigators of high academic distinction and with real University ideals, the students would easily overlook the lack of tradition. Unfortunately even in this respect, the Vizagapatam Medical College has not been very well served.

Within the last ten years of its existence there has been a frequent change of teachers. A few instances are enough to illustrate this fact. The first professor of Medicine was appointed about the middle of 1925. And within the last seven years, seven individuals have acted as professors. The chair of Medicine is a coveted one in any university or college. But in Vizagapatam, the men appointed to this chair have evidently thought otherwise. It may be that some of those appointed honestly felt unsuitable for the place or other considerations might have brought about the situation. We have no means of knowing the actual reasons. But the fact of frequent changes is noteworthy. Again, certain professors of the college are said to be anxious to be transferred to the Madras Medical College at the earliest opportunity. We do not criticize their attitude, but only desire to mention the probable existence of restlessness among some of these teachers. And as if the Government desired to demonstrate formally and fully the inferior status of this institution, two senior professors, *viz.*, the professor of Medicine and the professor of Surgery were recently transferred from Vizagapatam to the Madras College to hold secondary places.

If the Medical College at Vizagapatam were a private institution run on business lines, or financed by a voluntary organisation depending on the fees from the students as an important source of revenue, it would have been compelled to attract students to the college by appointing eminent men to the various chairs. But here, the increasing demand for medical education and the lack of rival institutions secure for it a sufficient supply of students. And the Government guarantees to this college the necessary revenue and also sees to it that a certain number of students is admitted into the institution. It therefore behoves the Government to ensure that the institution which has been established and maintained by them at very great expense should be much more useful and better patronized. They should lose no time in overhauling the staff by appointing experienced and well qualified teachers for the important subjects. It is far from our object to suggest that all the teachers in Vizagapatam are incompetent and that they should all be displaced by new men. We would suggest the application of the procedure which is resorted to elsewhere, *viz.*, in Europe and America and to which we have on previous occasions referred in these pages. We mean the occasional interchange of teachers, professors and lecturers between various medical colleges and schools. There are two colleges and two schools, apart from the two schools for women. Since the former four institutions are under State control, there could be no administrative difficulty in effecting such cross-changes. Suitability for a particular chair is measured by one's profound learning, achievement in active investigation, and excellence in imparting knowledge to young minds. Neither rank in service nor the scale of one's pay should ever be reckoned as qualification for these professorial appointments. If the interchanges are accomplished

under the above conditions, the present teachers would not suffer in prestige and they cannot reasonably object to such transfers.

By such interchange between the Madras and Vizagapatam colleges, the status of the latter would rise in the eyes of the public and the students get an even chance of learning under equally capable men. By this arrangement, the teachers themselves stand to gain, since such purposive changes provide new surroundings. And altered environment stimulates in the teacher the desire to emulate and to excel or to inspire and improve. In commending to the Government this policy of interchange of professors of the medical colleges, we cannot sum up its merits better than in the words of one who was a prince among modern physicians, a great teacher and organizer. Said Sir William Osler speaking of teachers of medicine, "We (*teachers*) are apt to grow stale and thin mentally if kept too long in the same pasture. Transferred to fresh fields, amid new surroundings and other colleagues, a man gets a fillip which may last for several years. Interchange of teachers, national and international, will prove most useful."

## ASSOCIATION NOTES.

### The Indian Medical Council Bill.

(By Dr. K. S. Ray.)

The importance of this measure lies in the fact that the future progress and well-being of the medical profession, medical services and medical education in India will be dependent on this Council.

Indian medical men approve of the formation of a medical council, and their opposition to the Bill would seem inexplicable until a careful scrutiny is made of its provisions. It will be found that the Bill has been cast on such lines as to defeat the real purpose

of such a Council and the revised Bill makes no material advance on the former.

In the first place, the preamble to the old Bill circulated for opinion made it clear that the main object of the Bill was to win back the recognition of the British General Medical Council. Accordingly, the constitution of the Council was framed in such a way as to appeal to the General Medical Council—the Official and I.M.S. elements were deliberately given predominance in representation and the independent medical practitioners, who stand to be most affected, were allowed only meagre representation, while the Licentiatees were granted neither representation nor registration. The President was to be nominated by the Governor-General-in-Council. In fact, out of a total of 28 members, only some 12 were to be elected, and even of the latter the provisions of the Bill practically ensured the return of quasi-official or official dominated representatives. This undoubtedly offered an ideal constitution from the point of view of the General Medical Council (who, by the way, in their own case would not accept a nominated President), for it reduced the independent practitioners to impotence and ensured the control of the I.M.S. Indeed, it is taken for granted that the Director-General of the Indian Medical Service would always be nominated President and with the other nominated representatives would carry all before him. In turn, his amenability to the General Medical Council could be depended upon, so that the real arbiters of medical policy and services in India, and also, the fate of independent Indian medical practitioners, would be the General Medical Council through the I. M. S. The disguise was too thinly veiled to deceive anybody.

Indian medical men contend that the primary object of such a Council should be to control and improve

medical education in the country, to maintain a high standard of medical ethics and that it should be utilised to give medical men the privileges consequent on registration, such rights as immunity in law in certain cases, the right to recover fees, etc., which medical men enjoy in other countries. The chief need in India is to establish a uniform standard of qualification in medicine, but the Bill treated medical education and the rights of medical men as merely incidental to the purpose of placating the General Medical Council. Whereas the first need is to set our own house to look abroad to Great Britain. Rightly Indian medical men will not accept such a condition, for to do so would be to sell the birth-right of the Indian medical profession. While they certainly wish to see Indian medical degrees recognised by foreign countries including the British General Medical Council and are also willing to recognise their medical degrees, they are not willing to sacrifice the interests of Indian medical education and the privileges of Indian medical men on the altar of the General Medical Council. The Bill, in fact, went so far as to make the recognition of British medical degrees in India a *sine qua non* to its enactment, without any corresponding assurance of recognition of Indian medical degrees by the General Medical Council. The Indian medical men stand solidly for reciprocal treatment, but they stand even before that for the rights and privileges of their profession in their own country.

