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Stricture of the Urethra

C R KRISHNASAWMY, M B; M S.

Honorary Surgeon, Govt Royapuram Hospital, Madras

Stricture of the urethra is a very common malady The normal urethra is a tube with its walls always in apposition except when permitting urine to flow through or allow the passing of an instrument. Anything which interferes with the available lumen in the urethra or anything which interferes with the dilatability of the urethra, must be deemed as a factor contributory to stricture formation.

The text book classification of strictures is

(1) The congestive
(2) The spasmodic
and (3) The organic.

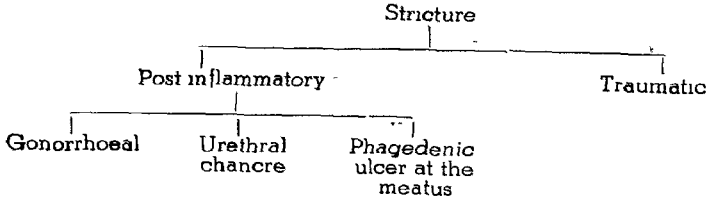
The spasmodic types are those associated with inflammatory affections of the rectum and anus. The post-operative retention after operations on the rectum and anus, is also of this type The congestive stricture is the one due to the oedema of the mucous membrane as a result of acute inflammatory conditions of the urethra e g gonorrhea

In both these types when retention of urine occurs it is not due to any permanent organic lesion but to spasm and congestion which are only of a temporary nature and pass off after a time. It is really a misnomer to call these, strictures But congestion and spasm are of importance being the final factors in bringing about acute retention in cases of an organic stricture, because no stricture is so tight as to bring about complete stoppage of urine

The commonest seat of organic stricture is at or about the bulb; being the most dependent part of the fixed curve of the urethra, the discharges of an urethritis tends to collect there and the resulting inflammation leads to denudation of the mucous membrane, scar tissue formation, and later organic narrowing of the lumen The penile part of the urethra is not however immune to the formation of strictures

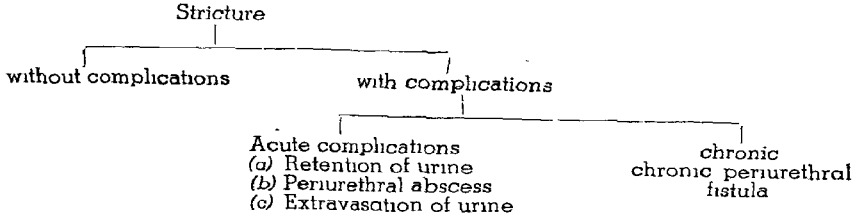
There are various terms used in describing strictures. They are. annular when the scar tissue involves the whole circumference of the urethra at one point, and bridle shaped when only one part of the circumference is involved viz, the roof or the floor or one of the sides. The term, ribbon shaped, is used when the scar tissue involves a certain length of the urethra.

The causes of stricture formation are schematically represented as follows.



The traumatic strictures are comparatively rare.

The patient with the usual post inflammatory stricture comes to you either with or without complications and the complications may be either of an acute type or chronic type and can be schematically represented as below.



A patient with a well developed stricture may come in with just a history of getting up once or twice in the night to pass water, or he may complain that the force of the stream is not so strong as before This diminished force of the stream is the symptom *par excellance* of a stricture of the urethra. In addition there is a history of the patient having to strain to pass urine. The usual symptom so often mentioned by students i e, the thin small stream or a forked stream is not really characteristic. These changes in the stream occur only when there is a mental stricture and will not be present even in a dense stricture at the bulb as long as the meatus is unaffected

The diagnosis is confirmed when there is a little difficulty in the passing of a No 7 size soft rubber catheter At this stage I like to lay special stress on the importance of washing out the urethra prior to any instrumentation; the lotion I use for this purpose is acriflavine, one in 1000 in saline

The so called catheter fever of former days was almost always due to the manifestation of mild sepsis from instrumentation in an unclean urethra This can be avoided by washing the urethra two or three times previous to the introduction of the catheter with the above mentioned acriflavine solution.

As a lubricant I prefer liquid paraffin to the messy vaseline usually presented to one Tragacanth solution or the proprietory Lubafax for those who can afford it are also very good, being easily washable. A fact not commonly realised is, that the catheter needs to be

lubricated only at its tip The urethra does not need any lubricant to facilitate the passage of any instrument through it, when once it has passed the meatus Easy gliding of an urethral instrument is hampered by the invagination of the glans by the instrument, and a little smearing of the meatus with the lubricant solves this difficulty

When the No 7 size catheter cannot be passed and gets stuck in the passage we diagnose a stricture. The majority of the strictures is at the bulb, a distance of 5 to 5½" from the meatus When a stricture has thus been diagnosed it is wise to ask the patient to have a lavage for a few days so that the hydrostatic pressure thus brought about might help in the relief of the obstruction and in dilating the stricture

