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That hardy Annual!

The month of August is generally one of addresses to university students and exhortation from the prominent men of the city. The ball is set in motion by the annual convocation of the university. The Madras Medical College has had its share, not by any means inadequate. There was the usual reception to the new graduates in Medicine followed soon after by a prize distribution. There were addresses at both these functions, in the one case, the advice was for the new graduates and at the latter, the students were also included. Both these functions were presided over by the Surgeon-General with the Government of Madras. Sir Frank Connor has had thus an unique opportunity of directing the minds of the students and fresh graduates of the college to the many pressing problems which usually present themselves to such young men and women.

The medical profession is not very prosperous just now. There is a great deal of unemployment, in spite of protestations to the contrary in some quarters. There is a natural tendency among the new graduates and licentiates to compare their present precarious living to the happy times of just a decade ago. The increase in the number of qualified men has a little to do with this state. But what is often overlooked is the general decline in the prosperity of the coun-

try as a whole. In these circumstances, the Surgeon-General's reference to the unemployment problem among the male members of the profession is but cold comfort. But the profession would do well to hold fast to the other aspect of the question emphasized by the speaker. We refer to the great need for efficient medical relief not merely in the rural areas, but in the mofussil towns and suburbs. It has been a constant charge levelled against the profession here that it lacks enterprise. The tendency to crowd in a few places, chiefly in the city of Madras, has been often bemoaned. But the critics generally overlook the fact that men trained in modern medicine have till recently been little encouraged in other parts of the presidency. But it is pleasant to note that a large number of young medical men, graduate and licentiate, are now settling down in district and taluk headquarters and in some of the larger villages. Many causes have contributed to this. First, there is the overcrowding in the city. Secondly, on account of the economic condition patients in the mofussil are not now nearly so prone to run up to Madras for medical advice. They are more and more willing to be helped by medical men nearer home. And lastly, and probably the most important of all, the average ability of the newly qualified men after their year of internship as house surgeons and physicians is so much

improved that the sick public have greater confidence in them. We are therefore confident that in the next few years the bias of medical men for city practice would greatly diminish and that rural areas would be much more effectively served by well qualified men. Sir Frank Connor's advice is already followed.

Space does not allow us to refer to the various other subjects dealt with at these two gatherings. But one of the problems confronting the medical college is that of a hostel for its students. This subject is almost gathering some antiquity. Successive principals, superintendents of the hospitals and surgeon-generals have been pressing the Government to provide the college with a hostel. It is our recollection that the difficulty in the early days was the want of a suitable site nearby. Later, this subject was obscured by the much more comprehensive scheme of shifting the college and the attached hospital to a new site. Now that it has been decided to keep the college and the hospital in the present site and since large sums of money have already been spent on well equipped commodious premises for several departments of the college and the hospital, there should be no difficulty about deciding on the location of the hostel. The Surgeon-General was in a rather reminiscent mood when speaking about the hostel. He thought that it makes the student more self-reliant and helpful when he shifts for himself in all sorts of environment. But almost at the same time as he was giving out his opinion about the need for a hostel Her Majesty the Queen was opening a large and well appointed hostel for hundreds of students working in the London Hospitals. We are confident therefore that the Government and the Surgeon-General are only waiting for slightly better financial conditions to put the hostel scheme into execution.

Urobilinuria.

The bilirubin passed out into the intestinal tract is converted there, by the action of bacteria, into urobilin. A part of this urobilin is excreted in the faeces as stercobilin and the rest is absorbed into the portal blood and taken to the liver. The polygonal cells of the liver re-transform most of it into bilirubin and excrete it in the bile. Minute quantities of urobilin pass into the bile unchanged. Thus, as Brown, McMaster and Rous have shown, there is an entero-hepatic circulation of bile pigment. Whipple, however, does not believe that there is any such process going on. But the recent experimental studies of McMaster and Elman confirm the view that it is solely of enterogenous origin.

A small amount of urobilin normally escapes into the general circulation and is excreted by the kidneys. But, as is evident from the experiments of Elman and McMaster, when there is inability of the polygonal cells to transform urobilin into bilirubin urobilin passes into the general circulation in increasing amounts and appears in the urine in large quantities. The margin of safety the liver possesses with regard to this function seems to be limited; for, as Elman and McMaster have shown, urobilinuria occurs regularly, when local obstruction of one-third of the liver is induced. Rous says, "If one tie off only a small twig of the hepatic duct, some of the urobilin absorbed from the gut passes through the injured portion of the liver and is excreted into the urine." Elman and McMaster have also shown that when the amount of urobilin reaching the liver is increased, the quantity of the pigment appearing in the urine is also increased, no doubt, due to the inability of the hepatic parenchyma to deal with the excess brought to it.

Urobilinuria is, as Elman and McMaster state, an expression of the inability of the liver cells to remove from the circulation the urobilin brought to them by the portal blood. They say: "Urobilinuria is a valuable finding in that it makes manifest biliary disturbances of mild degree."

Urobilin appears in the urine as a colourless chromogen—urobilinogen. But in urine which has stood for some time urobilinogen becomes converted into urobilin. The presence of urobilinogen in the urine may be detected by *Ehrlich's aldehyde reaction*. This is a qualitative test in which a pink colour develops in the urine if this substance is present on the addition of the aldehyde reagent. If it be present in pathological amounts, the colour developed is a deep red. The full development of colour may occur only after a few minutes.

Wallace and Diamond have recently adapted this test for estimating roughly the amount of the urobilinogen in the urine. They dilute the urine successively and determine the highest dilution in which a pink colour is obtainable on adding 1 c.cm. of the reagent to 10 or 15 c.cm. of the diluted urine.

Schlesinger's test may be employed for the detection of urobilinuria. If, on performing the test, a green fluorescence develop, urobilin is present in excess. The alcoholic extract may be used for examination with the spectroscope. If a thin band is present in the green of the spectrum, between *b* and *F*, urobilin is present.

