# The Bulletin

OF THE

# South Indian Medical Union.

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4. Medical Students and those *interested* in Medical Relief will be placed on the complimentary mailing list of the BULLETIN on application to the Publicity Section.

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# Annual Statistical Review for 1930
# King Edward's Hospital Fund for London.

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"These facts show that the vitality of the **voluntary** system is unimpaired, and has proved adequate to discharge the heavier tasks imposed upon it by changing social conditions. The financial and vital statistics contained in this review demonstrate that, so far as London is concerned, the community is ready to support in ever-increasing measure what has been described as 'our unique heritage,' and that the voluntary hospitals have been strengthening their hold upon the confidence of the public."

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*What have our traducers to say?*

BULLETIN
OF THE
SOUTH INDIAN MEDICAL UNION.
NOVEMBER 1931.



## Civil Hospitals and Dispensaries.

There are a few items in this report of the Surgeon-General for the year 1930 that would interest the independent medical profession of this province. We would here refer to two of these which refer to Rural Dispensaries and the Honorary Medical Officers. We are very pleased to have the testimony of the Surgeon-General about the success and popularity of the Rural Medical Scheme. He says, "*There is no doubt now as to the success and popularity of the subsidized rural practitioner scheme which was started in 1925.*" We have from the beginning attached great importance to the speedy expansion of this branch of medical relief. In spite of many faults that are frequently attributed to the scheme, we hold that the principle on which it is based is fundamentally correct. As is usual with all human institutions, the working of the scheme may not be perfect. But time and perseverance should rectify most of these defects. As a further effort towards rural medical relief the new experiment of "Visited Dispensary System" is rather interesting. This appears to be a sort of half-way house towards the subsidized rural dispensaries. We would much rather that such State or Local Fund dispensaries as do not provide enough work for a paid medical officer be abolished giving place to more subsidized rural dispensaries.

We are again glad to learn from this report that the honorary system has developed still further and that in a few instances—we are afraid very few indeed—the honorary officers have replaced Government medical officers. In view of the faint praise, lukeworm interest and excessive caution noticeable in certain influential quarters we consider it useful to quote at some length the Surgeon-General's opinion about the honorary medical officers.

"*Honorary medical officers*:—The scheme of employment of honorary medical officers in the Government hospitals which was introduced during the past years has developed still further. Many private medical practitioners with special attainments in the branches of Medicine and Surgery were appointed as honorary medical officers and honorary sub-assistant surgeons in the City State hospitals and the Government hospitals in the mofussal. Special clinics such as dental, ophthalmic and venereal, in charge of honorary medical officers, were opened and are working well. In a few instances the honorary medical officers are actually replacing Government medical officers, though in the majority of cases the honorary medical officers work in addition to the Government staff, and are of considerable aid to them. A further extension of the scheme is under the consideration of Government."

With such opinions about the usefulness and success of the *honorary scheme* from the head of the medical department and the hopeful and encouraging appreciation recently expressed by the head of the Government of the province, we would fain hope that there would soon be a reasonable acceleration of the avowed expansion of the honorary scheme in the immediate future. There is great scope for enlisting the aid of the practitioners—general and specialist, in connection

with the starting of new clinics in the several specialities in the different parts of this presidency. The ophthalmic clinics in the Royapuram and the Royapettah hospitals have been erected and worked entirely with the aid of honorary officers. The latter has only an out-patient department and till financial conditions of the country improve, it is not likely to be enlarged to provide facilities for in-patient work. Thus relief to the increasing work in the Government Ophthalmic hospital at Egmore would be inappreciable. It is still the popular complaint that patients have to spend much time at the out-patients' department of the latter hospital before they could be attended to. This inconvenience to the public could be easily avoided by appointing more honorary officers to this hospital. For an institution of its size and work, the staff is certainly meagre. The hope that the creation of new centres for ophthalmic work would tend to diminish the volume of work in this institution is contrary to the experience of all who are familiar with the great demand from the poor for more and more facilities for hospitalisation. We therefore trust that the Government would soon realise the need for appointing more officers to this central institution.

Apart from the above measures which indicate hope rather than achievement, the year under review has not been marked by any striking progress in the efforts towards medical relief of the province. Except for the fifty and odd subsidized rural dispensaries that were newly opened during the year there is very little in the way of new institutions. There is a growing tendency in some quarters to point to the gradual increase in the number of these rural institutions as an indication of the increasing interest on the part of the Government towards meeting the demand for medical institution. But a closer scrutiny of the report and an elementary knowledge of the actual conditions of the poor patients in the villages, and even in towns, would prove that what is urgently needed is greater accommodation for in-patients. We find that in the year under review, 17,592 more people were treated as in-patients, *i.e.*, about 9 per cent over the number in the previous year. It is well known that for want of accommodation day after day many patients are denied admission which they badly need. Admittedly, the State and the local bodies cannot find the money to provide additional hospital accommodation as well as to maintain an increasing number of dispensaries. It is therefore necessary for the State to take stock of the situation and revise its policy. If the Government and the local bodies would concentrate their efforts on the building, equipment and maintenance of effective hospital units and leave the simpler and far less expensive dispensaries, entirely to the care of private agencies, a great deal of the money that is now frittered away on these dispensaries could be saved for the establishment of new and well-equipped hospital centres. By this arrangement, dispensary facilities would not suffer. The dispensaries should be maintained by practitioners, aided or unaided by the State as the case may be. In addition, a large number of philanthophists would come forward to establish and maintain dispensaries since the expense involved would not be probititive for those who are ordinarily rich, whereas the building and maintenance of a hospital is only possible for the few very rich. We would like the Government and the public to carefully consider the above suggestion.

The Surgeon-General is evidently convinced that the Government institutions are working more efficiently now and that the efficiency is reflected in a diminished death-rate during the year. We are afraid he has not been quite happy in the choice of matter in his

reply to the occasional critic who rudely reminds people of the mounting expenditure on medical relief and administration. If he would allow us to help him, he would do well in future to justify the increase in expenditure by instancing the increasing number of people who seek relief at the dispensaries and hospitals. In spite of all the evil things said of the practitioners and institutions of modern medicine and in spite of all the enthusiasm that is imagined to grip the people for the indigenous methods of medicine, the sick public would prefer our services more and more and would continue to ask for more and more of our institutions. That over a million more of the population resorted to the hospitals and dispensaries is no small thing to be proud of, and as an argument for increased expenditure, it may be even convincing. But, to point to a death-rate which at best is fluctuating as one of the results of increased expenditure is rather hazardous, especially if the critic happens to know that the *increasing expenditure is chiefly to be accounted for by the increasing salaries* paid to the medical staff and that the bigger salaries are paid to the same set of men in virtue of the time-scale system, and not to a different and more efficient staff.