For purposes of dilatation my favourite instrument is the Lister's solid bougie Because of its olivery head we are able to dilate the urethra to three sizes with the passage of one bougie, as the olive head is size 7 and at the shoulder it is size 10 A bougie with a uniform calibre cannot accomplish this In passing the bougie I stand on the left side of the patient as being the more convenient position Proceeding, the penis is grasped behind the glans, the tip of the instrument passed into the meatus with the shaft of the instrument lying parallel with the Poupart's ligament, and the most important point to bear in mind is, that the penis must be made to climb over the instrument and not the instrument forced down the urethra For purposes of easy remembrance bear this formula in mind "Never push, but always pull." After reaching the bulb, the handle of the instrument is carried to the patients' abdomen, and onwards to the middle line and gradually raised thereafter. As the point passes down into the bulbous urethra, the usual site of stricture, the left hand leaves the penis and the fingers are used to support the perineum and at the same time guide the instrument along the urethra. The instrument now passes into the membranous urethra as the handle becomes vertical and swings downwards, and with a little further depression of the handle between the thighs, the point of the instrument enters the bladder. A finger in the rectum is a very great help and also prevents the formation of a false passage I prefer to carry out this procedure without a general anaesthetic and I recommend it as the safer method. However two solutions are used for local anaesthetic purposes, one the well known Canny Ryall's solution and the other made up from Alypin tablets,

In cases where one finds it impossible to pass an instrument the first time, a second attempt must be made about 2 or 3 days later, and when necessary a third or even fourth attempt. I can recall an interesting case in which, after four attempts at dilatation, on the fifth occasion, when all arrangements had been made for an external urethrotomy, the instrument passed in easily, avoiding an annoying operation.

In very dense strictures, when an instrument cannot be passed at all, a very useful method is the employment of the fine filiform bougies After the preliminary washing, the filiform bougie is passed and twirling manipulations of the bougie might make it enter the opening in the stricture and allow its further passage In cases where the first one does not enter the opening, a second or a third bougie is passed along side (the faggot method) and one may finally enter the lumen at the point of stricture Once it has been passed, it is left there for forty-eight hours and at

the end of this time, the stricture will have so softened as to allow the passage of ordinary instruments thereafter for dilatation

In the choice of bougies in the treatment of stricture, only three or four are essential i.e. from 7-10 to 11-14, very occasionally is 6-9 bougie used, but any lower size should never be used The smaller the instrument the greater are the chances of a false passage.

Operative methods of treatment can easily be avoided. Internal urethrotomy is only possible when a 4 or 5 size instrument can be passed Therefore such strictures can easily be tackled by the ordinary methods with patience and perseverance Internal urethrotomy may be considered probably in cases of resilient strictures, where though the stricture is readily dilated it quickly contracts

External urethrotomy is indicated in impassable strictures i e strictures which do not at all allow the passage of any instrument This operation is to be avoided as far as possible and it is quite possible to avoid it

In the treatment of strictures of the penile part of the urethra, straight sounds are ever so much preferable to the curved instruments, for a curved bougie presses to one side of the stricture when force is applied, and may easily cause a false passage

Periurethral abscess, a common complication of urethral stricture is really due to a minute extravasation with the subsequent formation of an abscess Incision of the abscess relieves the condition Extravasation of urine is combated by multiple incisions into the affected tissues and a suprapubic draining of the bladder A Kidd's trocar and cannula and a de Pezzer's catheter are useful instruments for this procedure. After the inflammation has subsided routine dilatation of the urethra may be commenced

Chronic periurethral fistulae where the urine sprays out in the perineum, as from the rose of a watering can, can be alleviated only after many sittings

I have not gone into the details of operative procedures as I honestly feel that the great majority of strictures can be treated by dilatation alone, if persevered with patience But I would feel more than amply compensated if I had been able to impress on your minds this evening, some of those detailed precautions which I have enumerated, and which I feel are so essential for a successful management of a case of stricture of the urethra

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DISCUSSION

Dr M Krishnamurthi enquired of the lecturer whether suprapubic cystotomy and perineal urethra were useful procedures in those cases of dense strictures where the scar tissue extended along the greater length of the urethra He also wanted to know whether the lecturer preferred preliminary suprapubic drainage for cases of stricture associated with cystitis, uraemia etc.

Dr P. Natesan said that over 300 cases of stricture were being treated every year in Govt Royapuram Hospital in the Venereal section and in no case has a urethrotomy been found necessary Even in cases of failure on the first occasion (in passing a sound) second attempt or sometimes third have always been crowned with success He also mentioned that instruments

over and above the size 11-14, although sold on the market, were not at all necessary

Dr. V C Sudarsanam mentioned the advantage of diathermy to the stricture area in making an impassable stricture a passable one

Dr P T Raghavachary wanted to know the details of the intervals in dilatation of a stricture

Dr P Govinda Rau said the lecturer of the evening was preeminently suited to talk on the subject of stricture of the urethra The lecture was full of practical points and very helpful

It had been mentioned that the bulb of the urethra because of its being the most dependent part was most affected by stricture. Thomson-Walker had suggested that the more probable reason was, it was the point on the fixed curve of the urethra where the force of the urine ejected from the bladder did the most damage (cf aneurysm of the arch of the aorta)

As regards anaesthesia for dilatation of a stricture he suggested the use of sacral anaesthesia. He had seen its occasional use in the venereal department of the General Hospital for this purpose

One common difficulty was to correlate the French and the English scales as applied to catheters and Bougies The numbers on the French or Charriere scale (as they are called sometimes) denote the external circumferential measurement in millimetres The American scale is two-thirds the French scale and the English scale is two divisions less than the American, 12 English being the same as 14 American

The three scales may be summarised as follows.