According to Elman and McMaster, urobilinuria may occur in alcoholic cirrhosis of the liver without bilirubinuria, jaundice, or other evidence of biliary obstruction. This is explained as due to the escape of portal blood directly into the general circulation

through the various anastomotic channels, the development of which is a feature of the disease; the urobilin absorbed from the intestinal tract, therefore, reaches the kidneys before it reaches the liver.

Wallace and Diamond have obtained the following results with their rough quantitative adaptation of the aldehyde reaction:—

Normal urine shows the presence of urobilinogen in a dilution of 1 in 10, and sometimes even in one of 1 in 20.

In the early stages of catarrhal jaundice, the reaction is obtained in even as high a dilution as 1 in 100. The pigment soon diminishes in the urine till only traces are present. Towards the termination of the disease, it again appears in increasing amounts, so that it may be demonstrated even in a dilution of 1 in 250. On recovery the reaction returns to normal.

In obstructive jaundice, urobilinogen quickly disappears from the urine; there is no stage of increased urobilin excretion. This is a useful point in the differential diagnosis between catarrhal and grossly obstructive jaundice.

In subacute conditions of the liver there is an increase in the urobilinogen content of the urine. In most chronic hepatic conditions it does not show any change from the normal. In exacerbations of chronic processes, the urine gives higher readings for the pigment.

In the primary anaemias there is an increase in the urinary urobilinogen. This point is of assistance in the differentiation of the primary from the secondary anaemias, in which no such increase occurs.

An increase in the excretion of urobilinogen in the urine is noted in malaria also.

Dean has noted that constipation exaggerates a pathological urobilinuria and evacuation of the bowels diminishes it. He has found that there is a period of maximum urobilinuria in the course of pneumonia. This may be related to the period of hyperbilirubinæmia described before.

Rowntree, Marshall and Chesney, in 1914, concluded that "*urobilinogen determinations* in the urine are valueless unless made daily for a period of two weeks and unless associated with urobilin determinations in the fæces." But to-day this position seems to have shifted. According to Piersol and Bockus, it is a reliable test, in the absence of obstructive conditions, in the biliary tract for liver cell damage.

Tinnitus Aurium.*

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Of all symptoms of ear diseases which the Aurist is called upon to treat, tinnitus aurium is the most elusive one and difficult to control. It may result from any form of tympanic or labyrinthine trouble and, as well, from other causes where the ear is perfectly normal. It is the disappointing experience of every Aurist, that even after successfully treating a tympanic lesion, the aural tinnitus remains unrelieved. Some times tinnitus may be the only symptom the patient is troubled with, and no abnormality could be detected in the ear physically or functionally.

It is mostly a subjective sensation of sound in the ear, and under rare conditions, it is objective. It is a pretty common complaint with which

every Aurist is familiar. It is a sign of irritation of cochlear mechanism, just as pain from irritation of sensory nerves. The sounds may be continuous, intermittent or synchronous with pulse. They vary in their nature. They may be bussing, roaring, rushing, hammering, the sound of sea, of bells, of hissing steam, etc. The sounds appear more troublesome at night, or when the patient is alone in the silent quarters. It is often very depressing, making the victim sometimes unfit for work, and even with a tendency to commit suicide. The onset may be sudden or gradual. Some of our patients come with a history of an ant or some other insect having entered the ear and to be responsible for the sound. It is very difficult to convince them otherwise. They get hysteric and run after different surgeons with a request to have the insect removed from within the brain. This condition is found in both the sexes and mostly in adult and later life.

The disease can be *classified under the five following headings* depending on the causal factors:—

1. *Obstruction Sounds* or noises due to occlusion or impaired mobility of a portion of sound conducting mechanism—a demonstrable lesion, commonly seen in acute catarrh of Eustachian tube or in acute purulent otitis media. The accompanying impaired hearing and tinnitus, disappear when resolution is complete and mucus membrane returns to normal. In studying this simple form of tinnitus, some Otologists (Pause) have advanced a theory that the function of the conducting apparatus is not only transmission of sound waves to the ear but also conduction from the ear of sound waves which would otherwise act too strongly on the perceptive mechanism. "Besides, it is well known that bone conduction is increased when

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the mobility of the ossicular chain is impaired; as such, the sounds in simple middle ear lesion are really the normal physiological process sounds, *e.g.* the blood current, etc., which by reason of the temporary increased bone conduction are permitted to reach the end organs of the auditory nerve. They disappear soon after resolution, when the ossicles move properly removing the temporary increase in bone conduction. Such outward conduction of sound may be interfered with by causes which occlude the external meatus, *e.g.*, cerumen, furuncle, foreign body, etc., and also by those conditions which interfere with the free mobility of the ossicles, *e.g.*, Eustachian catarrh with retraction of drum membrane, tubotympanic congestion, fluid effusions in tympanic cavity, or constricting bands which bind the ossicles together or to the tympanic walls. Treatment for the above causes is naturally a local one, and we can expect the tinnitus to disappear as the parts regain the normal position.

2. The second group of causes may be classified as *blood sounds*:

(a) They may be arterial or venous in origin. They are due either to congenital anatomical anomalies, in which case they are not looked upon as disease and no treatment is possible. They may continue during the life-time of persons whose hearing is invariably normal. For instance, the internal carotid artery, which is separated from the anterior wall of the tympanum, by a thin plate of bone, sometimes actually projects into the tympanic cavity, or the thin plate of bone separating the jugular bulb from the tympanic floor may wear away, giving rise to sounds in the ear, quite inevitable and yet due to no disease. Of course, the same conditions would also be caused by necrotic process of the bones. The above phenomena

have been found during surgical operations or post-mortem examinations.

(b) *Nerves* regulating the calibre of vertebral, basilar and consequently the internal auditory arteries which supply the labyrinth come from the inferior cervical ganglion of the sympathetic. The stomach and other abdominal viscera are largely supplied by the pneumogastric nerves, which communicate with the inferior cervical ganglion by means of a fasciculus from the former. Conditions such as subacute gastritis, chronic constipation or pathological conditions of pelvic viscera, send impulses to the ganglion and the blood supply to the area concerned (here labyrinth) may be increased ten times as great as under normal conditions giving rise to a tinnitus which is relieved by attending to the causal viscera (Woakes).