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## POST-GRADUATE STUDY.

### Why go to England?

(By a Post-graduate.)

The difficulties, which students going over to England with the object of pursuing medical studies, have to contend with, is not realised by students and educational authorities out here. Perhaps there was a time when the influx of students into England from India was a very limited one and the various institutions had no difficulty in providing for them. But now every season finds a good number of students crossing over to England either to begin their medical studies or to put in post-graduate study. The facilities afforded to these are very meagre and until the authorities out here open their eyes to these difficulties, the lot of the medical students or the graduates who go over to England for higher studies, will continue to be one of extreme dissatisfaction. What makes matters worse is that now a premium is kept on English medical degrees and diplomas, which in some cases is merely a fictitious one. From our presidency a large percentage of L.M.Ps. in *service*, cross over to obtain a registrable qualification and incidentally fit themselves for promotion into the assistant surgeon's cadre. These people have naturally to put in a longer period of work in the hospitals than the M.B. B.S. or L.M.S. whose course was till recently recognised in England. Besides these a number go to qualify themselves for the various diplomas—D.L.O., D.O.M.S., D.T.M. and D.P.H. and the M.R.C.S. and L.R.C.P. The number who appear for these are limited when compared with the regular and post-graduate medicos. A third lot go primarily to qualify themselves for the highest medical qualifications like the M.R.C.P. and F.R.C.S. The number of those who go for purely post-graduate work is very limited.

Let us see what are the facilities these four groups are afforded in the course of their stay in England in achieving their aim. In London the institutions which are thrown open to all outsiders are many. All the leading hospitals—Guy's, London, Bart's, St. Thomas, St. Mary, the King's and the University hospitals—all have no objection to take in regular medical students. But the number they take in is strictly limited and under no circumstance is this limit exceeded. In

the days when only a handful of students went over to England this percentage was quite adequate. But now it is hopelessly inadequate. The percentage includes all "Coloured Students" in which Indians, Negroes and Egyptians are included. Now Ceylon has no university of its own. By an arrangement between the educational authorities in Ceylon and those of the London university, the first two year courses are recognised by the London university. To complete their studies most of the medical students who want to get the M.B. or higher degrees must complete it in England. Naturally their stay in England is longer in hospitals like the University hospital and the King's. Most of the colored students are Ceylonese. A good lot of Negroes from West Indies come over to England and these have their whole medical education in English institutions. A good number of Egyptians also frequent the English universities. When these students whose stay is longer than the average Indian student who has either already a registrable qualification or as in the case of the L.M.Ps. a hospital practice of 18 months is insisted on get into a school they block the entrance of other students and effectively make up the allowed percentage of colored students. Hence arises the difficulty of finding accommodation in various medical schools. The student to whom time is no consideration, can wait and bide his turn. But most of our men have a limited time at their disposal and for the above reason are faced with the problem of finding entrance into these schools. In despair they go from school to school in London and then at the earliest opportunity quit the metropolis for Edinburgh or Manchester or Glasgow. Even the student who can afford to wait runs the risk of being rejected if he has not the fortune to possess some recommendation. Students from Bombay and other provinces find ready admittance on account of recommendations than the students from Madras. Besides the students from Bombay and other presidencies are given better information with regard to medical studies and the available facilities than the student from Madras.

While the regular student finds it difficult to gain entrance to the schools, the plight of the post-graduate student is even worse. Most of the medical schools are averse to taking post-graduate students as they have already the necessary quota of "Coloured Students." Even if they are fortunate to be taken, they are definitely made to understand that they are not to attend the coaching classes and other facilities afforded to the regular student. In fact, most of these hospitals frankly are not meant for post-graduate work at all. The student who wants to study for higher examinations finds it a great handicap that he cannot have any practice in these general hospitals. The hospitals—at least three of them—the London, Guy's and King's, run an advanced medical course mostly intended for the M.R.C.P. and M. D. students. Of these courses the one at London hospital is the best known and admission into it is very restricted. Only two coloured students are taken in and these are generally chosen from the I.M.S. on leave or people who are fortunate enough to get them recommended by old graduates of the college. To the ordinary student it is practically impossible to gain admittance into this course. The King's College one is of a recent date and has been going on for the past three years. Due to the admissions getting to be difficult it is no uncommon occurrence to find a student haing to wait fully a year before he can get into one of the courses. The courses are held twice a year only. The Guy's one is the most recent and this too is fast getting overcrowded. The student

who does not get admittance into these classes has to depend entirely on the special hospitals. Of these there are four which are most popular. The Heart Hospital, the National Hospital for diseases of the N.S., at the Queen's Square, the hospital for diseases of children. Great Ormond Street and the Brompton hospital for diseases of the chest. Admissions to these hospitals are always available and so far no restrictions are laid on the members. Each of these hospitals run a special course. Of these the one given at the Heart Hospital is the most comprehensive and thorough and the one at the Queen's Hospital is the longest and most useful. All these courses are very costly and some of them are very cursory. There are, besides, two hospitals entirely set apart for post-graduate studies. Here students are given all facilities for clinical work. While the teaching is adequate for the M.R.C.S., L.R.C.P. diploma it is in no way adequate for higher examinations. Besides these, there are the private coaching institutions who coach students for any examination. Sometimes very good men are found on the staff of these. But the instruction here is mostly confined to the theory, there being no hospital open to these where they can arrange for clinical instructions. The last method is private coaching by registrars attached to the various hospitals. The instruction given by them is good but it is very costly and beyond the means of the average student—a good coach charging as much as one guinea for an hour's tuition.

The problem of post-graduate study is a pressing one. To go for a registrable qualification is a waste of time. But it is absolutely essential, our graduates and practitioners should, from time to time, visit centres of medical culture both in England and on the continent. At present the post-graduate work is ill-organised in England. In London, the Fellowship of Medicine undertakes to co-ordinate post-graduate work. But all hospitals are not open to post-graduates from the Fellowship of Medicine. Besides the hospitals which are open to them are not fitted for post-graduate work. While the quality of work in the Heart and Queen's Square Hospitals is of the highest, that of Brompton—I mean post-graduate teaching—is very slipshod. Much time and money is wasted by the post-graduate in urging to find out what is worth having and what is not worth attending.