French scale of 21 (=circumference in mm)

American scale 14 (2-3 of French).

English scale 12 (2 less than the American)

He again referred to the great practical value of the lecture

Dr E V Srinivasan wanted to know from the lecturer whether any contrivances similar to the laminaria tents used in obstetrics, word help in dilating urethral strictures

Dr C R Krishnaswami in reply said that a preliminary suprapubic drainage was essential in dealing with cases of stricture associated with cystitis, high blood area, etc In stressing the danger of using larger instruments, he referred to the Kollmann's dilator and condemned its use As for the intervals between successive dilatations he referred to the quotation in Hamilton Bailey's book ' once a day for the first week, once a week for the first month and once a month for the first year " He did not agree with this dictum in its entirety and he said that in the beginning the dilatations are to be done once in 4 to 5 days but subsequent intervals of dilatation depended on the merits of the case such as difficult dilatability or quick recurrence of difficult micturition due to early contraction of the stricture after its previous dilatation In spite of the saying "once a stricture, always a stricture" a period of three years is generally a sufficient period for the successful treatment of stricture in the majority of cases

Dr T Satakopan concluded the meeting after congratulating the lecturer on his brilliant exposition of the subject and thanked him and the members, who had turned up in large numbers to hear the well-known surgeon

Conditions of General Medical Practice

Most of our members remember the *Questionaire* sent to us by the Bombay Medical Union to be circulated amongst our members with a view to inquire into the conditions of General Medical Practice. Although here, there was little or no response, the Bombay Medi cal Union itself received replies and a Sub-committee considered them and have submitted a report As the report will be found interesting to the majority of our members we have published it in full.

Conditions of Medical Practice in Bombay

The Sub-Committee consisting of:—

Dr V. G. Rele, *(Chairman)*
Dr S. P Kapadia,
Dr B B. Yodh,
Dr N J Modi,
Dr Geo. Coelho,

was appointed by the Managing committee on 23rd February, 1939 to report on the replies received to the "Questionnaire" sent by the Bombay Medical Union

2. The Questionnaire was answered by 71 persons of whom 48 are members of the Union Among those that sent replies 64 are practising in the City and Suburbs and 7 outside these limits. Other bodies like.

(1) Delhi Medical Association,
(2) Bagalkot Medical Union,
(3) Broach Medical Society

were also interested in the Questionnaire and sent replies

3. The hours of work are divided into two series by those who keep a dispensary. The morning session is from 8-30 to 11-30 and the afternoon 5-30 to 8 The majority seems to be satisfied with these hours The patients are visited at all hours of the day,—whether they be dispensary hours or not

4 The charges for medicine vary from annas 8 to Re 1 for a day's mixture and from annas 2 to annas 8 for powders The charges for Dressing vary from Re 1 to Rs 5 The fees for visits vary from Rs 2 to Rs 5 with those who keep dispensaries With the exception of a few, the bulk do not charge for consultation Those that do not dispense medicines charge for consultation and these fees vary from Rs 10 to Rs 20 for a visit All charge extra for injections if they are done in the dispensaries or rooms while there is no uniformity regarding extra charges if the doctor pays a visit to the patient

5 There is not much dissatisfaction at the above rates Some say they practise in poor areas where even these fees seem high There is no desire for raising these charges and even in those cases where a lurking suspicion may be seen, it is smothered by the force of circumstances

6 The reply to the question Whether fees should be charged in the dispensary?" is preponderatingly in the affirmative, but no suggestions regarding the amount of these are forthcoming Likewise it seems nearly the universal opinion that fees should be

graded according to seniority of practice, though a few say it will be difficult to work this out

7 Very few doctors have a holiday Those in years of practice still cannot get away But they all want to All think that they would like to have a holiday; some ask for a month, some ask for a fortnight twice a year

8 The practice of taking half holiday once a week is gradually spreading Majority wish that there should be the same day for everybody

9. Regarding consulting practice the general feeling is that there is nothing like consultation practice The general practitioners complain that the 'consultants' see cases on their own, keep assistants who do the job of giving injections etc This they submit, should not be done. A Consultant should only see a patient in consultation with a Doctor and never by himself He should not keep an assistant

The majority think that persons belonging to those countries who do not give reciprocity should not be allowed to practise in our country

A few complain of Hakims, Vaids and unqualified Homeopaths

10 There is also uniformity of opinion on treatment of well-to-do patients at public free hospitals These patients should not be admitted into the hospitals and if admitted should be charged heavily

Recommendations

11 The Sub-Committee after considering the above, is of opinion that the medical fraternity should be roused to action by greater propaganda and for this purpose suggest that a meeting of the medical profession should be held to discuss these points and create enthusiasm

12 They are of opinion that regarding sessions of work it would be advisable to have one long session and the other short one The short session will only deal with acute cases and may not last more than an hour We do not think that a doctor's work increases according to the number of hours he spends in the dispensary Idle hours in the dispensary are likely to set up ennui and a feeling of discontent We suggest that 2 to 2½ hours in the morning and an hour say 6 to 7 in the evening would be better The time of the short session should be completely devoted to the dispensary and no visits be undertaken during that time

13 Certain parts of the City observe a whole day holiday or half a day once a week. This should be universal, it is better to fix one common day like Sunday when the doctor will have some chance of spending his free evening in a social way It has been found that the objection to this half a day closing has mostly come from senior practitioners and an appeal could be sent round urging all to join The doctors will always be available for urgent calls

14 We are of opinion that a beginning should be made so far as charging consulting fees are concerned. The poverty of our people is always mentioned But the charges can be made to suit the locality Such charges will increase the income of the doctor, will really instal him as a medical man and not as a chemist and relieve him of unnecessary attentions of the relatives of the patient who expect quick results and want the doctor to change the treat-

ment twice a day We would suggest a single minimum consultation fee which may be repeated at next consultation or not This consultation fee may be raised according to the locality. We may mention that many lady doctors charge extra for a vaginal examination and that is willingly paid If this particular examination is charged, one fails to see why a complete examination of the patient should not also be charged.