(c) In patients suffering from chronic *endocarditis* and valvular disease a murmur is heard at the base of heart and is sometimes transmitted along the vessels as in aortic regurgitation. Just as we hear a sound in femoral or brachial arteries, we can also hear the same from the internal auditory artery by an otoscope applied to the external meatus. Under these conditions it is not unusual to expect the same sound observed by the patient subjectively also.

(d) In the same way intracranial *aneurysms* give rise to a tinnitus synchronous with the pulse as in the above condition. Such aneurysms are said to be common in the basilar artery in which case the tinnitus would be bilateral, and next in the internal auditory artery giving rise to a unilateral tinnitus in the corresponding labyrinth. In this case also, as in the above, the tinnitus can be heard objectively with an otoscope. Treatment in both the above conditions

is not satisfactory, except that cardiac sedatives may lessen their intensity to a small extent.

The blood sounds are supposed to be of lower medium pitch and they are to be diagnosed by excluding the other causes. Those of arterial origin are usually synchronous with the pulse; and if venous they are uniform, non-pulsating and humming in character. The latter usually appear in severe cases of anaemia, probably due to an altered condition of blood in its passage from the sinus to the jugular bulb. This is analagous to the bruit du diable or the haemic murmur over the pulmonary area. Obviously, treatment consists in the restoration of blood to its normal condition by iron, arsenic or otherwise.

3. *Labyrinthine Sounds*.—Subjective noises are present in acute suppurative labyrinthitis; but, they are overlooked by the other more distressing symptoms of the disease. Those appearing in some chronic nonsuppurative middle ear diseases and especially those that persist even after every known local therapeutic measure, are probably due to *irritation* of the terminal cochlear fibres of the auditory nerve. *Congestion and anæmia* of labyrinth, giving rise to increase or diminution of pressure on the delicate structures of the labyrinth, produce tinnitus as evidenced by repeated doses of quinine, salicylic acid, and especially amyl nitrate. In severe hæmorrhage a tinnitus is observed, probably due to anæmia and reduction of intra-labyrinthine pressure.

In chronic catarrhal otitis media, a low grade of hypertrophic or hyperæmic condition is maintained, which accounts for the very common tinnitus accompanying this disease. It may also be due to the chronic structural changes within the labyrinth, as a result of this slow hyperemic

process. Treatment for this condition is attention to personal hygiene and constitutional, than anything local.

4. *Neurotic Sounds* are due to a hypersensitive condition of the auditory nerves, which form only a part of a general *neurotic* condition. It is a manifestation of a functional disorder or increased abnormal irritability of the nerves, without any tympanic disease. Tinnitus is also seen when toxic matters circulate in the blood, as in *Bright's* disease, or acute infectious diseases, though rare, and is of a temporary nature. The toxins are supposed to irritate the auditory nerves. The most characteristic group is found in neurasthenia and hysteria, or after nervous exhaustion, after fatigue, overwork, anxiety, alcoholic or sexual excess. It is more at night and slightly relieved after a night's rest. It differs at different times in the same individual, and even when he speaks with different persons. A certain degree of deafness may also be associated with this type of tinnitus, and that too of varying type. On the whole, this condition is diagnosed only by eliminating other causes, organic or otherwise; though rarely, a mixed variety may be met with, showing the presence of slight organic lesion as well.

5. *Cerebral Sounds* are sounds due to irritation of the auditory centres in the cerebral cortex. They are usually rare, elaborated and varying in nature, such as often seen as an aura of an epileptic fit or in cases of mental instability, who are supposed to hear imaginary voices and conversations. Prognosis in these cases is not good and treatment is in the hands of a competent neurologist.

6. Tinnitus may also be found in chronic sinus suppuration or in intracranial tumours associated with other usual symptoms.

Prognosis.—It is necessary to assure the patient that the disease is usually very slow in its progress, that there is no fear of any brain disease which he commonly entertains, and also that the condition is not dangerous to life. Pregnancy, illness, and the use of certain drugs may increase the tinnitus. Prognosis is bad if the affection comes early in life.

Treatment.—In general, the patient should be advised to neglect the noises as far as possible. Since they are more troublesome when he is alone and unoccupied, a pretty loud tickling clock in the bed room is desirable. Bromides, iodides, or corrosive sublimate pills, 1/60th grain, twice daily for a month or so are occasionally helpful. Blisters over the mastoid or tragus or below the lobule, are sometimes useful. Galvanism also has been tried. Operative destruction of cochlea is justifiable if the tinnitus is intense and unbearable. Even radium has been used in the tinnitus of Meniere's disease. Different authorities have suggested some other lines of constitutional medication, such as salol in those cases associated with intestinal toxæmia, iron and arsenic in anæmic conditions, colossal iodine in otosclerosis, luminal in neurotic individuals, glycerophosphates, thyroid and calcium, etc., in others. Of late, a new preparation called acœgenol, is much advertised in the market as a panacea for tinnitus, deafness and vertigo; but the results are yet to be watched for.

Sleep.

Of the many privileges enjoyed by doctors, that of inducing sleep is surely, one of the most satisfying, and therapeutically it is also a most valuable means of combating disease.

Classification.—The causes of insomnia are numerous, but they may be classified under certain broad headings. Firstly, I would put insomnia due to pain, including physical discomforts, such as hot weather; next that due to various kinds of toxæmia and finally what may be broadly classified as insomnia due to mental causes.

Diagnosis.—“Oh Doctor I have not had a wink of sleep” is a common statement made by the patient to his doctor during the morning visit. Before accepting this pronouncement at its face value it is well to make certain enquiries from those in attendance. It is a matter of common experience that a couple of hours of wakefulness at night may seem an eternity, and though the patient is not consciously exaggerating, he may in fact have enjoyed 4 or 5 hours of excellent sleep. This brings us to the question of what we mean by Insomnia. Various amounts of sleep are necessary for individuals of various ages and the following table gives the figures:—

1st year.....	18	hours.
2—5 years.....	14	„
5—6 „	12	„
7—14 „	10	„
15—50 „	8	„
50—60 „	5—6	„
65 and over.....	3—4	„

It will be seen from this table that what is sufficient sleep in a man of 60 is quite insufficient for a boy of 14. The above table is of course only correct for averages—many persons of 65 and over enjoy 5—7 hours of sleep. It is therefore necessary to find out how much sleep a patient is getting, and then, assess how much is necessary

for him according to his age and habits.