In special departments the rush for admission is not very great. Even here it is rather difficult to gain admission into the premier hospitals. It is a common complaint that in these hospitals the staff is not out to impart what they do know to "the coloured students". The facilities which are available to the European student are not thrown open to the Indians. The professors and the honorary staff of these hospitals fight shy of teaching Indian students and giving them all facilities. One gets the impression sometimes that the hospital board wink at their conduct. Of course, there are exceptions to the above and when you get them, the Indian student gets his money's worth. These exceptions make one believe that post-graduate teaching if undertaken with a willing heart can be made really very profitable. The medical student who goes to Vienna, at once realises the difference between the work in England and on the Continent. In Vienna they are out to teach the students. All privileges are thrown open to you. You can be the house surgeon or physician or assistant to the Chief Medical officer and within a brief space of time you can finish a good bit of work. This is not possible in England. You have to take your chance with what is done in hospitals. But in Vienna you can chose your subject and the professor you want. The post-graduate student feels in England that nobody wants

to teach him but every hospital is keen on exploiting him for the sake of his money. The Fellowship of Medicine is trying to organise post-graduate work on the lines followed in Vienna. But the cost is prohibitive. In Vienna you can share the cost with other students but in London you cannot. So much for post-graduate work in hospitals and in wards. But post-graduate work in other departments is even more difficult, for example, the facilities to do post-graduate work in pathology, histology or bio-chemistry are indeed very meagre. It is up to the students who leave for England to study these facts and do their best to set things right. Much can be done by way of putting the student in the way before he leaves for England. The Government and universities can also do much to alleviate and erradicate existing disabilities. It is time these facts are broadly known among the student medical world, so that they may be disillusioned about the lure of British degrees and diplomas. In this way much money, energy and time can be saved and diffused into the proper channels.

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## South Canara District Association.

Proceedings of the General Meeting held on 24th October 1931 at 5-30 p.m. in the Wenlock Hospital, Mangalore :—

PRESENT :

Dr. W. E. Mascarenhas (*President*).
„ C. P. Kamath.
„ B. G. Acharya.
„ U. P. Mallya.
„ U. N. Nayak.
„ K. R. Kini.
„ B. M. Baliga.
„ H. V. Adappa.
„ A. G. Bhat.
„ M. Shiva Rao.
„ K. G. Rao.

1. This Association places on record, its deep sense of sorrow at the sudden and unexpected death of Lt.-Col. D. G. Rai, I.M.S., its first President, on 2nd October 1931 at Simla. Proposed from the chair and passed unanimously all the members standing.

2. This Association places on record, its deep sense of sorrow at the sudden and unexpected death at Mangalore, of Dr. B. Iswaraiya, M.B., C.M., its late President, on 11th October 1931, when in service. Proposed from the chair and passed unanimously all members standing.

3. This meeting authorises the Honorary Secretary to communicate the above resolutions to the members of the bereaved families. Proposed from the chair and passed unanimously.

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## Royapuram Medical Licentiates.

A meeting of all the Licentiates attached to the Government Royapuram Hospital and Raja Sir Ramaswami Mudaliar's Lying-in-Hospital was held in Bryson School on Sunday the 15th instant at the Government Royapuram Hospital at 11 A.M. under the Presidency of Dr. D. V. Venkappa, Provincial Secretary of the Madras Branch of the All-India Medical Licentiates' Association. It was a fairly big gathering of about 40 doctors who assembled and discussed the proposed All-India Medical Council Bill.

Dr. Kolagatla Rama Rao, House Surgeon and Organiser of the Meeting in proposing the President touched briefly about the Bill and impressed upon the necessity of those present by enlisting themselves as members of the Madras Branch of the All India Medical Licentiates' Association. Doctors C. Ramachandra Iyengar and K. S. Sivaramakrishna Iyer and others spoke

at length about the desirability of the inclusion of the L. M. Ps. in the proposed All-India Medical Register and detailed to the meeting about the services rendered by the Sub-Assistant Surgeons. The following resolution was then unanimously passed :—

This meeting of the Licentiates attached to the Government Royapuram Hospital and Royapuram Medical School views with great concern and anxiety the proposed All-India Medical Council Bill in which it is contemplated to exclude Licensed Medical Practitioners in the purview of the All India Medical Register and hence earnestly appeals to the Government to remove the obstacle in view of the fact that they are qualified Medical Practitioners recognised by the Provincial Medical Council.

The President whilst thanking the organisers of the meeting gave a brief history of the origin and growth of the Association ever since its birth at Bangalore in 1906. It was an organisation about a quarter of a century old and the Association was on the eve of celebrating its Silver Jubilee at Dharbanga next month. It traced the origin of the class ever since up to the present moment when the denomination of the L. M. P. took different names and how the different heads of the Medical Department including the Director-Generals of Indian Medical Service and Governors of the different provinces presided over their conferences and how they spoke of the invaluable services rendered by the class as a whole. He gave extracts from the speeches of Lord Chelmsford, Sir Pardey Lukis, General Giffard and Major-General Megaw and other important personages and pointed that there were the everlasting testimonials given to the class which well nigh befitted them for recognition in the All-India Medical Council. He pointed out that the Association was carrying on a vigorous campaign all over India and hence wished that more should join the rank and file of the Association at this juncture.

With a vote of thanks to the chair and the authorities of the Hospital, the meeting terminated at 12-30 P.M.

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## Bombay Medical Union.

Resolutions passed by the Managing Committee of the Bombay Medical Union at its meeting held on 16th November 1931, regarding an advertisement in the issue of the *Times of India* of the 26th October 1931 inviting applications for the post of the Professor of Pathology at the Grant Medical College.

1. The Managing Committee of the Bombay Medical Union strongly disapproves of the terms and conditions advertised, inviting applications for the post of a Professor of Pathology at the Grant Medical College.

2. The Committee is of opinion that the Professorship in Pathology should be a full time post as in Anatomy and Physiology.

3. The incumbent should be debarred from consulting as well as any other practice.

4. The Committee here begs to point out that in contributing jointly Rs. 5 lacks for the Pathology Institute, Sir Dorab Tata and Government had the idea of research uppermost in their mind. This will never be fulfilled if the incumbent is given a meagre salary and permitted private practice as a compensation.

5. The Committee is further of opinion from past experience that allowing private practice to such appointments have always interfered with the legitimate progress in research in the subject and have proved detri-

mental to the interests of the Students and of the Medical Profession.