One of the reasons advanced for not granting representation to Licentiatees on the Council and for keeping them out of the All-India Medical Register was that their inclusion would preclude the recognition of Indian medical degrees by the General Medical Council since the standard of the Licentiatees was considered to be too low. This attitude is certainly in keeping with the Government's intention to placate

the General Medical Council at all costs but it is certainly not in keeping with the real purpose of a Medical Council, and it is useful to recall that the British Medical Act gave registration to all practitioners, even dentists, from its very inception. The Licentiates from the largest medical element in the country, in the closest touch with the people. They have for long clamoured for improvement of their education and status and to deny them representation and registration would be to retain them at the tender mercies of the Provincial Councils of Medical Registration, wherein the official element repulses all their efforts at advancement. Their exclusion from the privileges would be not merely a crime, but it would introduce and perpetuate an invidious sectionalism between graduates and licentiates, between whom Government would succeed in driving a wedge to the interests of neither.

Contemplation of these issues leads inevitably to the conclusion that the Bill merits only one fate, namely, total rejection at the hands of the Assembly. We want Medical Swaraj as much as any other Swaraj, rather than place on India such an infliction as this Bill contemplates we would await the decision of wider constitutional issues. As a matter of fact, we have done without an Indian Medical Council so long that the delay of another couple of years or so would make little difference. The heavens that were expected to fall upon withdrawal of the General Medical Council's recognition of Indian Medical degrees have not done so and will not do so. To say that the interests of Indian medical practitioners abroad are thereby jeopardised is not true and in any case the interest of a handful of practitioners abroad must not be allowed to vitiate the interests of thousands at home in our own country. The only reason for hastening the Bill through the Assembly will be found in

the desire to secure its passage before any new constitutional reforms are introduced, so that the position of the General Medical Council and I. M. S. elements might be safeguarded while large autocratic power still rest in British hands. But Government should be warned of the reaction that would follow upon the enactment of so grossly unpopular a measure.

Having regard, however, to constitutional developments, we think the time is singularly inopportune for the passing of such a Bill. For a long time the idea of a central controlling agency was held up by provincial ministers, so zealous of their provincial powers that they resented any hint of infringement. With a larger measure of provincial autonomy in the future, they are likely to be even less amenable to the suggestion, but in any case things are so much in the air at present that it is impossible to say how a Medical Council formed now would stand to be affected, financially or otherwise, by constitutional changes. That being so the wisest course would be to postpone consideration until constitutional and political issues are settled. It would not do to pass an Act to-day, which in a short time may have to be seriously overhauled. As we have said before, this little further delay would cause no inconvenience or harm. It would on the other hand be a decided gain.

So far as the I.M.S. are concerned, Indian medical education has been in their hands over the last eighty years and it speaks volumes against them if, as a result of their efforts over this long period, the General Medical Council find themselves unable to recognise Indian medical degrees. On their record one could hardly recommend that important interests such as Indian medical education and policy should continue in the control of the I.M.S. and it is high time that Indians were

afforded a chance of proving themselves where the I. M. S. have failed.

### **Rural Medical Relief.**

The Secretary, the Madras Provincial Rural Medical Practitioners' Association, Viraganur, writes :

Government have been pleased to pass orders on the resolutions passed at the third provincial conference of the Madras Provincial Rural Medical Practitioners' Association and discussed at the time of the deputation to the Hon'ble the Chief Minister on the 4th and 5th April 1932. The following is a summary of the Government Order.

The present policy of the Government is not to sanction the opening of rural dispensaries in places where private practitioners have already settled. In opening rural dispensaries Government advise the taluk boards to give preference to the natives of the place in the matter of appointing rural medical practitioners and midwives thereto. The Association's request for an increase in the subsidy cannot be entertained at present on account of financial stringency but Government have no objection to the taluk boards paying additional subsidy from their own funds and would also advise the local boards to provide accommodation for the dispensary and the practitioner on such terms as may be agreed upon. Midwives will not be placed under the control of the practitioners but will be directed to attend the dispensary during office hours if they have no midwifery work.

In the matter of inoculation work, Government consider that rural medical practitioners should, if required by the presidents of taluk boards or officers of the Health department, attend to inoculation work after dispensary duty on a remuneration of nine pies per individual inoculated subject to a

minimum of rupee one and a maximum of rupees five per day, in addition to travelling allowance, if any, for journeys beyond five miles. Government subsidy for days so engaged not being deductible. For duties in connection with fairs and festivals, the rural medical practitioners will be paid Rs. 5 per day, in addition to travelling allowance, if any, for journeys beyond five miles.

In the matter of leave to rural medical practitioners Government consider that the continued absence from duty for more than three months should be a ground for terminating the agreement and that the period of casual leave now limited to 15 days be converted into leave of absence for the same period without any limit as to the number of days for which a rural medical practitioner can be absent at a time. The Government have however no objection to the grant of leave for more than 15 days, provided the presidenttaluk board, finds a substitute or the practitioner himself arranges for one acceptable to the president. The maximum period for which the subsidy is admissible while no one is on duty at the dispensary is limited to 15 days in a year.

Government will issue orders in due course on the question of disbursing the subsidy through the District Medical Officer instead of through the president, taluk board.

Subsidised rural medical practitioners can have copies of the Government order on application to the undersigned; such of them as are in arrears of their subscription will have the copies only when they have remitted it. In future it is proposed to send to individual practitioners copies of all G.Os. circulars, etc., issued in a quarter at the beginning of the next quarter.



## CORRESPONDENCE

## L. M. P. Board Examinations

*Five years course an immediate necessity prior to the raising of the percentage of pass marks.*

It has been now authoritatively confirmed that "Orders have issued already raising the percentage of pass marks to 40, in the case of the 1st, 2nd and 3rd year Board Examinations and to 50 in the case of the Final Examination."

Although this was one of the resolutions unanimously passed at a public meeting held under the auspices of the All-India Medical Licentiates' Association, Madras Branch, on 16th July 1932, with The Honourable Diwan Bahadur B. Muniswami Nayudu Garu, B.A., B.L., Chief Minister to the Government of Madras, in the chair, I wish to bring to the notice of the Government and the public that merely raising the percentage of pass marks without giving effect to the most important resolution, *viz.*, "that the course of medical instruction imparted in the medical schools in this Presidency be raised to 5 years *forthwith*" unanimously passed the same day and which has been the very first recommendation of the committee of the Government on Medical Education in the Presidency, will not serve the purpose for which the resolution was passed.