15. The Sub-Committee also strongly recommends that there should be a variation of fees according to seniority. The Union must carry on sufficient propaganda to bring moral pressure on the senior practitioners to raise their fees The present state of fees for visits is so low that we cannot advise the beginners to accept a lower fee The beginner will not get more work by lowering his fee while the senior is wanted by a good many and some of them will pay his higher fees to get the benefit of his advice It is the raising of the fees that raises the prestige of the man, and has a psychological action on the patient. The present system where a raw graduate charges Rs 2 per visit and an old practitioner who has no time to eat his food also charges Rs 2, where a fresh graduate with a foreign qualification charges Rs. 20 for a visit while his senior also does the same, must be changed In Calcutta the fees vary from Rs 4 to Rs 64 and there are patients who pay them By the seniors raising the fees there is a chance of the work being better distributed.

16 An increase in the income will facilitate the Annual Holiday It is so common to hear that so and so has worked for 20 years without a day's holiday This is neither in the interest of the doctor nor of the patient With a large influx of fresh graduates who are now on the loose end it should not be difficult to get a *locum tenens* for a general practitioner By charging a small consultation fee and by raising the fees for visits an Annual Holiday will come within the reach of many a doctor

17. A source of extra income for a good many doctors seems to be the examinations of lives for insurance The Union has already sent its protest against the lowering of the fees We would also urge upon the attention of the Union to the present unsatisfactory state of affairs where a doctor is under the thumb of the agent for getting insurance work This forces the doctor to connive at many a thing he would not do if he were assured of the support of the Company

18. There is a strong feeling against the methods of the "Consultants' The common opinion seems to be that a Consultant should not see a case without an introduction from a doctor. This is an ideal interpretation of the term "Consultant"; but as far as we are aware this does not exist in any part of the world There is always a small group of patients who see the Consultant directly without a middle man The more practical conception of a "Consultant"; would be that of a person who would be approached for opinion in case of difficulty It cannot be laid down that a Consultant should not see a case directly but it can be laid down that as far as possible he should not see any patient on his own and this he should particularly avoid when he knows that the patient has a general practitioner treating him

Laboratories,—X-ray Outfits, Electrocardiographs are the armamentaria to arrive at correct diagnosis and to appre-

ciate the progress of a disease. One cannot reasonably object to a Consultant having these at his disposal by owning them or running them himself with the aid of an assistant. The laboratories should not be used to furnish reports for outside patients nor X-ray apparatus be used to take plates for patients that are not his What we mean is, that a Consulting Physician should not receive only blood or urine or take a patient for an X-ray without seeing the patient Further the specialist in these branches of diagnosis will still remain so and will get his share of work when an expert opinion is desired and they too will be raised to the standard of the Consultants To obviate the financial loss that is bound to accrue, it is advisable that teams may be formed consisting of these various units and the proportionate fees be charged to the patients The position of the Surgeon should be likewise

We are of opinion that consultant should not have an assistant te give his injections etc, as there is a danger of his retaining the work that should legitimately go to the general practitioner.

Regarding electric treatment like ultra-violet rays, diathermy, short waves and also injections, a consultant shall not offer his services unless he finds the patient and the general practitioner wish him to carry it out after pointing out to them where else such treatment is available When a patient comes directly the consultant has as much right to utilize the means at his disposal as anybody else

19. We entirely agree that rich patients should not be treated in free hospitals and dispensaries, whether they are supported by the Government or Municipal rate-payers or private benefactions But here "rich" is a relative term For instance, there is no need to admit a person earning Rs 100 a month suffering from malaria for 2 days in a hospital But we should certainly admit him for a major abdominal operation or a serious illness like typhoid fever. Those earning Rs. 1,000 per month should not be admitted into a hospital unless there is a nursing home attached so that they can be charged proportionately.

20. The Out-Patient Department is also over-crowded by people many of whom can afford to pay for advice and treatment The general practitioner legitimately feels that a good bit of work is taken away from him Introduction of the system of almoners would help in the solution of this problem

21. To carry out any of the above recommendations we must carry the profession with us But never has any movement got the majority at once. We must make a beginning and for that purpose contact with the profession must be established by calling frequent meetings and discussions Then the issue will be crystallised and progress will be possible.