6. The Committee therefore urges upon the Surgeon-General to reconsider the question and offer an adequate salary ranging from Rs. 750 to Rs. 1,500, according to the merits, qualifications, and experience of the incumbent in the subject. It further urges the selection of the best man only without any other consideration.

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**Rajahmundry Medical Licentiates.**

A meeting of the licentiates and other medical diploma holders residing at Rajahmundry was held on Sunday the 22nd instant at 2 p. m. It was decided to start a branch of the All-India Medical Licentiates' Association at Rajahmundry. Dr. P. Gurumurti was elected President and Dr. V. Kamaraju Secretary of the Association.

The following resolution was passed: "This meeting strongly protests against the non-inclusion of licentiates and other medical diploma holders of medical schools and colleges in India in the purview of the draft Indian Medical Council Bill and wishes to point out to the Government that the purpose of the proposed legislation will not only not serve the interest of the medical profession in India and disorganise the same still further but will defeat the very aims and objects of the bill in the matter of establishing a uniform minimum standard of qualifications in medicine for all provinces so that persons attaining thereto shall be acceptable as medical practitioners throughout British India."

The meeting appealed to all the branches of the Association all over the country to organise protest meetings and urging the Madras Medical Council to recommend to the Government to include in the proposed Indian Medical Register all registered practitioners in in the Provincial Registers.

## CORRESPONDENCE.

### The Indian Medical Council Bill.

Sir,

While thanking you as one among the Licentiates for the sentiment expressed in the Editorial of the October issue of the Bulletin with special reference to the Licentiates' position in the All-India Medical Council Bill I am constrained to point out that your fight on the side of the Licentiates is seemingly half-hearted. As our silence would tantamount to whole-hearted approbation in what you write, in view of there being many Licentiates in the South Indian Medical Union, I have hurried up to write this letter, to put forth our views on the matter.

We agree with you when you say,

> "But.....methods should be devised by which the Licentiates could qualify themselves without unnecessary difficulties for the requisite standard."

But we cannot agree to the following, *viz.*, "Thus all Medical men who are authorised by the Government of the land to be fit to engage in the practice of medicine could be brought under one common roll," to be made an inevitable requirement to enter into the All-India Medical Register. The contention should be to include us in the All-India Medical Council and Register in view of the simple fact, that we are recognised by the Government as qualified medical men. This is the irreducible minimum from which we cannot, I am afraid, afford either to swerve or depart.

The Editors need not feel shy to vociferate our cause, which is an elementary right, which cannot be given up under any circumstances whatsoever, if they simply take pains to remember that it is based on prece-

dent. The precedent I prefer to can be found from the British Medical Act of 1858 from which it can be in ferred, that the British Medical Council allowed the medical men then practising who had not even undergone any medical course, much less College course, and hence not medical graduates, become members of their Association. Such being the case it surpasses our imagination how such a body being fully cognisant of its origin, could vainly think of raising objection to the inclusion of the Licentiates in the All-India Medical Council—the Licentiates who have undergone four years arduous course in medicine and who have been all the while recognised and employed by the Government throughout India. Summing up it cannot be lost sight of and I cannot forego mentioning it at this juncture that the alleged objections are beyond all reason and proportion.

Dr. U. Rama Rao, whose brilliant services for the uplift of Licentiates which, I am sure, nobody can afford to forget, rightly states in the correspondence column of the October issue of the Bulletin that either one Licentiate from among the private practitioners from each province should be included in the All India Medical Council, if it is to be called as such or the designation should be changed into "The Indian Medical Graduates Council".

In conclusion, we the Licentiates hope, that the South Indian Medical Union Bulletin will take up our cause in the light of our views above stated and fight for one and all, whenever attempts are made to hinder or jeopardise their legitimate interests and privileges.

DR. K. VENKAT RAO, L. M. P.
PURASAWALKAM,
*8th November 1931.*

## The Honorary Scheme and the Licentiates.

The Licentiates form the bulk of the medical profession both in towns and the mofussil. The Government Honorary Committee have disregarded the claims of these medical men to hold honorary posts. Practically the Honorary Scheme debars the L. M. Ps. from honorary appointments in any of the State hospitals of the presidency.

The Committee is not true to its own recommendations. The first paragraph of the report is thrown into insignificance by the third para. The removal of the designation of the honorary sub-assistant surgeon and the eligibility of the Licentiates to hold the appointments and the name as graduates, seem to be insincere and impracticable encouragements when we read the third para, where, under cover of Teaching and non-Teaching institutions, the Committee clearly excludes the Licentiates by the qualification bar from almost all the big hospitals of the presidency. These medical men have no place for honorary work in any of the chief hospitals of Madras. Their own hospital and school where they learnt the abcd of medicine and surgery close the gates against their entrance as honoraries. In the mofussil these men are placed in the teeth of competition and at the mercy of the recommending authority for honorary offices.

This exclusion naturally prompts the licentiates to question the sincerity of the Committee's recommendations in the first para of the report. These recommendations are against the policy of the South Indian Medical Union which stands for Unity in the Profession. "That there shall be a right of access of general practitioners in the hospitals in their area with facilities for taking a responsible part in the work of the hospitals."

Members of the South Indian Medical Union are not unaware of the above policy published in the Bulletin and this has been a stimulus for many a licentiate in general practice to join the Union. May I ask the Committee how far the above policy is fulfilled in the honorary scheme by excluding the Licentiates from Madras hospitals? Because the members of the Committee were nominated the Union had no voice to remind them of the above policy. Further it is argued in defence of the third para, restricting the honorary appointments in Teaching institutions to graduates that only highly qualified men should be entrusted with the teaching work. This holds good as long as there is no class division in the profession. As it is, the Licentiates have had been employed in Teaching institutions and they have been very successful in this line. Both the licentiates and the graduates who have had the opportunity to study under these men know their efficiency for teaching. No doubt in the interest of the medical education, teaching institutions should be manned by highly qualified efficient people. But the object of the Committee will not be fulfilled if it allows two standards of medical education and debar a particular group from teaching work. The present system is far better than what it would be according to the honorary scheme.

In the light of the above points it is high time for the Government to take immediate measures to raise the L.M.P. standard of education to that of M.B. & B.S., and then only adopt the honorary scheme recommended by the Government Committee. Without this preliminary step the recommendations of the Committee cannot be considered as sincere and true (reference to the licentiates). There is no meaning in the division of the honorary labour field into Teaching and non-Teaching institutions as long as there exists a division in the medical education. Instead of union this favours disunion and the consequent unhealthy competition in the Independent medical profession.