In fact this new order has made it harder for the students to stand the strain of the increased standard of examination. It is only the very bright few that could hope to attain this level without an extra year's study. Speaking from experience and from affairs abroad, I think an average medical student must put in two years' hard study in medicine and surgery before he appears for his final examination. Without giving him this primary facility of ploughing hard in the field of medicine and without providing him

with the necessary preliminary of lengthened course of instruction, it is not reasonable or fair for the authorities concerned to insist on a 50 per cent standard with a four years' course.

The question of "Financial stringency" the only reason put forward by the Government to put off this popular demand for raising the course to 5 years, can easily be solved if the Government takes up this matter seriously. The abolition of several medical schools in the Presidency has lessened the drain of annual expenses, and the enhancement of school fees will add to the finance. The Royapuram Hospital and Hostel buildings, well equipped with all the latest and up to date requirements to run a Teaching Institution on a scientific basis, will suffice to stand the strain of an extra year's study, and increasing the appointment of honorary medical officers with much experience in teaching will minimise the teaching expenses. A rigid control over admissions into medical schools as it has been done this year, will amply provide practical facilities for an extra year's course.

Thus it would be clear that the reason put forward by the Government "financial stringency" to put off the extension of the L. M. P. course is weak and as such I earnestly appeal to the authorities concerned to put into execution *forthwith* the recommendations of their own committee and the most popular demand of the profession for increasing the course to 5 years and thus put an end to the caste system in the profession and afford ample opportunities for the medical students to stand the strain of the raised standard of examination.

U. L. GOPAL ROW,  
Secretary,

The All-India Medical  
Licentiates' Association,  
Madras Branch.

1st July 1932.

### **The Need for a College of Physicians and Surgeons in Madras.**

Medical Education in this presidency, as elsewhere in other parts of India, is in a most unsatisfactory state, calling for thorough overhauling and immediate reform. The Government were no less impressed with the need and urgency for reform than the public, especially in regard to the education of the class of Medical men called the Licentiates, for which they are solely responsible and the latest move on their part was the appointment of a Committee in 1928 to report among other things on "the need for a uniform minimum standard of medical education". The Committee submitted its report in 1929 and though three long years had elapsed, nothing tangible was done to give effect to its recommendations. It would be interesting to recall the findings of the Committee in respect of L.M.P. qualification and for the sake of precision, emphasis and impressiveness, I had better quote its own words here :—

"Considerable dissatisfaction has been expressed with regard to the existing L.M.P. qualification especially by holders of the Diploma. At present there is no provision for higher education for L.M.Ps. in this country and those who aspire to a higher qualification are compelled to proceed to England and take up a continuous course for at least two years. So long as they remain in India, it is impossible for them to obtain a qualification which is registrable in the United Kingdom unless they are prepared to go through the University course from the very beginning. L.M.Ps. also demand a higher standard of professional education. The Committee agrees with them and advises that the minimum course of instruction should be of five years' duration. For the

present there may be two standards of qualification one being the University degree and the other a Diploma will entitle the holders to registration in the Madras Medical Register. The lower standard of qualification should be raised as soon as possible with a view to attaining the ideal of a uniform high standard of training with a single high minimum standard of qualification. The University degree which is controlled by the University authorities has not come under the consideration of the Committee but it is recommended that the Diploma be granted by a licensing body which should control the examination, curriculum and instruction for the Diploma. The Committee recommends that the prescribed minimum standard of preliminary education should be the University entrance examination with Science as the optional group, this standard should not be lowered because of a paucity of candidates or any other consideration. The Committee recommends that the selection of students should be purely on merit and should not be on any communal basis ..... Students of the Medical Colleges should be allowed to appear for the examination for the diploma so that those who fail in the University examinations may have an opportunity of obtaining a qualification. These holders of the Diploma who possess the minimum educational qualification which is prescribed for admission to the Medical Colleges should be eligible for recruitment to Government Service on the same terms as the University Graduates".

2. Since the above recommendations were made, two events had occurred which must be considered as two silver linings in the dense darkness that is enveloping the L. M. P. horizon. The first is the resolution of Dr. M. R. Gurusami Mudaliar brought before the Academic Council of the University of

Madras on 14th March 1931 providing for L.M.P. diploma holders to qualify themselves for M. B. B. S. degree under certain conditions. While it aims at levelling the existing inequalities in the Medical Profession, there is no denying the fact that the obstacles thrown in the way of the L.M.Ps. gaining their end have been rendered too formidable to be easily overcome. I mean the condition requiring the L.M.P. diploma holders to pass the Intermediate Examination in Arts or an examination accepted by the Syndicate as equivalent thereto. This preliminary qualification is in my opinion unnecessary, as the L.M.Ps. must have already picked up sufficient general knowledge in the English language, during their five years and more of practice of their profession and have had sufficient grounding in Science, while reading in the Medical School for the L. M. P. course. It is indeed a ridiculous waste of time and energy to force the L. M. Ps. to pass the Intermediate Examination or Cambridge Senior with credit in three subjects, as the Syndicate, I understand, now require them to do, as being equivalent to Intermediate in Arts. The fate of a few unfortunate L.M.Ps. is now hanging in the balance, because having passed the Cambridge Senior they were unable to secure credit in three subjects. The Syndicate would have acted wisely if they had only ruled that L. M. Ps. desirous of studying for M. B. B. S. Course, should sit for the English paper alone in the Intermediate Examination exempting them from the rest or pass an entrance examination in English, Physics, Chemistry and Biology and exempt them from Vernacular and other subjects which are obviously not wanted for their purpose. Thus, this resolution is destined to be a dead letter as the L.M.Ps. who can run this obstacle race will only be few and far between. The next event alluded to above refers to the chief minister

recently agreeing to raise the percentage of marks obtainable by the final year L.M.P. students to 50 per cent. This is undoubtedly a step in the right direction as the L.M.P. will no longer be branded as inferior to M.B.B.S. his efficiency in the subjects which are common to both, being equal and not below the minimum prescribed for the latter.