Having come to the conclusion that the patient is getting insufficient sleep, a careful physical examination is necessary to arrive at the cause of the insomnia. Should he complain of pain the cause should be treated and certain drugs administered. These will be dealt with later, but I would like to mention one or two causes of nocturnal pain that are significant, and in which ordinary analgesic methods are not effective.

The first is severe nocturnal headache. This condition is usually associated with organic disease of the Central-Nervous System, and this must be carefully sought for, particularly the examination of the eyes for papilloedema, and the cranial nerves, etc., for evidence of cerebral syphilis. The second, is the pain due to duodenal ulcer—pain occurring about 2 a.m. and waking the patient out of sleep is almost diagnostic of this condition. The treatment in this case will not be administration of sedatives, but of a large dose of Bismuth Carbonate, or injection of Atropin, last thing at night. This pain disappears rapidly under one of the diatetic treatments for Peptic Ulcer.

The toxic conditions giving rise to insomnia are the fevers, of which the most characteristic example is Lobar Pneumonia. Certain drugs, for instance the over indulgence in tea, coffee, or tobacco and the withdrawal symptoms of the narcotic drugs must also be classified with toxæmic insomnia. Metabolic toxins, such as accumulate in the blood in Interstitial Nephritis may give rise to intractable Insomnia.

The mental conditions that are common causes of sleeplessness are numerous. Mental and physical

activity before bed time is particularly important as a factor in children. Adults often think out or worry about the events of the day, prior to trying to sleep. Anything which fixes the attention is apt to prevent sleep. The emotions of fear and anxiety and also joy often prevent sleep, but sorrow, strange to say, does not do so. The Anxiety Neurosis may be associated with sleeplessness, but not the true Neurasthenic Syndrome.

Insomnia should be remembered as an early symptom of Psychosis, and in cases of Maniac Depressive Insanity it may be one of the early symptoms.

Treatment.—This resolves itself into

- (a) General Measures including Hydrotherapy.
- (b) Drugs.
- (c) Psychological treatment.

General Measures.—If the insomnia is due to acute fevers, the general measures consist of good nursing and hydrotherapy; this last is also of great value in excitable psychotic patients. It may be administered as either tepid or cold sponging or a cold pack. Strict instructions should be given to the attendants that the patient should not be woken for any purpose. This is of particular importance in Lobar Pneumonia.

In all cases of chronic insomnia, the habits of the patient should be reviewed and corrected, and it may be necessary to enjoin periods of physical and mental rest. It is well known to the lay public that if fatigue is carried beyond a certain point spontaneous rest becomes difficult, and the term "overtired" is usually applied to this condition. This is also true of chronic fatigue, especially prolonged mental strain and worry, so common in modern times. It is probably partly responsible for the "week end habit"

which has become so indispensable in the rush of modern city life.

A few simple measures may assist in cases where no definite organic disease can be demonstrated, such as the administration of hot milk or ovaltine before going to bed. A small dose of alcohol is effective in certain people, in fact the drink of whisky or other spirit before retiring is known as a "night cap" Some not too exciting book or other quiet occupation should be indulged in for 2 hours prior to retiring and the last meal of the day should be taken about 3 hours before bed time.

It is particularly important that excitement should be avoided in children before bed time. Exciting and energetic games, stories of an exciting nature should be forbidden for at least an hour before bed time.

In India, in the hot weather, clothing must be light, and provided a bath towel is wrapped round the abdomen, chill need not be apprehended. A fine grass mat to sleep on also helps to keep the individual cool, while a slowly revolving ceiling fan is the best of all measures.

Drugs.—The drugs that will assist sleep, may be divided into three classes:—

- (a) The Sedatives.
- (b) The Hypnotics.
- (c) The Analgesics.

The sedatives act by their soothing effect on the nervous system, and of them Bromide is by far the most valuable, though I think alcohol may be placed in this group. It must be remembered that for Bromide to be effective it must be given a couple of hours before bed time. Sedabral, a combination of Bromide and meat Extract is of value.

Bromides are of great value in those patients who suffer from excessive mental activity after retiring to rest. Such persons often complain that they cannot stop thinking. Bromide prevents this mental perturbation, and sleep follows naturally. The dose of the Bromides is 5-30 grs.

The Hypnotics may be divided into—

- (a) The Halogen group.
- (b) The Aldehydes.
- (c) The Sulphones.
- (d) The Urea Derivatives including the Barbitone group.

The most important member of the first group is Chloral Hydrate. It is an excellent hypnotic drug of wide application and usually administered in conjunction with Potassium Bromide. The dose is 5-20 grs. and as long as it is used in these doses, its depressant effect on the heart need cause no anxiety.

The second group has only one member of importance and that is Paraldehyde (30-120 minims). It is however an important drug used extensively in toxic states, especially Pneumonia. It is without toxic effect except in huge doses and it may be administered rectally in Olive oil in doses up to four drachms, thus avoiding the taste. This may also be done by prescribing in Mist. Amygdalae B.P. and also with Brandy. It is a valuable drug in excitable states, especially Status Epilepticus. It should always be exhibited in full doses.

The third group contain a great many drugs, many of them proprietary preparations. They are powerful hypnotics and have been well reviewed by N. Mutch.

There are many drugs of great value, but it is only possible to refer to a few.

Barbitone (B.P.) 5-10 grs. Syn. Veronal.

Barbitone Solubile (B.P.) 5-10 grs. Syn. Medinal.

Both drugs are useful, but should not be used in renal disease owing to slow excretion and cumulative poisoning effects. This applies to all the Barbitone and Sulphone hypnotics.

Pheno Barbitone (B.P.) Syn. Luminal and Sodium Luminal $\frac{1}{2}$ -2 grs. These are powerful hypnotics and are useful in sleeplessness associated with excitement.