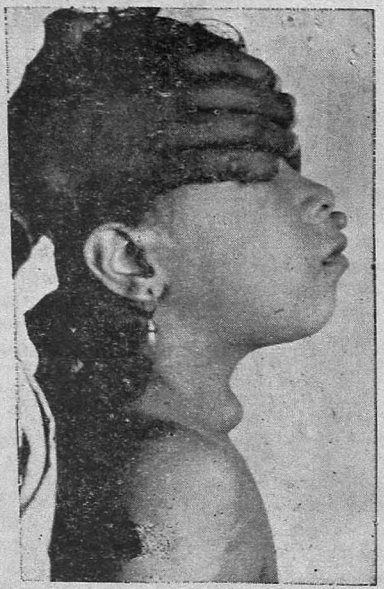
Sd. V G. Rele.
Sd. S P Kapadia
Sd. B B Yodh.
Sd N I. Modi
Sd Geo. Coelho

A Rare Type of Branchial Cyst

Dr. K. C. NAMBIAR, M.B., B.S., F.R.C.S., (Eng. & Edin.)

Hon. Surgeon, Govt. General Hospital, Madras

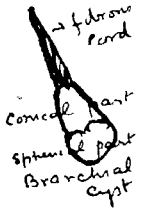
A girl named L aged about 8 years was admitted into my ward for a small lump in the lower part of the neck, on the right side, just lateral to the insertion of the sternomastoid, in the angle between the sternomastoid and the clavicle. The lump is said to have made its appearance from birth, gradually but steadily growing, and now remaining stationary. The patient gave no history of pain, no temperature, no bursting, and no complaint regarding this lump. She has been brought for operative removal of this lump entirely on cosmetic grounds.



On examination, she presented a smooth soft rounded swelling, of the size of a marble 1.5 c.m. in diameter; situated just above the the right sternoclavicular joint, cystic in nature and fluctuating to the fingers, not adherent to the skin, nor the surrounding structures, movable slightly from side to side, but not from above downwards; not translucent, nor warm to the touch and no discharging sinus on top of it. Further examination of the chest and throat showed no evidence of a tubercular or septic foci. The absence of periadenitis, history from birth, and

general condition of the patient was against its being tuberculous in origin Branchial cyst has never been known to occur in the lower part of the neck; but always presented itself in the upper part of the side of the neck partly underneath the sternomastoid and partly behind the angle of the jaw, whether it was superficial or the deep type; according as it arises from the external or the internal aspect of the branchial cleft Absence of attachment to the skin and occurrence from birth were points against its being a sebaceous cyst Therefore I clinically diagnosed it as a lateral dermoid in the neck before operation and pathological report

The cyst was approached by a horizontal incision above the right clavicle Skin, fascia, platysma etc, were divided, and the sternomastoid retracted It was bluish in colour and consisted of a spherical part and on the top of it a conical lump up wards as is shown in the diagram below I traced the



conical lump upwards and found it gradually merge into a thick band of fibrous tissue This fibrous tissue was traced in its turn upwards behind the posterior border of the sternomastoid as far as the greater cornu of the hyoid bone.

The cyst contained about 5 c c. of thick, dark, muddy looking fluid, which when floated on water showed glistening crystals of cholesterol. The cyst-wall was sent to the pathologist, who reported it as consisting of lymphoid tissue and columnar epithelium, surrounded by a thick lining of fibrous tissue Therfore the diagnosis of branchial cyst was made beyond doubt.

The interest of this case consist in the fact that branchial cyst has never been noticed in this site so much so some have suggested that branchial cyst can never occur in the lower part of the neck But it is a curious fact that the above-mentioned spot is the commonst site for branchial fistulae; and one cannot guess why these cysts which are of the same origin cannot occur at this spot

Abstracts and Notes

INDICATIONS FOR REMOVAL OF TONSILS AND ADENOIDS IN CHILDREN

Sir Lancelot Barrington-Ward: *Journal of Royal Society of Medicine* March 1, 1940

The term "tonsils and adenoids" is used rather loosely for a common condition in children without differentiation between the relative importance of tonsils and adenoids. The tonsil is the more dangerous element, and its structure allows organisms to lie dormant, to remain moderately but continuously active, leading to chronic general poisoning, or flare-up into acute inflammation at indefinite intervals. Adenoids, on the other hand, only act mechanically by obstructing normal respiration or by a lowgrade infection causing inflammation of the ear or certain cervical glands The importance of adenoids is greatest in the earlier years of life and they may require removal within the first few months In later years, if adenoids are present, the tonsils are usually affected as well, and it is wise to deal with both If adenoids only are removed and septic tonsils are left behind, adenoids are very likely to grow again

Mere size of a tonsil is not an indication for its removal, unless by reason of its size it is injuring the patient Sometimes a persistent cough, with all other causes excluded, may justify interference, but this is rare More commonly there is actual obstruction to the food and air passages A septic tonsil, whether large or small, is a menace to its owner, and should always be removed.

Among the direct effects of septic tonsils are:—

1 Repeated tonsillitis. If a child suffers from sore throat from time to time, with or without fever, it is wiser to take a long view and realize that the only certain way of stopping further attacks is to remove the tonsils The tonsil is low-grade tissue with a poor blood supply, with little power of recovery and difficult to disinfect Organisms lie latent in its recesses for long periods of time, as is well shown in diphtheria carriers Tonsillitis in children is one of the commonest causes of unexplained pyrexia, and it is a frequent cause of abdominal pain.