3. There remains now the raising of the course of the L.M.P. from 4 to 5 years. There is no valid reason for the Government to sleep over this matter, after the unequivocal and unanimous recommendation of the Medical Education Committee. The Medical and lay public have already sufficiently expressed themselves in favour of this measure and the Government can no longer take shelter under the plea that 'public opinion is wanting in this respect.' The Committee has further recommended that a Diploma be granted by a licensing body which controls the examination, curriculum and instruction for the Diploma. The establishment of a Statutory body in Madras like the Royal College of Physicians and Surgeons in the United Kingdom, has thus become imperative. As matters stand at present, medical education is in the hands of the Minister, whose sole adviser is the Surgeon-General. The democratization of Medical Education being the cry of the hour, the transfer of control from the minister of medicine to a body of Medical Men is an essential reform which must not be delayed a moment longer. College of Physicians and Surgeons exists in Bombay but it is not a statutory body but a Society registered under the Companies Act functioning at the direction and dictation of the Government. If we remember aright some two or three years ago, the College of Physicians and Surgeons in Bombay resolved to raise the Licentiate course to five years but their proposal was knocked

on the head by the Government. The Provincial Governments in India with no exception whatever, are generally opposed to raising the course and standard of qualification of L.M.Ps. But they cannot continue long in this state of indifference if not defiance to public opinion. A College of Physicians and Surgeons should immediately be established in Madras with, say, 30 members consisting of the pick of the Medical Profession in the Presidency, the non-official element preponderating. They must have statutory powers vested in them, like the University and other bodies. The existing medical schools in the City may with suitable modifications be utilized for imparting the necessary instruction, the Mofussil Medical Schools being affiliated to this institution. The syllabus should be so arranged as to conform to the standard and requirements of the General Medical Council of Great Britain or the All-India Medical Council, when it comes into being. The College will conduct examinations and award Diplomas. There may be three diplomas—the Fellowship (F.C.P. & S.), Membership (M.C.P. & S.) and Licentiatehip (L.C.P. & S.). The course of instruction should be raised to five years. Then there will be only two classes of Medical men, those who come out of the University, obtaining degrees such as M.B. B.S. and M.D. and those who are awarded diplomas by the College of Physicians and Surgeons. Both will have the same training, same examination to undergo, possess the same qualifications only, they come through different doors. Here efficiency is not sacrificed at the altar of cheapness. As regards entertainment in Government Service and conferring of honorary appointments no distinction whatever should be made between University candidates and Diploma holders. The candidates for Provincial Medical Service should be

selected on competitive basis. This will do away with the baneful caste system now prevalent in the services. As the Committee on Medical Education has also expressed itself strongly in favour of the above proposal, the Government cannot afford to shirk their responsibility in the matter. Financial and other considerations need not deter the Government from giving effect to this proposal. With the existing allotment for Medical Schools and the collaboration of Independent Medical men as honorary workers, both as teachers and as hospital staff, no great financial strain need be felt.

We trust the lay public and the Medical Profession in Madras will lend their hearty support to the above scheme and force the hands of the Government and the Legislature to launch it at no distant date.

MADRAS, } U. RAMA RAO.  
30th July 1932.

We publish in this issue two communications, one from Dr. U. Rama Rau and the other from the secretary of the local branch of the All-India Medical Licentiate's Association on the subject of Medical Education in Madras. None is more interested in Medical Education than the general practitioner. We trust that our readers would study these questions carefully and let us have the benefit of their considered views.

\* \* \*

We agree almost entirely with most of the views expressed by Dr. U. Rama Rao. There can be no controversy about the need for a high preliminary general education and for increasing the period of training to five years. But we think that these measures would not by themselves achieve the object of abolishing the pernicious caste system in the medical profession which is deplored by everybody concerned.

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

**AUGUST 1932.**

**Bronchography.\***

Dr. P. Rama Rau, D.M.R. (Vienna).

Bronchiectasis or dilatation of the bronchi occurs most often as a sequel to lung diseases like chronic bronchitis chiefly, and in the order of frequency, pneumonia, fibroid phthisis, pneumokoniosis, pleurisy, carcinoma, inhalations and syphilis. As a result of chronic inflammation the bronchial wall slowly atrophies, the mucus membrane, the elastic tissue, the muscular tissue and finally the cartilage disappear and are replaced by a pyogenic membrane. Inspiratory pressure and traction by surrounding fibrous tissue causes dilatation of the affected bronchii first and commonest type is fusiform, and as the disease progresses it becomes varicose and eventually saccular. The various stages are rendered clear by filling the affected bronchii with iodipin or lipiodal and various methods of introducing them into the bronchial tree have been mentioned by different authors.

But all these have the common characteristic that the X-ray examination is carried out only after the iodised oil has been introduced into the bronchii. The introduction of the contrast fluid is done without the guidance of the radiologist and often leads to lack of filling in precisely those bronchi which are of diagnostic interest.

Haslinger with Lenk in Vienna used a bronchial sound which was passed into the desired bronchus after anaesthetising the larynx and trachea and the contrast media was injected. But this needed a high degree of specialisa-

tion and was a strain on the patient. The modification of Beck and Sgalitser's methods as used at the Hozknechts clinic in Vienna is simple and has the advantage of introducing the oil into the bronchi directly under control of the X-ray with a fluorescent screen and observing the same analogous to the screening of the stomach. The method consists in anaesthetising the pharynx and larynx with 10 per cent solution of cocaine and spraying into the trachea and larger bronchi a mixture of cocaine solution with a few drops of adrenalin. A soft rubber catheter is passed through the nose and guided into the larynx and passed right until the bifurcation of the trachea. Perfect anaesthesia of the trachea and larger bronchi is necessary or else the patient gets cough and the tube is thrown out. If anaesthesia is complete the catheter remains in place during the entire examination without discomfort. The adrenalin relieves spasm in the bronchi. The patient is then taken behind the screen and turned into various positions so that the lobe we desire to fill is the lowest and the oil is injected under screen control. Iodised oil of 40 per cent strength is used and 10 to 15 c.c according to necessity. No mentionable dyspnoea is observed and as we fill under control of our own observation even lesser quantities will do. Slight rise of temperature for a day may be observed. Splitting off of iodine from the oil in the bronchi proceeds very slowly and rarely symptoms of iodism occur. For the prophylaxis of the patient who perhaps swallows a small quantity of the oil, it is a good practice to administer a purgative after such an examination.