Allonal (Roche). This is a valuable hypnotic for routine use; it also has some analgesic effect, being a combination of Amidopyrin and Barbitone Derivatives. The dose is 3-9 grs. or 1-4 tablets of the above preparation: 2 tablets are usually effective.

There are innumerable other hypnotics of this class, and their use has become so general that there has been some alarm in medical circles about the possible ill effects of these drugs. The effects of hypnotics have been recently reviewed by Willcox, and his views are extreme, in that he never prescribes the Barbitone or Sulphonal group of drugs. In most of the cases that he quotes, the drug has been administered in full doses for an unduly long period, or else has been taken in excessive doses. Nembutal, a drug of this series, while more potent, is also more toxic than others, and has given rise to a number of fatalities, but again with maximal doses.

Willcox's views have been combated by R. E. Gillespie who considers these drugs of great value, provided they are exhibited in moderate doses, over a short period of time.

There have also been cases of Thrombopenic Haemorrhagic purpura recorded after the use of a certain area

derivative, presumably in persons with idiosyncrasy.

To sum up, there seems to be no reason to condemn the whole class of Barbitone compounds. Given in recommended doses, and only for a day or two at a time, there seems no reason to suppose that any harm results from their exhibition. Luminal should not be given for more than 3-4 months at a time in Epileptic cases, but should then be gradually decreased and the dose of Bromide increased until the Luminal may be omitted for a month.

Poisoning by these drugs has become commoner of recent years and it has been found that in addition to the ordinary methods of elimination and stimulation, lumbar and cisternal drainage of cerebro spinal fluid are measures of great value.

The fourth group of analgesic drugs may be sub-divided into sub-groups:—

The Coaltar Derivatives.
The Opium Group.

Certain proprietary preparations are a combination of Amidopyrine (Pyramidon) and a drug of the Barbitone series, and some of these have become exceedingly popular. The best known are Veramon and Allonal. They are useful in that they combine mild hypnotic and analgesic properties.

Of the analgesic Coaltar drugs, Aspirin is the most commonly used, and is useful as symptomatic treatment of headache and other mild pains. All these Coaltar drugs are antipyretic and somewhat depressant to the heart, but given in ordinary doses aspirin is a very safe drug of very wide application in the field of therapeutics, and overcomes insomnia due to mild discomfort or pain.

Acetanilide—This is a powerful depressant and is somewhat toxic. Patients with idiosyncrasy develop

alarming symptoms as in the case of the following patient:—*Mrs. F.* aged 40 suffering from Dengue with very severe headache. Acetanilide grs. 2 in cachets was prescribed—to be taken at once and repeated in 4 hours if the headache is still severe. About half-an-hour after first cachet, the patient complained of feeling collapsed, the respiration was shallow and slow, the pulse feeble and rapid of low tension, the skin became covered with a blotchy erythema. Stimulants were administered and the patient recovered after about 12 hours.

It is better to avoid this drug and to prescribe either Phenacetin grs. 5-10 or Amidopyrin (Pyramidon) grs. 5-10, but in debilitated patients it is better to give smaller doses or to use aspirin. The ordinary A. P. C. powder is an excellent routine, mild, analgesic.

Opium and its products still remain our main standby in the relief of severe pain, and in procuring comfort in some cases of extreme distress, such as congestive cardiac failure. I do not intend to give the opium derivatives as they are well known, and no recent addition has been made to our knowledge of their uses, except that some authorities use Morphine freely in conditions of kidney disease. It has little effect on urinary secretion, and is excreted by the bowel. It is a matter of common knowledge that opium is an exceedingly dangerous drug in children, and should be administered in small doses—the best preparation being Compound Tincture of Camphor and Powder of Ipecacuanha (Dover's Powder); of the latter gr. 1, t. i. d. for a child of 2 years and grs. 2 for a child of 5 years may be useful in certain conditions, such as at the onset of Lobar Pneumonia.

It must be remembered that all the drugs mentioned, with the exception of Bromide and possibly Paraldehyde,

are capable of producing addiction. For this reason the general rule for administration should be that the drug should be withdrawn the moment it is no longer necessary, in spite of the wishes of the patient. Remembering this point, addiction must not frighten us from giving these drugs freely. They relieve much real suffering and render the course of a disease easy for the patient.

In cases of Insomnia unassociated with demonstrable organic disease the risk of addiction is greater, but it is as well to remember to give an adequate dose, to produce sleep at the beginning of the treatment, in order to give the patient confidence in the drug, and to break the habit in insomnia; then gradually to reduce the dose without the patient's knowledge until it be omitted altogether.

For cases of this type, tablets are unsatisfactory and the drug should be prescribed in cachets or mixtures, in which forms the dose may be altered without the patient's knowledge.

Psychological Treatment.—In cases of mental disorder causing insomnia, the emotion of fear is usually the cause of the trouble. This is most easily seen in certain children who are profoundly afraid of the dark and who lie awake in an agony of terror. In older people fear of sleeplessness itself, is commonly found, owing to the idea that insomnia leads to insanity. More profound psychological causes for anxiety may be present, while as stated earlier in this paper persistent and intractable insomnia may be the early symptom of a developing psychosis.

The treatment of this group of conditions consists in the first place of re-assurance and persuasion. A child suffering from night fear should be given a night-light and be allowed

to sleep in the same room as other individuals or an adjoining room. Patients should be reassured about the question of insomnia giving rise to madness—it has never done so, and never will. For more profound anxiety states, expert psychological treatment will have to be invoked. In all these cases judicious use of drugs may be necessary, especially as stated above, in order to break the habit of insomnia and to re-establish the patient's confidence in his powers of sleep.

These few indications will have to suffice in the present paper, but many cases of mental insomnia will yield to this type of simple treatment.

It will be seen that the physician of to-day is exceedingly well equipped for the relief of pain and the induction of sleep. But it is as well for him to start with simple methods, and to use a few well tried drugs, especially those that are to be found in the B.P. rather than change his methods with every bright and attractive piece of literature thrust upon him by an enthusiastic agent of one of the Manufacturing Chemists.