2 Chronic enlargement of the upper deep cervical lymphatic gland: (Wood's tonsillar gland) on one or both sides of the neck, without enlargement of other glands, always indicates a tonsil infection In the treatment of tuberculous glands, whether radical or conservative, removal of the tonsils is an essential stage

3. Otitis media with its sequences, mastoiditis and deafness, are in the majority of instances, the result of nasopharyngeal catarrh secondary to infected tonsils and adenoids.

In some, the tonsil can be blamed indirectly only as the portal of entry of a specific organism, and to remove the tonsil after the damage is done is useless It is only reasonable to perform tonsillectomy in such a case if there is continued infection or reinfection. *Rheumatism* with its associated conditions, heart disease and chorea, is a good example There is some evidence that rheumatism is less likely to

attack individuals, who have undergone tonsillectomy but the influence of the tonsils in precipitating a relapse is even more striking and more easily proved *Nephritis* is another disease which in many cases is secondary to tonsillitis, and although grave damage has already been done, further injury can be arrested by timely attention to the source of infection *Chronic sepsis* may have a wider effect Any child of poor nutrition and stamina may suffer from such a condition as enuresis, which is cured by restoring the general body tone, and it may be that infected tonsils are playing their part and require attention.

The least definite of all indications, and perhaps the one that has brought the most disappointment with the operation, is recurrent or persistent nasopharyngeal catarrh and the common cold If a patient is subject to colds, and if every cold starts with a sore throat, there is reason to remove the tonsils in the hope of preventing further attacks Experience shows that this is successful in the majority of cases, but complete immunity cannot be guaranteed In the more frequent form, where the child every winter develops a persistent stuffy catarrh of the nose and throat, it is possible that the sinuses are affected, or there may be some general metabolic fault, and tonsillectomy is useless

TREATMENT OF CANCER

Editorial. *Calcutta Medical Journal*, Sept, 1939

It is an unfortunate fact that India is no less affected with cancer than the rest of the civilised world Indeed in certain situations cancer would appear to be even more prevalent in India than in Europe. At the present moment there exist a sense of defeatism amongst the members of the profession as to the possibilities of treatment of cancer. In some cases their sentiments are reflected on to the patients and a feeling of despondency and mistrust is thus created It is time therefore that members of the medical profession should educate themselves and their patients as to the possibilities of the treatment of cancer

Cancer is a disease that might exist in many situations in the body, internal or external In the early stages, in quite a high percentage of cases it is a curable malady In many instances, even quite advanced cases of cancer can be cured, or when this is not possible, given relief for very considerable periods of time during which they might carry out their avocations

The method of treatment of cancer may be divided into two main groups, those in which radical excision of the growth by means of surgery is adopted, and those in which radiotherapy plays the major if not entire part These methods may in some cases be combined It has been found that in such conditions as cancer of the gastrointestinal tract, radiation has proved of little or no value, with the possible exception of carcinoma of the rectum. In other situations such as the breast, in many early cases radiation alone by a combination of radium and deep X-ray therapy has proved effective In the majority of these cases of cancer of the breast, however, the consensus of modern opinion is that the best results are obtained by a combination of radical operation and deep X-ray therapy. In some situations, such as the cervix uteri, radiation by means of radium alone, or a combination of radium and deep X-ray therapy, has almost entirely displaced operative methods The

reasons for this are obvious. In the first place the high initial mortality in Wertheim's operation, namely 40 per cent, is reduced to nil; in the second, the five year survival figures equal those of Wertheim's operation in the hands of its most skilful exponents

In recent years, in a certain limited number of cases of small growths superficially placed and readily accessible, a form of short distance low voltage therapy, also known as "Chaoul therapy", or "contact therapy" has been found to be effective This method is one which employs an X-ray tube specially constructed so that the focal spot can be brought up to within an inch or two of the lesion It must be emphasized that though this method of therapy is extremely useful when properly used in the right type of very superficial case, where the depth of the lesion does not exceed half an inch, it might be exceedingly harmful when improperly used, for in such cases not only will it have little or no effect in alleviating the patient's condition but it will make further more effective treatment by other means impossible. Of late an impression has gained ground in the minds of the lay public as also amongst some members of the profession that "Chaoul therapy" can cure all cases of cancer It is the duty of all those who are engaged in the treatment of cancer to try and dispel such notions from the minds of the public by impressing on them the usefulness of the treatment as well as its limitations

It is the duty of practitioners to point out to their patients that cancer is in many cases a curable disease It must also be made known to them that in cases where radical eradication of the growth is not possible or probable, efficient treatment by means of deep X-rays or radium will produce considerable alleviation of symptoms with loss of pain and discomfort, and prolongation of life.

TREATMENT OF AURICULAR FIBRILLATION WITH QUINIDINE AND STRYCHNINE SULPHATE

H L Smith & E W Boland *Journal of A M A* Sept 9, 1939

The authors report 41 cases of auricular fibrillation treated with quinidine and strychnine sulphate. The latter was found to act as synergist to quinidine In most cases 5 grains of quinidine every 3 hours and 1-40 or 1-30 grain of strychnine sulphate t d.s was administered Normal cardiac rhythm has persisted in this group, in some cases for 2 years and in a few cases four months The same dose of quinidine was continued for a few days after normal rhythm was established The authors contradict the statement that administration of quinidine causes embolism and death in patients, the incidence of mortality in their patients due to embolism not being in favour of this—only 3 deaths occurred out of 41 cases of rather severe heart disease In the opinion of the authors quinidine is specially indicated in (1) young persons who have idiopathic auricular fibrillation but who do not have any other evidence of heart disease; (2) those with minimal amount of heart disease and with auricular fibrillation of only short duration; (3) cases with hyperthyroidism with very little evidence of heart disease It is contra-indicated in (1) elderly patients with serious hypertension and coronary sclerosis with rather marked cardiac enlargement; (2) severe congestive heart failure