Even a more simple method is "Swallowing the wrong way" (Verschlucken in German) based on an observation of Nathers who, in injecting contrast media in the oesophagus of a patient with an oesophageal carcinoma,

\* Read before the South Indian Medical Union on 22-8-32.

simultaneously, but unintentionally, also injected the bronchial tree with barium mixture. The patient who was anaesthetized, had simply swallowed the whole mixture down the trachea (he later coughed the mixture up and had no complaints). This and other observations show that a patient whose larynx and pharynx are anaesthetized, often swallows the wrong way, as is not unknown to laryngiologists. What had happened unintentionally at that time was then later used as a method for filling the bronchial tree.

First, have the patient clean his teeth and mouth by brushing and gargling repeatedly. Then the pharynx, hypo-pharynx, and laryngeal entrance are thoroughly anaesthetized with a 10 to 15 per cent cocaine solution. As soon as anaesthesia is complete the patient is allowed to drink the contrast oil behind the fluoroscopic plate in repeated small portions. If the anaesthesia has been really complete, the great majority of patients will swallow the oil down the trachea and the flowing in of the oil as well as the direction of its course by any desirable position of the patient, can be observed behind the plate. But now and again the method of swallowing fails.

The simplest portion of the lung to fill is the lower lobe. Tipping the body of the sitting patient at an angle of 30 or 45 degrees towards the desired side will lead to the perfect effect. The introduction of the iodised oil into the upper lobes of the lungs is more difficult. The patient being placed horizontally on one side is rotated anteriorly at an angle of about 30 degrees. In addition to these lateral turnings it will usually also be necessary, to create some elevation of the pelvis, by placing some flat pillows under the patient's buttocks. One should pay especial attention to the fact that the patient's head must not be the lowest point of the body. The head should be raised somewhat by

means of a pillow or a roll in order to keep the entering oil from collecting in the wind-pipe and thus provoking coughing. If with this method the iodised fluid enters only the larger bronchi of the upper lobe in question, it will be well to increase the elevation of the pelvis as soon as the filling has been completed, simultaneously to tell the patient to breathe deeply a few times. One then observes, that the contrast fluid enters the finer bronchii also and sometimes even fills the apical portions of the lung. It will not be difficult to fill the right middle lobe if the patient is placed horizontally on the table on the right side rotated anteriorly 30 degrees.

Observations on patients with bronchial fistulae, in whom the contrasting media agent was introduced without the use of cocaine anaesthesia have shown, that the small branches of the bronchi and the alveolar tissues tolerate the presence of bismuth without reaction. Coughing begins only when the bismuth has reached the hilus region, *i.e.*, the bronchi of the first and second order. A violent coughing reaction is then provoked at the bifurcation and in the trachea. On the basis of this observation it becomes apparent that not only the larynx and the pharynx but also the trachea should be anaesthetized by means of a cocaine spray.

*Therapeutic value.*—On the suggestion of Pal equal parts of Iodipin (40%) and agoleum have been introduced into the bronchial tree in cases of bronchiectasis and chronic bronchitis. Agoleum is a silver preparation which was introduced by Pleschner for the treatment of the bladder. The density of the shadow despite this dilution was nevertheless so good, that the 40 per cent iodopin alone hardly gave a better picture, although agoleum alone is hardly noticeable in the X-ray picture of the lung.

Bronchial filling with Iodine oil is not dangerous if quantities no greater than the ones mentioned are used. Aside from one transient Cocaine intoxication which is not the fault of the method itself, no damage has been noticed despite a great number of cases thus handled. However I do not consider the method fool proof. A filling should be carried out only if there is a possibility of real diagnostic or therapeutic gain. It is natural that we should not only take the condition of the lungs into consideration before making a filling (I believe that an exudative form of pulmonary tuberculosis is a contra-indication to the filling), but we should also pay attention to the general condition of the patient. Thus for example patients with severe cardiac or aortic changes or very nervous patients should not be treated.

In conclusion the introduction of iodipin into the bronchial tree is undoubtedly a great help in the radiological diagnosis of pulmonary affections. Bronchography is especially valuable in the diagnosis of bronchiectasis, because of the difficulties in clinical diagnosis and localization of this disease, and in the X-ray examination without a contrasting agent. Bronchography can also be of great importance in the diagnosis of doubtful tuberculous cavities, foci of destruction in the course of gangrene, abscesses and their resultant cysts, and bronchial carcinoma.

Some authors insist on bronchography in every case of haemoptysis, provided general condition is favourable.

#### SKIAGRAMS.

1. Normal bronchial tree by the catheter method.

2. Normal bronchial tree by swallowing the wrong way.

- |                               |              |
|-------------------------------|--------------|
| 3. Varicose bronchiectasis    | } lower lobe |
| 4. Cylindrical bronchiectasis |              |
| 5. Saccular bronchiectasis    |              |
- two stages.

6. Cylindrical bronchiectasis—right upper lobe.

7. Saccular bronchiectasis—both upper lobes.

8. Empyema—lipiodol filling was done to ascertain the presence of any lesion in the lungs. The collapsed lung shows normal bronchial tree.

### Elephantiasis.

By C. R. Krishnaswamy, M.B., B.S.

*Definition*—A progressive histopathological state characterized by chronic inflammatory fibrosis and hyperplasia of the dermal and hypodermal tissues which is preceded by and associated with venous stasis.

*Difference between elephantiasis and lymphatic oedema*.—In the latter there is only solid oedema with distension of the cells and spaces. There is no real hypertrophy as in the former. Probably the venous stasis causes the hyperplasia and hypertrophy of the dermal tissues. The venous obstruction is probably the result of the Bacterial infection such as Streptococci.

*Histology*.—First or soft stage—Active subcuticular metamorphosis of certain areas takes place. The connective tissues form plasma cells which are concerned in the formation of collagenous material. This greatly increases the bulk and gets arranged in coarse bundles parallel to the skin. Elastic tissue is absent.

Second or hard stage—There is still further increase of the collagenous material and the soft swelling gives place to hyperplastic tissue. The surface epithelium first shows hyperplasia but later it retains its thickness by hyperkeratinization and finally mottled pigmentation occurs.