R. D. Alexander,
in Madras Medical College Magazine.

From the Archives of the South Indian Medical Union.

On Wednesday, the 27th February 1924, before a Meeting of the South Indian Medical Union, held at the Y. M. C. A. Auditorium, Esplanade, Madras, Major K. G. Pandalai, M.B., F.R.C.S., I.M.S., opened a discussion on "SOME PRESSING MEDICAL PROBLEMS" by reading a most interesting and exhaustive paper on several of the outstanding medical questions that stood in need of very urgent reforms and reconstruction in several of the Educational and other institutions in the Government Medical Department.....Major

Pandalai "deplored the utter stagnation in Medical Education that is noticeable in our country. This is attributable to the fact that the controlling authority of Education is not the University but the Government, and this naturally tends to one man guiding and controlling the whole medical education. Time has come to uproot such a system. He held that firm conviction that the South Indian Medical Union should have a separate Statutory representation on the University, the Medical Council, and the Academic Council. The Medical Council, as it stood at present, was purely a Registering Body, and was not representative of independent medical practitioners. (He was of opinion) That pressure should be brought for the admixture of non-official medical opinion on the Academic Council and on the Board of Studies. It was a matter for regret that Teaching was not looked upon as a predominant duty towards students, but was made to take a subordinate place to the Hospital duties..... There should be schemes laid out for the extension of Hospitals and allied institutions. This should comprise the question of replacing the paid staff by Honoraries and also the system of Public Charities and endowments."

Let your colleagues know
what you think.

**Say it in the
BULLETIN.**

UNION NOTES.

*Publicity Section.***The South Indian Medical Union.**

Annual Report for the year ending March 1934.

S. Rangachari,
U. Rama Rao.
T. Satakopan.
T. Krishna Menon.

THE COUNCIL

President.

S. Rangachari.

Vice-Presidents.

U Rama Rau,
E. V. Srinivasan.

Members.

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

Honorary Secretaries.

P. Rama Rao (*Social and Scientific.*)
K. C. Paul (*General.*)

NOTE:—Owing to the death of Dr. S. Rangachari on April 24, 1934, Dr. E. V. Srinivasan was elected by the Council of the Union on May 7, 1934, to be the *interim* President.

REPORT.

Membership.—During the year under review there were several additions to the membership of the Union. One ordinary member resigned his membership and one member was lost to the Union through death; *Dr. S. Rangachari, M.B.C.M., who was President of the Union, since April 1928, passed away on April 24, 1934.*

Finance.—The financial statement of the Union as certified by the auditor is herewith appended.

Meetings of the Council.—The Council of the Union met during the year under review on 11 occasions. Of these 9 meetings were for transacting the routine business of the Union. One special meeting was held (on Thursday, April 26, 1934) to consider what should be done in consequence of the demise of Dr. S. Rangachari, President of the Union. Another special meeting was held to consider the Report of the Committee appointed by the Government to consider the extension of the appointment of Honorary Medical Officers in Government Hospitals. The thanks of the Union are due to those members of the

Council who were regular in their attendance at these meetings and who guided the affairs of the Union by their wise counsel.

General Meetings.—One extraordinary general meeting of the Union was held on May 2, 1934, to express condolence at the sad demise of Dr. S. Rangachari, President of the Union.

Socials.—Two socials were held during the year. The first was at the instance of an anonymous donor, and was utilized to meet Dr. S. Rangachari, President of the Union, after his European tour. The second was a subscription tea to meet Major-General C. A. Sprawson, I.M.S., retiring Surgeon-General with the Government of Madras. Both were well attended and were unqualified successes.

Clinical Meetings.—The following papers were read before the Union:—

1. 11th September 1933. "The treatment of burns" By Lt-Col. V. Mahadevan, F.R.C.S., M.R.C.P., I.M.S.

2. 18th September 1933. "X-ray evidences of pathological appendix" By Dr. P. Rama Rao, D.M.R. (Vienna).

3. 25th September 1933 "Sacral anaesthesia" By Dr. P. Govinda Rao, M.B.B.S.

4. 9th October 1933. "The Dysenteries: their diagnosis and treatment" By Dr. V. Govindarajulu, M.B.B.S.

5. 23rd October 1933. "The principles of electrocardiography" By Dr. T. Krishna Menon, M.B. C.M. L.R.C.P., M.R.C.S.

6. 2nd November 1933. "The lungs and anaesthesia" By Dr. M. Krishnamurthi, M.B.B.S.

On the 17th November 1933, Mr. M. Ruthnaswami, M.A., C.I.E., Bar-at-Law, gave a lecture before a meeting of the Union on "A layman's thoughts on Physick and Physicians."

The Bulletin.—The *Bulletin*, the official organ of the Union, is enjoying a wide circulation, and its usefulness to the Profession and to the Public has been steadily increasing during the year. The thanks of the Union are due to the members of the Publicity section for their efforts in running the *Bulletin* with such credit.

The advertisement revenue of the *Bulletin*, which had fallen off considerably during the last year, is slowly increasing, thanks to the untiring efforts of Dr. T. Krishna Menon, who is in charge of both Publicity and Advertisements.

Acknowledgments.—Dr. E. V. Srinivasan has once more placed the Union under a deep debt of obligation to him by permitting the use of his premises at 32, Broadway, for the activities of the Union.

The Union is indebted to Mr. K. Gopalakrishna Rao, Accountant and Auditor, for kindly auditing the accounts of the Union for the period ending April 1934 free of all charges.

ANNUAL GENERAL MEETING.

The Annual General Meeting of the South Indian Medical Union was held on Monday, the 27th August 1934, at 6 p.m. at 32, Broadway. 37 members were present.

After Tea, which was over by 6-30 p.m. the proceedings commenced.

Dr. E. V. Srinivasan, the President, took the chair.