JOURNAL OF SOUTH INDIAN MEDICINE

SEPTEMBER, 1940

A Ray of Hope

There is a great deal of unemployment in this country Everybody is agreed on that. Well qualified medical men have more than a reasonable share in this universal unemployment The young practitioner has spent a long number of years in equipping himself with a qualification and additional practical experience And in the process he has spent a large amount of money. The Government of the country spends a further large sum in educating him for a career in medicine One could therefore easily understand the anguish of young medical men and their parents, when at the end of it all, many of these young men find themselves idle for want of opportunities for work. Many of them are distressed that they are not able to make a reasonable living. And all this happens in spite of the fact that there is said to be a dearth of qualified medical men to look after the large sick population of the country The young practitioner despairs of getting a living by the practice of his profession, and the older practitioner is distressed that when he is nearing the end of his career he has still to work hard for a mere living And he is haunted by the thought of leaving his dependents absolutely unprovided

It was in this environment that the Surgeon-General with the Government of Madras attempted to carry some solace to the young men, who are on the threshold of their career Evidently to cheer them up, he made the most of the very tenuous prospect held out by the new changes contemplated in the organization of medical relief And more he held out the hope that if the State hospitals only looked after the sick poor, the richer men, will requisition the services of the practitioners outside the hospitals. Thus the latter might have better chances of getting a living We are indeed, sorry that General Wilson should have held out such hopes For knowing the conditions as they are, it is a vain hope that the rich will as a class realize the justice of the contention that the State hospitals should chiefly look after the poor and needy. It has been the experience of those who have had anything to do with these hospitals that many of those patients who occupy the beds which are so sorely needed by the large indigent population, really come from the trader classes. And many who come from the mofussil own much property. We do not now attempt to apportion the blame between those concerned. But we are sorry to note that some of the dailies of Madras should have come out with criticism

even against such a reasonabl esuggestion from the Surgeon-General.

It is contended by the critics that the rich pay taxes as well as the poor, and since the hospitals are run with the funds collected as rates and taxes, the rich have as much claim as the poor to be looked after, in the hospitals It is true that the rich pay more taxes than the poor, but it is never strictly in proportion to their incomes The taxes that the poor pay, bear a larger ratio to their incomes than those of the rich. It is only fair therefore that the rich should not encroach on the facilities provided by the State Institutions meant primarily for the benefit of those who cannot afford them. The rich certainly have a claim on the State for the proper provision of facilities for medical relief This the State does, by providing competent medical men. The Government of the land spends large sums of money in training qualified medical men The rich cannot therefore complain if the State compels them to avail themselves of the services of the practitioners outside the hospitals.

In countries where the rich pay more taxes, the Governments do not provide free hospitals for them. All the effort there, is, to provide for the poor The rich make their own arrangements for medical help. Why then should they, in this country alone, claim such privileges from the Government

It is difficult to appreciate the arguments of the advocates of the rich. When the Government bring out measures to curtail the privilege of private practice of the Government Medical men, there is a huge cry that the skill of the hospital doctors should be made available for the rich, who seek their services outside the hospitals. And on the other hand, when a suggestion is made that the rich should get treated outside the hospital, it is said that the facilities of hospitals should not be denied to them

In all these arguments, the critics forget that if the necessary expansion of medical relief for the poor is to be undertaken, some restriction has to be placed some where. It is certainly better that those who can afford to pay for the services of doctors outside the hospitals should help the Government by not utilising the State hospitals to the extent that is at present done

Apart from what some of these critics say we are confident that the richer classes will realise to an increasing extent the soundness of the Surgeon-General's advice.

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Association Notes

PROCEEDINGS OF THE COUNCIL OF THE SOUTH INDIAN MEDICAL UNION

Minutes of the meeting of the Council of the Union held on Thursday the 22nd August 1940 at 6-15 p m, at No. 14-A Ritherdon Road, Vepery, Madras Members present.

Dr, T Satakopan,
" P Govinda Rau,
" P, T Raghavachary,
" Syed Niamathulla,
" J. A. S, Masilamani,
" L V, Srinivasan,
" E V, Srintvasan,
" K B Bhujanga Rau,
" N. Gangadharan,
" G Zachariah.

Dr Syed Niamathulla was in the chair

(1) The minutes of the last meeting were read and confirmed

(2) The financial statement of the month of July was presented and approved

(3) The application for membership from the following gentlemen were considered and approved

Dr B Srinivasa Rao, M B B S,
217, Thiruvothiyur High Road,
Tondyarpet, Madras

Dr. G. S Gopalan, L M P.
246, Thambu Chetty Street,
G T Madras

Dr. S. Kesavulu, M.B B.S.
497, Mint Street,
G T Madras.

(4) This Council resolves that the annual subscription of Rs. 6 (Rupees Six) for the Union includes the subscription of Rs 2 per annum for the journal

(5) With a vote of thanks to the chair the meeting was dissolved.