*Pathology*.—The essential pathology is that there is venous and lymphatic obstruction (both must be present) associated with Streptococcal infection.

The various causes of lymphatic obstruction are :—

(1) Congenital—Hereditary mal-development of lymphatic vessels.

(2) Traumatic—Resulting from extensive dissection of glands.

(3) Infection—(a) *Filaria bancrofti*. The adult worm and the ova die in the tissues. This forms the nidus for subsequent infection and when repeated attacks occur elephantiasis results. Thus the predisposing cause of the resultant elephantiasis is the Filarial infection and the exciting and the essential cause is the secondary or septic infection.

(b) Tubercle.

(c) Syphilis.

(d) Leprosy—Invasion of the lymphatic system by *B. lepra*.

(e) Malignant disease.

That another factor besides lymphatic and venous obstruction is necessary for the development of elephantiasis is suggested by :—

(1) The presence of obstruction for long periods without the appearance of elephantiasis.

(2) The development of elephantiasis in solid oedema after attacks of inflammation and fever.

The conclusion is that not only must there be an exudate of lymph, but it must be changed in some way as it happens when the exudate is due to inflammation when the lymph is charged with a high percentage of albumin. This, instead of merely helping the repair, seems by its continuous and prolonged action to stimulate the connective tissues to growth.

*Clinical features.*—First Stage—Smooth uniform swelling, the skin being smooth, pale, and cold.

Second Stage—The skin shows definite thickening and the muscles connected with the part is hypertrophied to match with the increased burden.

Third Stage—The skin and subcutaneous tissues are greatly hypertrophied. There may not be attacks of lymphangitis.

*Treatment.*—In the early stages frequent doses of anti-streptococcal serum must be given. This must be followed by autogenous vaccine.

Lymphangioplasty is not successful in this disease as the background of this complaint is a streptococcal infection and the silt by its irritation causes frequent attacks of inflammation and the channels become occluded. Deep fascia forms an impenetrable barrier to the exchange of lymph between the superficial and deep lymphatic systems.

The principle of the Kondolean operation is removal of long strips of deep fascia and thereby establishment of communication between the superficial and deep lymphatic systems.

*Kondolean's Operation.*—Lanz operated for elephantiasis in 1911, but the operation was not properly described. Kondoleon in 1912 improved the operation.

The principle, on which the operation was devised, could be more or less summarised in the following manner:—In an elephantiasis there are two chief elements.

1. Lymph stasis and overgrowth of cutaneous and subcutaneous tissues which is the result of prolonged soaking of the tissues with lymph.

2. The skin responding to the stress from within becomes elephantine.

Lanz thought that the deep fascia acted as a watershed between the deep and superficial lymphatic systems. Hence small slits in the deep fascia were made, but this was a failure. Kondoleon therefore provided adequate drainage of the subcutaneous tissue into the muscles through wide openings in the deep fascia.



Handley's operation of Lymphangioplasty is a failure in cases of elephantiasis, though it was a success in cases of oedema of the arms consequent on cancer of the breast. But the stagnation of lymph in cases of elephantiasis was lacunar and not uniform and hence the inability to drain by Handley's operation.

In a case of elephantiasis where both the superficial and the deep systems are more or less blocked, how is the lymph absorbed which passes through the openings cut in the deep fascia? Rapid absorption of substances injected into the subcutaneous tissues takes place through the blood stream. Therefore it is clear that in cases treated by Kondoleon's method, the superfluous lymph is absorbed by the blood vessels of the muscles and not by the deep lymphatics. The lymphatic and venous outflow from a part are alternative in action, *i.e.*, if the veins of a limb are tied, the flow of lymph from lymphatic trunk is greatly increased.

Why should not the blood vessels of the skin drain the subcutaneous lymph? It is not able to, because the subcutaneous lymph is in loculi, and divided by fibrinous intersections, and hence could not be efficiently drained. The muscular strata in the limb afford intervals in which fluid might, as it were mould into delicate laminæ and take the cast of the capillary interstices of the muscles. The success of Kondoleon's operation is due to the facilitation of absorption into the muscle strata.

Further the muscles act probably like a pump removing the lymph from the subcutaneous tissues. Kondoleon's operation actually produces a series of wide muscle hernias, and the alternate bulging and withdrawal by these muscles serve to aspirate the fluid from the subcutaneous to muscular strata.

The two factors then that contribute to the success of this operation are (1) The drainage through the blood vessels (2) The pumping action of the muscle hernias.

## EXTRACTS.

### AN USUAL ATROPIN EFFECT ON VENTRICULAR TACHYCARDIA.

S. M. Salley, M.D.

It is generally accepted that auricular fibrillation and auricular flutter are due to a circus movement and the most important factor in maintaining the circus movement is the length of the refractory period. If the length of the refractory period is maintained or increased the circus movement is abolished and *vice versa*. Quinidine has conflicting effects, but it often abolishes the circus movement by lengthening the refractory period.

There is growing impression that ventricular tachycardia is also due to a similar circus movement and quinidine has similar effects as in auricular fibrillation by lengthening the refractory period. Atropin by its paralysing effect on the vagus also lengthens the refractory period of auricle and ventricle. In a case of ventricular tachycardia atropin often produces complete heart block either by its paralysing effect on the vagus thus increasing the refractory period of ventricular muscle or by direct action thereon. This unusual effect of atropin suggests that it might serve as an additional aid in restoring normal rhythm where a circus movement fails to quinidine alone. (*The American Journal of the Med. Sciences.*)

### CORONARY DISEASE IN DIABETICS.

M. H. Nathanson, M.D.

Since the discovery of Insulin, the clinical picture of diabetes mellitus has been changing. Coma, surgical

complications, etc., were the chief problems in the pre-insulin days; we now find that vascular disease is playing a more prominent part.

Peripheral arteries of diabetics are prone to sclerose, hence the frequency of gangrene. In an investigation to find out if the coronary vessels of diabetics are also sclerosed, it has been found that above the age of 50 years, the incidence of coronary sclerosis in diabetics is 52·7 per cent. as compared with 8 per cent. in non-diabetics, *i.e.*, six and a half times more. There is an indication that in diabetes the tendency to coronary arterial change is almost as great in the female as in the male. It is also found that coronary disease is twice as frequent in Hyperpiesia with diabetes than in uncomplicated hyperpiesis.