Before the items on the Agenda could be dealt with, Dr. U. Krishna Rao raised a point of order on which he asked for a ruling from the Chair. He said that the Secretaries had given notice early in June that the Annual Meeting would be held on the 28th June 1934 and had called for from the members resolutions which were to reach them not later than the 15th June 1934. Owing to some circumstance or other, the meeting was not held on the specified date. But no fresh notice, stating the date or calling for the fresh resolutions, was issued before the Agenda for the present meeting was sent round. This prevented members from sending in resolutions other than those they had already sent for the meeting announced for June, 1934. Furthermore, the Secretaries have not included on the Agenda they have circulated the resolutions which had been sent to them for the June meeting after the 15th June, even though the present meeting is being held two months after the date originally announced in the *Bulletin*. The Secretaries have, no doubt, expressed apology for not having held the meeting on the date first announced; but as they did not call for resolution again after the change of date, this meeting should not be considered in order. The Annual Meeting should be held at a later date after calling for from the members resolutions afresh. Concluding, Dr. Krishna Rao, requested the Chairman to give a ruling

whether the holding of the Annual Meeting this evening was in order.

The General Secretary explained that apology had been made for the change of date, that no resolutions other than those included in the Agenda were received by him even after the 15th June 1934, and that calling for resolutions before the Annual Meeting was not mentioned in the Rules or Bye-laws of the Union, and was an act of courtesy on the part of the Secretaries. The Bye-laws stated that resolutions should be sent in writing to the General Secretary by the members desirous of moving them not later than the 1st day in March, and that the Annual Meeting should ordinarily be held in the month of April or as soon after as is found convenient.

Dr. U. Krishna Rao, in reply, stressed that there was no question of courtesy involved in asking for resolutions, but it was the right of every member to expect the notice calling for any resolutions he has to move, and that it is the duty of the Secretaries to call for resolutions to be placed before the Union at its Annual Meeting. As such notice did not reach him after the date originally fixed had been changed, he was prevented from placing before the Union at its Annual Meeting two very important resolutions he was desirous of moving.

Dr. P. S. Kuppaswamy said that as a matter of courtesy Dr. Krishna Rao, may be permitted to place his resolutions before the Union at this meeting though previous notice had not been given of these.

Dr. T. Krishna Menon objected to the consideration of any resolution of which previous notice had not been given.

Dr. Krishna Rao pressed for a ruling from the Chair.

The Chairman ruled that the Meeting of the day was in order and added that any resolutions other than those on the Agenda may be submitted for consideration by the Union at a Special General Meeting which may be called for, if necessary, at a later date.

The Chairman then called upon the General Secretary to present the Annual Report on the working of the Union for the year 1933-34. As a copy of the Annual Report had been sent to every member, the General Secretary requested permission to take the Report as read. This permission was accorded. A discussion on the report ensued.

Dr. M. Sanjiva Rao desired information why the expenditure under the heading *Bulletin* was so high and the receipts so low. He wished to know also why it was proposed to change the *Bulletin* into a *Journal* when the expenses for the latter would be higher than that for the former.

The Secretaries explained that the receipts from advertisements had fallen considerably during the period of world economic depression, and that was the reason why the receipts were so low. As regards the change of the *Bulletin* into a *Journal*, it was a proposal only at present, but it was considered to be a necessary change as it would enhance the usefulness and prestige of the Organ of the Union.

Dr. U. D. Gopal Rao expressed the opinion that the numerical strength of the Union should be included in the Report.

The General Secretary said that he will make a note of it.

Continuing, Dr. Gopal Rao drew attention to the progressive falling off in the income of the Union from receipts of subscriptions.

The Secretary-Treasurer explained that this was owing to many members being in arrears for considerable periods.

Dr. Gopal Rao desired to know about the Service Bureau maintained by the Union.

The Publicity Officer said that it was purely a Bureau to help members of the Union. It gave something for nothing.

The General Secretary, in requesting that the Report may be adopted, read out the concluding portions of the Report. He pointed out that the Union should thank Dr. E. V. Srinivasan for permitting the Union to make use of his premises at 32, Broadway, for its activities, Dr. T. Krishna Menon, Publicity Officer, for his strenuous efforts in managing the *Bulletin*, and Mr. K. Gopalakrishna Rao, Accountant and Auditor, for his services to the Union in auditing the accounts of the Union free of all charges.

The Report was adopted unanimously.

The next item on the Agenda was the election of the Office-bearers for the year 1934-35. The following were elected:—

President.

Dr. E. V. Srinivasan

Vice-Presidents.

Dr. U. Rama Rao

„ T. Satakopan

Secretaries.

Dr. P. Rama Rao

„ K. C. Paul

*All the above were elected
unanimously.*

Members of the Council.

Dr. V. Govindarajulu
 „ P. Govinda Rao
 „ Mrs. L. Jacob
 „ T. Krishna Menon
 „ M. Krishnamurthi
 „ C. R. Krishna Pillay
 „ C. R. Krishnaswami
 „ U. K. L. Narayana Rao
 „ P. Natesan
 „ V. D. Nimbkar
 „ S. Rajagopal
 „ M. Sanjiva Rao

Elected by ballot.

The General Secretary moved

“That a sum of One Thousand Rupees be transferred from the Savings Bank Account (Indian Bank) of the Union to the Current Account (Indian Bank) of the Union.”

The resolution was seconded by Dr. P. Natesan, and was carried unanimously.

The Chairman next called upon Dr. U. D. Gopal Rao to move the resolution standing against his name.

Dr. Gopal Rao moved that

“As the editors' criticism on “the recruitment of honorary medical staff” contained in the May issue of the *Bulletin* of the Union, on page 124, lines 3, 4, 5, and 6, which runs thus—“Instances are not wanting when men with lesser qualifications have been appointed in spite of the fact that better qualified men were available”, level against the status of the medical licentiates who are members of the South Indian Medical Union and some of whom have been appointed as honoraries in the City hospitals, the Union while strongly protesting against the criticisms, is of opinion that the action of the editors in this respect is unwanted, uncalled for, and undermining the policy of the Union.”

In moving the resolution, Dr. Gopal-Rao discoursed at length on the impriety of the criticism on the ground that as such criticism is likely to affect adversely on the members of the Union who hold lesser qualifications and who have been appointed as honorary medical officers, even though the Government had acted against the principles contained in their order, the organ of the Union should not point out to the Government that they had gone against their own order.