My humble appeal to the members of the South Indian Medical Union and the medical profession to request the Government of Madras to reconsider the decision of Honourable Committee in view of the foregoing points and either to do away with the L.M.P. class or raise the standard to the level of M B. & B.S. and thus help unity in the medical profession.

U. D. GOPAL RAO,
*Independent Medical Practitioner,*
*57, Thambu Chetty St., Madras.*

## Query.

Sir,—Will you or any of your kind readers of the medical profession or any one who is conversant with the Rural scheme of medical relief kindly enlighten me as to whether a Rural medical practitioner is justified in demanding fees from one whose income is more than Rs. 30 per mensem though treated in the dispensary; as a Rural medical practitioner is asked by the President of the Tinnevelly Taluk Board why he should not be dealt with suitably for charging fees from such patients (whose income is more than Rs. 30 per mensem) who resort to the dispensary for treatment?

V. N. CHARI, L.M.P.
PAVOORCATRAM,
*18th October 1931.*

Sir,—Will you or any of your numerous readers enlighten me on the points raised in an instance such as the following:

A quack is regularly in the habit of getting the services of a registered medical practitioner in cases which have already been mismanaged by

him. Now the registered medical practitioner undertakes to treat the case in conjunction with the quack (otherwise the medico will not get cases through the quack) and invariably there is the fatal result. This practice is regularly done and he seeks practice through such quacks.

Now I wish to ask "Is it breach of professional etiquetta and if so is there any remedy?"

NANDYAL. B. SUKHAVANAM.

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## Suka-sanni.

Sir,—I was much delighted to read the "original article" on Suka-sanni written by Dr. T. S. A. Padmanaban. But I wish to offer a few remarks and I hope you will kindly publish the same.

As regards the aetiology, the typical history is given. I may add to this any departure from normal health on the part of either the husband or the wife leads to this kind of fever if they mate during such period (of ill-health.)

Coming to the symptoms, a faithful picture is given; but the fever is rather atypical and the symptoms vary from mild degrees of fever to severe toxæmia. As regards the conservative treatment the one described is rather misleading. The doctor seems to be impressed by the view that the old treatment is "Auto-hæmo-therapy" in modern senses. But really it is "hetro-hæmo-therapy." As soon as the fever sets in, if the wife is laid up, the blood is taken from the husband's big toe and given as described with betel leaf juice and *vice versa*. (In either case, the party laid up is below par in health before the sexual act.) Many cases get well and equally many cases are fatal. The rationale of the treatment is based probably on the theory that the fever is a toxæmia and the blood of the opposite party contains the antitoxins or antiserums which effects the cure.

As the doctor rightly observes the oil-bath is a depressent and vitiates the favourable prognosis. It increases the weakness already present in the body, though an oil-bath after the sexual act (next day) is a tonic in the healthy man (our age long custom).

Coming to the sympathetic system the doctor confuses the "proper sympathetic system" with the "para sympathetic" or "extended vagus" so to speak. In natural health (both are antagonistic in action) there is a balance between the systems. This is upset in this fever to a remarkable degree. Hence the symptoms are protean. It may be typical of vagotonia or sympathetico-tonia or both types alternating at different hours.

In conclusion, many a reputation has been wrecked on this rock while the Vaidyan or Hakim scores a victory in diagnosis and treatment. Essentially, the treatment is symptomatic with a judicious use of stimulants coupled with the conservative treatment.

RANGOON. G. RAMASWAMY

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## Sex Factor in Course of Syphilis.

Summarised BY DR. C. R. KRISHNASWAMY, M.B, B.S.

*Royapuram Hospital, Madras.*

Col. Burke submitted a brilliant thesis before the Medical society for the study of venereal diseases which produced a good deal of discussion, for some of the hearers demurred that it was based on a good deal of imagination, but he affirmed that surely it was "By, with or from" a reasonable use of the imagination that one was enabled to interpret any series of facts or

observations. Imagination according to him was a necessary preliminary to any experimental worker. "Facts and observations are, by themselves, a worthless, inert and indigestible mass until they are vivified by the vitamins of reasoning and imagination. Deductive and inductive processes must be linked together, controlled, and co-ordinated by imagination — without which scientific research is impossible. Any hypothesis is an essential preliminary to any scientific experiment."

The basic difference between the two sexes is that the female is anabolic in diathesis and the male more katabolic. Without going through a litany of examples, he states that the same principle runs through the whole animal kingdom. In the human race these distinctions alluded to, still remain. The woman though she weighs less than the man absolutely, the surface area of her body is much larger than man's in proportion to body weight.

The relative largeness of the female is a 'fat largeness' being the inevitable expression of the female anabolic habit. The close connection between the fats and lipoids warrants the statement that the female has a higher lipoid content.

"Fats are synonymous with lipoids. They may be saturated or unsaturated. In some of the unsaturated Esters, the carbon atomic affinities are free which readily combine with Iodine, *i e.*, Iodine saturates the Molecule.

Col. Burke's explanation of Iodide Therapy in Syphilis is worth examining. There are natural enzymes in the blood whose function is to prevent formation of Fibrous tissue. These ferments are rendered inactive by their union with the unsaturated lipoid radicles. Iodine having a greater affinity to the radicles, liberates these ferments to exercise their autolytic function.

He recalls, in this connection, the close relationship that exists between the secretion of Thyroid with its high Iodine content and the course of Female syphilis. Symptoms of syphilis are not so manifest in these periods in a woman's life when the thyroid hyperfunctions as in puberty and pregnancy.

The proposition put forward in his thesis are :

1. The Treponema Pallidum directs its main attacks upon lipoid-rich tissue and especially upon that which is both lipoid-rich and highly organised tissues as those of the cardio-vascular and the cerebral nervous system.

2. The higher the lipoid content of a tissue, the greater is the affinity of the parasite for it in the first instance. Soon however some protective process takes place and the attack is beaten off.

3. The more highly organised tissues, because they have not so high a lipoid content as the subcutaneous structures, do not attract to themselves the parasites so soon or in such large numbers. For the same reason they do not elaborate or attract to themselves the antibodies to the same extent and so the attack upon them persists.

4. The cardio-vascular and nervous systems in the male and female are identical, in as much as there appears to be no difference in their respective lipoid contents in the two sexes.