Other pathological changes sometimes present in the heart in diabetic subjects are, toxic myocarditis, and rarely endocarditis.

Different explanations are forthcoming for the cause of arterio sclerosis in diabetes.

One is that it is due to the increased cholesterol content of blood in diabetics. Another is that the arteriosclerosis is primary and involves the arteries of the pancreas or that it may be a localised arteriosclerosis of the pancreas. The aetiological relationship between the two is by no means settled. (*The American Journal of the Med. Sciences*).

#### INSULIN AND APPETITE—A METHOD FOR INCREASING WEIGHT IN THIN SUBJECTS.

Clinical and experimental evidence exists that insulin plays an important role in the hunger-producing mechanism. Insatiable hunger has been noticed in patients suffering from hyperinsulinism and case records are available where administration of insulin in abnormally thin subjects otherwise

normal was followed by increased appetite and a gain in body-weight.

A plea is therefore made for a more frequent resort to this effective method of increasing appetite since the number of thin patients otherwise quite normal is considerable and since most of these resort to the usual bitters and stomachics without avail before finally resigning themselves to their poor figures and reduced physical proportions.

*The Method.*—Treatment begins with 3 units of insulin subcutaneously every 3 hours. Insulin reactions are avoided by urging patients to eat liberally  $\frac{1}{2}$  to  $\frac{3}{4}$  hour after injection. The dose of insulin is gradually increased until 10 units or more are injected every 3 hours. Patients are acquainted with the insulin reaction and enjoined to keep sugar available for immediate use in a crisis.

*Results.*—Appetite is restored and food intake increases with remarkable rapidity and food which formerly was nauseating is ingested with real pleasure and gusto. Gain in weight of 22½ lbs. in 28 days, 10 lbs. in 12 days, 12½ lbs. in 23 days and 15 lbs. in 39 days have been seen. Untoward insulin reactions have been surprisingly rare even with 45 to 65 units of insulin per day.

*Discussion.*—The increase in weight is not due to water retention because the gain in weight remains for most part after the insulin is stopped and because exhibition of diuretics is not followed by profuse water-elimination and loss of weight. On the other hand evidence exists that insulin promotes fat-deposition.

The relation of depressing mental states to anorexia is well-known; also that adrenalin tends to inhibit insulin activity while sympathetic fibres paralyse gastro-intestinal mobility. Since anatomical pathways have been traced between the hypothalamus and the

sympathetic fibres of the cord, emotional state may through the sympathetic nervous system interfere with insulin mechanism and so diminish appetite. (*The American Journal of the Med. Sciences*).

#### METABOLIC CHANGES AND TREATMENT OF OBESITY.

The obese are of medical interest not only because some of them desire to reduce for aesthetic reasons but also because they are more susceptible to infectious disease, especially pneumonia, to diabetes and to degenerative diseases of the heart and blood vessels.

Obesity is exogenous when the individual eats too much and exercises too little. On the other hand we do not know why certain individuals grow fat and what additional factors besides excess of food and lack of exercise account for the obesity. This is the so-called endogenous variety. In practice however it is difficult to know where exogenous obesity ends and endogenous begins.

Some obese have an excessive desire for food and reduction of their caloric intake results in weakness, fatigue, headache and dizziness but without loss of weight. It is this type that constitute a problem in the management of the disease.

The study of obesity involves a consideration of the total and basal metabolism of the subject, the effect of exercise on oxygen consumption, the specific dynamic action of food and water and salt metabolism.

*Basal metabolism.*—Of 21 obese persons whose B. M. R. was observed 17 had rates within the range of normality while of 7 cases hypothyroidism all of whom had reduced B. M. Rates, four were under weight than over weight. The response of individuals to thyroid medication is divergent since some develop thyrotoxicosis with small doses quickly while others can take

thyroid medication for long periods and in heavy doses without any induce of intoxication. Also the loss of weight in some individuals under thyroid therapy is rapid while in other it is not noticable. Patients suffering from certain diseases of the C. N. S. such as epilepsy and cerebral syphilis are resistant to thyroid therapy. On the whole therefore thyroid hypofunction and consequently a low B. M. R. is of no great moment in the pathogenesis of obesity.

One would expect that *the specific dynamic action of food*, i.e., the stimulation of metabolism following the ingestion of food was low in the obese. Observation on the obese have however shown no marked difference of this from normal. The conclusion is therefore drawn that the specific dynamic action of food is of no practical moment in obesity.

*Water and salt metabolism.*—There is in some obese persons an unsuspected fluid and salt retention. Such persons strictly dieted lose no weight through water retention though actually under nourished. Water and salt restriction is therefore important in the treatment of obesity.

McClive and Aldrich have injected 0.2 c.c. of 0.8 per cent salt solution intradermally into the flexor aspect of the forearm and have shown that the wheal that appears remains in the normal person for one hour or longer. In renal oedema the wheal disappears in a much shorter time. In the obese who tended to retain water the wheal disappeared in 5 to 20 minutes after injection.

In normal persons the ingestion of common salt is not followed by any difference in the NaCl concentrations of the venous and capillary blood while in the obese the concentration in the capillary blood is in excess of that in the venous blood. It is noteworthy that the patients lost weight under a salt restriction and dehydralin scheme.

To increase the water elimination in the obese who fail to reduce on diet alone salyrgan intravenously may be used. The diet is equivalent to the basal caloric need for the desired weight. Protein is allowed  $1\text{--}1\frac{1}{2}$  gm. per kg. of desired body weight and the C. and F. divided in the ratio 1 : 3 ; this gives an anti-ketogenic of 1.5 to 1. Fluids are limited to 1000 to 1200 c.c. in 24 hours and salt to 5 to 7 gm.

Theocin may be used but causes gastro intestinal disturbance.

Salyrgan is begun with  $\frac{1}{2}$  c.c. and in the absence of kidney damage increased to 1 c.c. twice a week for one week and then 1 c.c. every week for 2 weeks. Salyrgan gives good results with types of obesity accompanied by water retention. An individual who retains water tends also to deposit fat and therefore when dehydrated not

only loses weight but is prevented from accumulating fat.

There is reason to believe that certain centres exist in the hypothalamus and in the neighbourhood of the supra optic nucleus near the optic tract which govern water and salt metabolism and in the hypothalamus for fat metabolism.