Dr. T. Krishna Menon seconded the resolution. He said that he was seconding it so that it may be discussed by the members, and not because he was in sympathy with it. He remarked also that in his opinion such resolutions were moved because of the class feeling which the Union was trying to dispel, still existing in the minds of some members of the Union. He personally believed that there was no inferiority or superiority among medical practitioners, that all practitioners had an equal status.

Dr. C. R. Krishna Pillay opposed the resolution. He could not find anything in the criticism the editors had made that was derogatory to the interests of the licentiates.

Dr. P. S. Kuppuswamy said that the resolution was based on fallacious arguments, and was unnecessary. He drew the attention of the members to the work done by the editors, which was of an honorary nature and often was none too easy to carry out.

Dr. P. Govinda Rao said that the editors' criticisms referred to were justified, and the resolution should be opposed.

Dr. M. Krishnamurthi remarked that the licentiates were in no way inferior as doctors, but for teaching appointment high academic qualifications were necessary, and that the

Union should insist upon a policy of highly qualified individuals being appointed to honorary places in such hospitals as the Government Royapuram Hospital.

Dr. T. Satakopan said the Editorial Board was guided in such criticisms as they made by the memoranda which the Union had submitted to the Government on the appointment of honorary medical officers. These memoranda contained the carefully thought out policy of the Union. The criticisms referred to by Dr. Gopal Rao were made in accordance with the subject-matter of these memoranda.

Dr. Gopal Rao, in replying, pointed out that the Union had previously passed resolution requesting the Government to appoint licentiates in teaching hospitals as honorary medical officers. He asked of the members to support his resolution.

The Chairman applied the closure, and the resolution was put to vote, 16 voted against the resolution, 1 for the resolution, and 11 remained neutral.

Owing to the lateness of the hour, the meeting was adjourned.

ADJOURNED ANNUAL MEETING.

The Adjourned Annual Meeting of the South Indian Medical Union was held on Monday, the 10th September 1934, at 6-30 p. m. at 32, Broadway,

Dr. E. V. Srinivasan, the President, took the chair.

The Chairman called upon Dr. U. D. Gopal Rao to move the second resolution standing against his name

Dr. U. D. Gopal Rao moved that—

“The South Indian Medical Union thanks the Government of Madras for their forward policy of maintaining a uniform standard of medical education

by not only raising the medical licentiates' course to 5 years but by appointing them as honoraries in the City hospitals.”

Dr. P. Rama Rao seconded the resolution.

Dr. V. D. Nimbkar proposed an amendment “that the Government of Madras be requested to speed up the raising up of the standard of education in the medical schools so that there will be no inequality in the standards in the medical colleges and in the medical schools.”

Dr. C. R. Krishna Pillay seconded the amendment.

Dr. U. Krishna Rao suggested that the amended resolution should read as follows:—

“The South Indian Medical Union thanks the Government of Madras for their forward policy in medical education by not only raising the medical licentiates' course to 5 years, but also by appointing them as honoraries in the City hospitals, and requests the Government of Madras to raise the standard of education in the medical schools speedily to that prevailing in the medical colleges and thus make the Licentiates and the Graduates equal in status.”

Dr. Nimbkar accepted the amendment proposed by Dr. Krishna Rao. Dr. U. D. Gopal Rao agreed to the amendment.

Dr. T. Satakopan opposed the amendment and the resolution. He said that he found no cause for thanking the Government. The Government had done next to nothing, and deserved no thanks.

Dr. K. C. Paul supported the amendment. He remarked that the Government deserved the thanks of the Union for what they had done, even though what they did was little enough.

But he did not find cause enough to thank the Government for appointing licentiates as honoraries.

The resolution, as amended by Dr. Krishna Rao, was put to vote, and declared carried. Eight voted for the resolution, and 2 against.

The Chairman asked Dr. Gopal Rao to move the next resolution standing against his name.

Dr. Gopal Rao moved that—

“The South Indian Medical Union requests the Government of Madras and the Corporation of Madras to give facilities for the supply of small-pox lymph and cholera vaccine free of all charges to the members of the independent medical profession whenever they apply for the same with a declaration that such vaccines would be used for the benefit of the public.”

Dr. V. D. Nimbkar seconded the resolution.

A discussion arose in which several members took part. It was agreed in the end that the General Secretary be authorised to send a letter to the Health Officer, Corporation of Madras, stating that a member of the Union was refused small-pox lymph when he asked for the same for use in cases he was attending on, and requesting that small-pox lymph and cholera vaccine be supplied to every medical practitioner on request provided that they undertake to intimate the names and particulars of the persons for whom the lymph and the vaccine are intended.

The Chairman next called upon Dr. M. Sanjiva Rao to move the resolution of which he had given notice.

Dr. M. Sanjiva Rao moved that—

“A Standing Honorary Committee be appointed, consisting of five members, of whom the General Secretary shall be an *ex-officio* member, two

members elected from the Council, and two members from the General Body.

“The said Committee shall be in charge of all questions relating to the honorary medical officers, and shall supply all necessary information from time to time to the members through the *Bulletin* or otherwise.”

Dr. M. R. Bail seconded the resolution.

Dr. U. Krishna Rao said that there was no need for the appointment of a standing honorary committee as the Council of the Union was composed in the main of honorary medical officers who could enquire into all questions concerning the honoraries.

Dr. T. Satakopan opposed the appointment of a honorary committee on the plea that such committees were appointed before without any tangible result.

Various amendments were proposed, but in the end Dr. P. Rama Rao's amendment—

“A standing honorary committee be appointed, consisting of five members, of whom the General Secretary shall be an *ex-officio* member, and the rest be elected by the General Body.

“The said Committee, etc. ... otherwise.”

was put to vote.

On a poll being taken it was found that the meeting was equally divided on the amendment. The amendment was declared carried by the Chairman who gave his casting vote in its favour.

The original resolution of Dr. Sanjiva Rao was put to vote, and declared lost. The amended resolution was put to vote and declared carried.

With a vote of thanks to the Chairman the meeting terminated.