5. If then other things were equal, syphilis should make no differentiation in attacking these systems.

6. We know however in the two sexes there is a most marked modification of the attack upon these systems that upon the male being much more severe.

7. There must, therefore, be some factor or combination of factors, operating upon the views of syphilis making it more virulent in male.

8. He quoted Warthin's statement "of all the important plagues affecting mankind, no one shows greater differences of reaction and manifestations in the two sexes that does syphilis. Recognise its milder quality in the female, a certain degree of immunity in her and of the tendency for the disease to become latent in her during the child bearing period but revealing itself in her children.

Before puberty the sex differences of syphilis are slight or non-existent because the woman develops her femaleness at puberty and retains it till the menopause:—That is between the two peroids, puberty and menopause she is highly anabolic in her tendency. Consequently Juvenile General Paralysis or Tabes occurring in a congenitally syphilitic *female* child commences to improve with the onset of menstruation, apart altogether from treatment and conversely in a neurosyphilitic male child, there occurs at the time of puberty a tendency to progressive deterioration. During pregnancy and lactation—periods of considerably higher lipoid richness in the female than at other periods there develops a high degree of immunity or resistance to syphilis. He quoted Stokes who remarked that the bearing of children might be spoken as part of the treatment of the disease in women.

Pursuing the subject of sex differences Burke draws attention to the fact that the primary lesion of chancre in man is more superficial, external and exceedingly conspicuous lesion, whereas in the women it is very rarely seen. This is accounted for by the fact that the testis in man gets very early infected in the post primary stage and as coitus is impossible for a man with a primary chancre, he infects the women through his spermatic fluid deposited in the columnar-celled mucous membrane of the cervix, this being the usual mode of infection in the female.

An interesting clinical point was stressed by him, *i.e.*, that no erosion or ulceration of the cervix should be passed over casually but must be dark grounded; otherwise many chancres in women will be missed.

The cutaneous reaction in early syphilis of woman is of a much milder character than it is in man.

Syphilis delivers its death-thrust at man through the cardio-vascular and nervous system where the disease does not kill members of the female sex.

Syphilis of the suprarenal glands in women is so common that Warthin has come to regard it as the most important histological criterion in the decision regarding the presence of the disease in women.

The ovary is the acme of anabolism and the testis of katabolism and so ovary appears to be immune to syphilis and the testis in striking contrast to this, being the earliest to get involved in this disease.

When discussing the serological reaction Burke adduces strong grounds for considering the parasite a protozoon and as protozoa are rich in lipoid and have an affinity for tissues of like nature, he makes an interesting remark that the Treponema is a lipoid-rich attracter of lipoid-rich tissue.

He interpreted the Wassermann reaction in the light of the lipoid attack of the organism and his presentation will certainly bear repetition.

"When it (Spirochete) attacks such tissue (lipoid rich) Lipo-proteins are

formed which are set free in the circulation. These stimulate the production of Lipo-proteo-lytic ferments—antibodies or amboceptors—which become bound to lipoid-rich tissue and which exercise a lytic action upon protozoal organisms. They have both a *combination tissue* and *lytic organismal* reaction. These ferments which are simply antibodies for lipoids, again attack fresh lipoid-rich organisms and tissues, more lipo-proteins are produced and so the same goes on."

Although the ferments are antibodies, they are not absolutely specific for any particular type of protozoon parasite. They act upon all protozoa and lipoid rich tissue. Their specificity increases directly with the lipoid content of the parasite. In like manner their affinity for body tissue varies directly with the lipoid richness of the tissue. For the higher the lipoid content of the parasite injected, the more severe will be the attack upon lipoid tissue and the greater the production of ferment.

In the compliment fixation test such as Wassermann we are concerned mainly, not with the parasite but with their essential and characteristic lipoids. If then a patient has syphilis, or more accurately if his syphilis is such that there has occurred a sufficient destruction of lipoid rich tissue, then his serum will contain an appreciable amount of lipo proteolytic ferment or amboceptors and so will give a positive result to the Wassermann reaction."

Why is it then, that women who have syphilis and especially when they are pregnant, so frequently show a negative serology? Either they don't produce sufficient of the ferment to give a positive result or although the production of the antibody is adequate it does not reach the serum. in sufficient quantity to be detected.

Why is the heart and the nervous system of the women especially preserved from syphilitic damage? It is because of the high lipoid content and the consequent production of super abundance of antibody ferment which in its turn not only protects the tissue but due to an abundance of the ferments to combine with a large number of parasites and reduce their virulence.

It is not that syphilis is milder in female but rather it is more virulent in the male. It looks as though the woman is the habitual host with whom the parasites lives in greater amity or that there is a better state of symbiosis between the spirochete and the female than between it and the male.

After discussing these biological, serological and clinical facts he goes on to the rationale of treatment. Arsenic and Bismuth when injected are first converted to Arsenoxyl and Bismoxyl in these parts of the body which have the high lipoid content. Hence a liposoluble Bismuth salt is much more efficient as a therapeutic agent than any other preparation.

Burke explains the comparative failure of Chemo-therapy in neuro-syphilis in this way In general paralysis of the insane the parasites are deeply embedded in the issue. The chemo therapeutic agents reaching the nervous system tend first of all to become bound to the tissue. They are thus to a great extent neutralized or absorbed by this 'lipo protein sponge tissue' before they can reach the more inaccessible treponemata'. Following this argument he also explains why malarial therapy is effective in G. P. I. in this way. The first effect of the induction of malaria is a destruction of R B. C.'s which brings about a flood of *dead autogenous lipo proteins* entering the serum. These act as a

stimuli for the production of *lipo-proteolytic enzynes* which act on the treponemata. At the end of malaria by the exhibition of quinine, more dead foreign lipo-proteins are thrown into the circulation. These ferments combine with the lipoid-rich nervous tissue preventing the Arsenoxyl and Bismoxyl which may be subsequently administered from becoming bound to these tissue but available to the deeply seated treponemata.

Proceeding onwards in this strain he revealed to the members present at the meeting that he was working with a *lipo-protein mixture* (*L. M. P.*) and that he would give them some samples to try when he was successful in his attempts.

The discussion that followed later on was very illuminating since on every point he was challenged he gave convincing reasons to support his theory.

Dr. Hainschell refuted that spirocheta was a protozoon and taking the examples of other protozoon diseases like malaria and kala-Azar, he wondered why there should be any difference in the manifestation of this disease in the different sexes. He illustrated his point by further emphasizing that in yaws, an allied disease there was no sex factor in the course of the disease.