The retention of water in the tissues is probably influenced by the above centres through the interaction of some of the glands of internal secretion.

*Conclusion.*—Disturbance in the water and salt metabolism with water retention in the tissues should be borne in mind in obese patients we do not lose weight or even gain it in spite of a low intake of food. Obesity of a hypothyroid nature seems to be infrequent. Every case of obesity is a problem in itself and the full lines of treatment. (*The American Journal of the Med. Sciences*).

#### STATISTICS OF MEDICAL PRACTITIONERS REGISTERED IN SIX PROVINCES.

(From the Bombay Medical Journal.)

Degrees & Diplomas, etc.	Madras.	Bihar & Orissa.*	Burma.	Bombay, Bengal & Punjab.	Total.
I. British and Foreign ...	198	139	147	714	1,198
II. Indian Universities ...	896	421	181	6,262	7,760
III. Licentiates and others ...	3,080	1,470	1,018	9,487	15,055
Total ...	4,174	2,030	1,346	16,463	24,013

\* N.B.—These figures are approximate only.

#### TOTAL NUMBER AND RATIO OF DOCTORS TO POPULATION.

Country.	Population.	No. of Doctors Registered.	Average ratio of Doctors to population.
Great Britain ...	50,000,000	55,604	1 per 1,000
Bombay ...	26,700,000	5,289	5,000
Bengal ...	47,500,000	7,556	6,000
Bihar and Orissa ...	42,238,812	2,030	22,000
Madras ...	42,794,155	4,174	11,000
Punjab ...	25,100,000	3,618	7,000
Burma ...	14,667,146	1,346	14,000
Total ...	199,000,113	24,013	1 per 10,000

**Injection of the Gasserian  
(semilunar) Ganglion.****HARTEL'S METHOD.**

The method of Hartel, who injects the Gasserian Ganglion through the foramen ovale, is the one most widely used. The strictest asepsis is imperative, for the injection is to an extent an intracranical operation, especially since the subdural space may be opened. The escape of cerebrospinal fluid through the needle indicates that this has occurred. Hence the needle must not be pushed through the mouth, nor through infected soft parts. The puncture is usually done in a semi-sitting position. The operator must be able to observe the patient from the front as well as from the side.

A mark is made on the skin of face with a coloured solution 3 cm. to the side of, and a similar distance above the angle of the mouth. The patient is at first carefully observed from the front and a line is drawn from the point of the proposed entrance of the needle to the approximate location of the pupil with the patient looking forward. The patient is then observed from the side and a second line is drawn from the point of origin of the first to the articular tubercle of the same side. A wheal is made at the point where the needle is to be inserted. A needle at least 12 cms. long is used for the deep injection and a marker is placed 8 cm. from its tip. The needle is directed so that when viewing it from the front it parallels the first line while viewing it from the side it lies at a more acute angle to the first line than to the second line. It is directed towards the centre of the Zygomatic arch. The direction of the needle is maintained, without inserting a finger in the mouth of the patient, as the needle is pushed through the tissues. As a rough guide for direction, the continuation of the needle lying in the foramen ovale should meet the scalp at

a point 4 cm. in front of the lambdoid suture and 2 cm. to the opposite side of the mid line. If considerable pain is felt while the needle is being inserted, a few c.c. of novacain should be injected. Aspiration of the needle should be attempted in order to ascertain whether or not the needle is in a blood vessel. If the needle has been directed properly it should strike the bony resistance of the infratemporal plane at a depth of about 6 cm. From the side one observes whether or not the needle is in the direction of the second line and then viewing the patient from the front changes the direction of the needle by gently withdrawing it a short distance and then reinserting it, so that it is inserted more in the direction of the second line and away from the first line. As the needle becomes parallel with the second line it slides along the bony surface of the infratemporal fossa towards the foramen ovale, until it finally slides through this opening. Successful entrance of the foramen can be determined in two ways: objectively, by a sudden cessation of resistance against the needle; and subjectively, in non-anaesthetized patients by radiating pains along the mandibular distribution of the nerve. The needle, as a rule, is 6 cm. deep and this distance curiously is the same regardless of the size or shape of the patient's head. If it is desired, an assistant can direct the needle from the anterior view while the surgeon watches the needle from the lateral position. After the foramen is entered the needle is pushed 1.5 cm. when as a rule paraesthesia along the other divisions of the nerve is observed. If blood or cerebrospinal fluid comes out of the needle, the solution should not be injected. If this occurs the needle should be withdrawn slightly and the solution should be injected only if the operator is convinced that the point of the needle is outside the subarachnoid space and not in a blood vessel. Before

injecting alcohol for trigeminal neuralgia, 1 or 1.5 c.c. of a 2 per cent novacain is injected and after 5 minutes at most the entire trigeminal area should be anaesthetized, if the needle is in the proper place. It is recommended by some to inject novacain also around the ganglion. After the injection the patient should be kept quite and in no circumstances should they be permitted to lower their heads. The simultaneous injection of both ganglia is permissible.

There are no serious complications connected with the injection of novacain into the ganglion if properly carried out, only occasionally nausea, vomiting, rapidly disappearing abducent paralysis and pupillary dilatation may occur. However permanent changes may occur by the injection of alcohol, if this is not entirely confined to the ganglion. Blindness, paralysis of the ocular muscles, of the facial and

acousticovestibular nerves have been reported.

(Kirschner's *Operative Surgery*.)

### Dangers of Soap Enemas.

R. Hubert.

Soap enemas are quite common. Dr. Hubert reports a case which illustrates the possibility of corrosion of the rectum due to soap enemas. A woman aged 26 years was given a soap enema. This was followed by hæmorrhage from the rectum. On rectoscopy the rectal mucus membrane was found to be red and swollen. The condition of the patient became steadily worse and she died. He reports the results of post-mortem and cites factors that are evidence against a bacterially caused dysentery and for the causal significance of the soap enema. There are also reports about severe corrosions of the genitalia in cases in which soap was used as an abortifacient.

## To the Members of the Profession.

You have certainly come across some interesting facts or new difficulties in the course of your daily professional work.

You are anxious that other members of the profession should have that knowledge with you.

*The Bulletin is at your service.*