Correspondence

To
The Editor,
The Journal of South Indian Medicine.

Dear Sir,

Your leading article "Twilight thoughts" in the August issue of our journal this year, is likely to give the impression, that the independent medical practitioners as a whole, are pouring forth their wrath upon the honorary medical officers for all the ills of the practitioners arising from various factors, and thus creating differences among practitioners where n o n e should exist

I can never conceive of the honorary medical officers who form a very small percentage of the medical profession, being responsible for the difficult financial conditions of the practitioners. It is just possible that some practitioners might have attributed their difficulties in practice to the ways of a few honorary medical officers.

It would be regrettable and very unfair to the majority of the indepedent medical practitioners if the impression gets round that the independent practitioners are trying to create differences accusing the honorary officers for no fault of theirs

I can assure you, that the practitioners whose mind I had the opportunity of knowing from my conversations with them, bear no ill will against the honorary medical officers For after all, the honorary system was secured by the strenuous efforts of the independent practitioners, for the independent practitioners It will be like killing one's off spring if we should run down our honorary medical officers Nothing can therefore be more remote from our minds than creating differences among ourselves.

At the same time the honorary medical officers should feel that they continue to be independent practitioners even after their appointments and should not look down upon other independent practitioners So long as the honorary officers bear these facts in mind the independent medical practitioners will have no cause to complain On the contrary they will be proud that the officers selected from among themselves have contributed to the successful working of the honorary system

With such a state of relationship, I do not think there will be any possibility of differences arising amongst us

Yours truly,

17-9-40. P T Raghavachari

(We thank Dr Raghavachary for his helpful letter We are glad to learn that we have misunderstood the attitude of the independent medical practitioners We are indeed very happy that the great majority of the independent medical practitioners feel one with the honorary medical officers Editor)

Our Members

Capt V D. Nimbkar, F R C S. retires from the Government Ophthalmic Hospital after about fifteen years of service as an Honorary Ophthalmic Surgeon He is one of the few who took an active interest in the organisation of the Honorary Medical Scheme at its inception He occupies a high place in the executive of many medical and social organisations of the city A man of principles, he never sacrifices his convictions just to win popularity or praise His work in the Government Ophthalmic Hospital has always been characterised by uprightness and independence He is one of the leading members of the profession, and the present President of the South Indian Medical Union We very sincerely hope that the profession will have his guidance and support for many years to come,

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Dr P S Varadarajan, M D, M.R C P (Lond) whose term of office as Honorary Physician, Government General Hospital, has recently been terminated, is an eminent physician of the city In the hospital he was a great favourite of the students for his ever ready fund of knowledge and his *bon homie* The staff had a great regard for his erudition He continues to carry with him the good wishes of the profession and the esteem of the public The South Indian Medical Union, of which he was till recently the Vice-President, wishes him a continued career of success

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We are proud to mention that "Dr P Rama Rau, D M R (Vienna) under whom His Excellency Sir Andrew Caldecott, Governor of Ceylon, under went radiotherapeutic treatment last year, has named a free bed at his Institute after His Excellency, and has reserved its use for deserving cases from Ceylon."

The profession in Madras is very proud to know that Dr Rama Rau's Radiological Institute has attracted the attention and gained the appreciation of the high authorities of our neighbouring island, Ceylon We have reasons to believe that this spontaneous and generous appreciation has caused a certain amount of flutter in the administrative circles of this province The independent medical profession feels that the honour which has been done to one of its members is an honour to the profession itself It is in the fitness of things that Dr Rama Rau should have returned the compliment by instituting a free bed for the poor from Ceylon who may need his specialist care

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Dr G Zachariah, L R C P, M R C S, D O M S (Lond) has been appointed Honorary Surgeon, Government Ophthalmic Hospital Modest and unassuming by nature, he commands a high place in the ranks of the medical profession of the city by reason of his thoroughness in the practice of his speciality. He is an acquisition to the Government Ophthalmic Hospital.

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Dr T. Satakopan, M D. the Secretary of our Union, once again joins the staff of the General Hospital as Honorary Physician It is said that great things are expected of him, by students and staff alike He has been very energetic in furthering the scope and activities of the South Indian Medical Union of the interests of which he has always been ever watchful He is one of those who is very jealous of the rights of the independent medical profession We are sure that the reappointment of a physician of Dr. Satakopan's eminence to the premier hospital of the Presidency will add to the status and dignity of the independent medical profession of South India

NOTICE.

3rd ALL INDIA OBSTETRIC & GYNAECOLOGICAL CONGRESS.

The 3rd All India Obstetric and Gynaecological Congress will be held this year in Calcutta from the 27th to the 30th December 1940 both days inclusive.

The subjects for discussion are:

(1) Anaemia of Pregnancy,

(2) Functional Uterine Haemorrhage; and

(3) Maternity & Child-Welfare

For particulars please apply to the Joint Honorary Secretaries, The Bengal Obstetric and Gynaecological Society, 91B, Chittaranjan Avenue, Calcutta.

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Acknowledgements.

We are pleased to receive the following publications. We thank those concerned for the courtesy of sending us the same.

1. Essays on Cardiology by Dr Jai Gopal
   (I. M. J. Publications)

2 Trends in Organized Medicine by Dr A. Viswanathan
   (I M J Publications)

3. Prince of Wales Medical College Magazine, Patna

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