Col. Burke was ready with an answer that like the malarial parasite the treponema have an intermediate host other than man, the intermediate or natural host for the spirocheta was the human female. The similarity between yaws and syphilis was disputed and the following dissimilar points were brought about.

(*a*) In yaws the primary lesion is extragenital.

(*b*) A congenital form has not been demonstrated,

(*c*) Cutaneous lesions are divergent from those of syphilis.

(*d*) There is no alopecia in yaws.

(*f*) Itching is a permanent factor in yaws.

(*e*) Eye lesions are absent.

As is usual with medical men having strong views, while Col. Harrison held that hydro-soluble Bismuth compounds have more effective, Burke affirmed that lipo-soluble Bismuth was more effective and quoted Illexo and Weissenback in his favour.

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## Tonsillectomy and its indications*

By Dr. C. V. C. Rao,

(Diplomate of Vienna)

*Eye, Ear, Nose and Throat Surgeon, Broadway, Madras.*

*Indications for Tonsillectomy.*—No physician should be guilty of recommending the removal of tonsils and no surgeon of performing of the operation when those tonsils are seen to be normal, healthy, and capable of performing their functions. The size of the tonsil is not a criterion to the damage it may be causing.

An enlarged tonsil may be harmless while an apparently normal tonsil may be the most dangerous one. In cases of repeated inflammations the tonsils may form adhesions to the surroundings and may shrink deeply into the tissue, hardly projecting beyond the level of the faucial pillar. Such a tonsil appearing to be small may be passed over by a casual observer, as harmless. But in fact this variety of 'buried tonsil' contains masses of thick pus and becomes a veritable cesspool for blood stream infection and thus is the most harmful one and a source of constant

* Read before the South Indian Medical Union.

ill-health. Thus it is clear that the size is apt to misguide one. The most important thing is to decide if a tonsil is diseased and if a given malady is the result of the diseased tonsil. If one has been subject to frequent attacks of tonsillitis, the probability is that he is suffering with chronic tonsillitis, and it is a certainty and a positive indication if that inflammation of tonsil is of the type of peritonsillar abscess or quinsy. Invariably cases can also be observed where the tonsils are badly diseased and septic and so likely to give rise to general and focal infection in patients who are not conscious of any focal trouble and who have seldom had sore throats. An experienced doctor must be able to detect in these cases evidence of disease. The oozing forth of purulent secretion on pressure upon tonsil is found in many, without any other pathological symptoms; on the other hand very often many people with frequent anginas and other diseases coming from the tonsils have frequently perfect normal tonsils with no secretion oozing forth on pressure.

To decide if a given malady is due to tonsillar disease, it is evident that one should possess a special knowledge of what kind of maladies arise from tonsils. The decision should also be governed by the observation that the general malady in question shows exacerbation coincident with the increased local inflammation. The most important and decisive factor to help us is the history of the patient.

To sum up I can't do better than repeat here the universally observed indications for tonsil removal in Vienna.

(*i*) History is important and decisive. (*ii*) Frequently recurring attacks of angina with or without regional complications (as peritonsillar abscess) from positive indications. (*iii*) Articular rheumatism, nephritis, endocarditis and sepsis. In all these affections there is a positive indication for performance of the operation only in one single circumstance. If the patient acquired in connection with angina, a general affection or if after every new attack of angina, his condition grows worse. In all other cases one is entitled to perform the operation only when demanded by the general physician, who cannot find any other cause. Here the operation is done with reserve and without responsibility as a last desperate expedient. (*iv*) Continuous or periodical subfebrile temperature. The question here is latent tuberculosis or cryptogenic infection coming from tonsils. In these cases an improvement can set in after operation or the case can get as well an exacerbation. Therefore one should even in these cases make the decision for operation never alone but always only in consultation with general physician and with reserve.

*Preparation of patient.*—Although different surgeons in different countries prefer to perform the operation in different ways, yet the preparation of the patient is practically the same everywhere. Give a purgative a day before the operation and light liquid diet on the day of operation. Better, not to allow the patient anything to eat a couple of hours before operation. This applies only to general anaesthesia. With local anaesthesia, it is better to give the patient something to eat an hour or two before operation than keeping him on an empty stomach. Do not operate on ladies during the menstrual time. Make sure that heart and lungs are sound. Estimate coagulation time of blood and be careful to improve it before operation, lest the patient may bleed to death. Sod. bicarb is given in every case for two days before operation to reduce the acidosis. Remove all tight fitting dress especially round the neck and waist. A hypodermic injection of $\frac{1}{4}$ gr morphia with 1/100 gr atropine is

given about half an hour before operation where the operation is done under local anaesthesia. The operation of tonsillectomy is done either with local or general anaesthesia. In Vienna local anaesthesia is used for adutls and for children general anaesthesia is employed.

*For general anaesthesia.*—Aether is employed with mask generally and in very obstinate cases a little of chloroform is given. Complete anaesthesia need not be aimed at. It is enough if the muscles of the child are completely relaxed. The advantages of this form of anaesthesia are the patient gets round by the time the operation is done and even during operation he is never very deeply under, so much so the risks of the patient aspirating blood into lungs are practically nil and the anxiety of the parents is less when they see the child talking to them so soon after operation. Aether is perferred to chloroform, in as much as the after affects of aether like vomiting, etc., are never so bad as with chloroform and another most important advantage is, the risks of post-operative haemorrtage is less with Aether. Nitrous oxide and ethylchloride are also being used by some surgeons with equal advantage.

*Local anaesthesia.*—Invariably employed in adults. 10 to 20% cocaine with a few drops of Adrenalin hydrochlor (1 in 1000) in it, is first employed with a brush to paint the throat. Repeat this every three minutes taking care that all parts of the throat including posterior wall of the oropharynx and base of the tongue are being anaesthetised. In about twenty minutes the throat should have been thoroughly anaesthetised. Warn the patient never to swallow the excess of the solution but to spit out. When there is no reflex from the throat, inject Novocaine 1 or 2% sol. in the tonsillar region as follows. Injection is never made into the substance of the tonsil itself, as it distorts the outline of the tonsil. The solution is injected in six places depositing in every place about 2 c.c. of the solution. The places are in order, Three injections between tonsil and post pillar, one at the superior pole, one at the middle of the pillar and one at the inferior pole. Three injections between anterior pillar and tonsil, one at the superior pillar, one at the centre and one at the inferior pillar. It is necessary first to enter the needle about an inch in each of the areas and inject the fluid slowly drawing out the needle while injecting. After dealing with one side, do the same with the other side. By the time the other side is finished, the first injected side will be ready for operation or at least in a few minutes. If this anaesthesia is thoroughly done, the patient should not complain of the least pain during operation.

*Operation.*—I do not propose to deal here with the details of the several methods of operation as they are sufficiently described in text books. But I very much like to mention a few points about the choice of operation and the advantages of the same.

There is not much difference of opinion about the operation under local anaesthesia. This is the method of dissection. The tonsil with its capsule is separated from the submucosa and the operation is finished with a tonsil snare. Of course even here there are a few who advocate the method with guillotine but they are a negligible factor. Guillotone can be used if tonsils are enlarged and not of buried type.

About the operation under general anaesthesia there are two methods prevailing, one is the operation of enucleation with guillotine with patient in the sitting posture ; the other is the dissection with patient lying on the

table. The second method, I believe, is being used mostly in England and is also practised in the General Hospital of Madras. The first method is the one universally employed in Vienna and naturally is the one adopted by me. Of course each method has its own advantages to its advocates, but still I venture to give out my opinion of them as I view them.

The first method, *viz.*, enucleation with guillotine in sitting posture is undoubtedly the quicker method and hence not much of anaesthesia is required and consequently the patient saved the unpleasant after effects of narcosis. But the very fact that it is a quicker method means that it is essential for the doctor to be quick and thorough as the patient might come round. In other words the doctor must have a little experience in this method before he could do it successfully. Guillotine requires, simple as it may seem, a little skill and practice for its successful application. Otherwise it is a failure. The advantages of this method are the patient comes round immediately after operation and thus there is no risk of aspirating the blood into lungs. No severe post narcotic effects and anxiety of parents is very much relieved when they see the child talking to them so soon. Thus the advantages of this method are many and the only thing wanted is a little experience and skill to use the guillotine successfully. The advantages of the second method, *viz.*, dissection in lying posture are :—There is plenty of time for operation. Narcosis is pushed on while operating. The view is less impeded and interrupted by tongue and other movements and so much of skill is not necessary. Bleeding points are readily seen and controlled. The disadvantages are :—Much of anaesthesia and its severe after effects, liability of the patient stopping breath in the middle of operation, aspiration of blood into lungs, post Operative haemorrhage, the awkwardness of dissecting the tonsils in the upside down position.

*After treatment.*—The patient should under no circumstances be sent away until the surgeon makes sure that the bleeding is completely stopped and is not likely to recur. For this purpose it is advisable that the patient is kept under observation for at least 4 or 5 hours and then sent home with instructions to report at once if blood stained sputm or vomit continues. Ice collar is applied immediately after operation and the following instructions to the patients are necessary : (1) Ice collar is to be applied as long and as frequent as possible. (2) Everything that is given to the patient must be ice cold. (3) Any warm drinks or applications are absolutely prohibited, for the first two days. (4) Feed the patient only on iced milk for the first day. (5) Fruit juice can be given the second day. (6) Jelly, coffee and such liquid foods can be given on the third day. (7) From the fourth day semi liquid diet as porridge, bread soaked in milk can be given with biscuits. Twice cooked rice can be given. (8) As the patient is progressing well and able to eat without discomfort and digest, gradually the return to normal food can be brought about. Never be anxious to introduce solid foods until the wound in the throat is healed. Gargle the mouth with an antiseptic mouth wash every time a feed is given. Show the patient to the doctor once in two days for the first week and later once a week by which time the wound must have been healed completely.

The most important later instructions to the parents are :—(1) Do not think that the child is alright, because the tonsils and adenoids are removed. (2) the havoc they have done is still there and it can only be combated successfully by the nourishment and care of the parents. (3) Give the child nourishing diet and tonics. Educate

the child to overcome the habits of mouth breathing and keeping open the mouth always, by checking it frequently and by watching it at nights. Encourage the child to play about and take good exercises.

*Post-operative haemorrhage and its control.*—The cause of the haemorrhage may be arterial or capillary. Arterial bleeding may not be seen at the time of operation but may occur later when patient recovers from shock and comes round from anaesthesia, or it may be that there is no bleeding at the time of operation due to too much loss of blood, but it might start bleeding later when the volume of blood is made up. Capillary bleeding depends on the coagulation time of the blood. It might happen that the coagulation time is normal before the operation but might be changed during or after the operation due to compensatory acidosis. Hence it is very important to estimate the coagulation time of blood and to regulate it by neutralising the acidity by giving alkalies. Sod. bicarb is a valuable drug for this purpose. Calcium chloride is generally used for improving the coagulability but many of the present surgeons doubt its efficacy. All the same it is widely used because it is become customary.

*Control of haemorrhage.*—It is not always necessary to ligature the vessels unless there is profuse arterial bleeding showing clearly that an artery is cut. These cases are far and few. Generally what we see is capillary bleeding. The methods employed in Vienna to control this are in order of severity. (1) Packing the fossa with gauze and suturing the pillars over it if necessary. (2) Applying the tonsil haemostat. Generally these methods suffice to stop bleeding. But if after a reasonable time the bleeding still continues, one should make a search for the bleeding points and ligature, taking care that the bleeding vessel is well undermined.

I have tried my best to deal with the Adenoid and Tonsil problem as elaborately as I possibly can with my limited knowledge and scope, in this and in my previous paper read before you some time back. My idea is only to impress on you more fully the importance of handling this question by medical men in particular, and the vast scope left in this field for one, interested in the subject to improve and perfect the methods and to impress on inexperienced practitioners that it is not such a trivial affair as be handled easily without special knowledge of the same.

I am much obliged to the Secretary of this Union for giving me this opportunity of reading this paper before you and I close this, thanking you all very much for your patient hearing.

[In England and in the Madras General Hospital the Guillotine is hardly used. The usual method is by Dissection. Sitting posture is adopted of a local anaesthetic is used and lying down if under a general anaesthetic.—Ed.]

## Reviews.

Pears Cyclopaedia—The well-known house of A. & F. Pears have brought out a revised edition of their original Cylopaedia. It has outgrown both in bulk and the volume of up-to-date information its original predecessor. A very useful book of reference it should be on the desk of every medical man, and can be had of all booksellers or free under certain conditions from their local agents T. T. Krishnachari, Georgetown, Madras.

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