The Bulletin

OF THE

South Indian Medical Union.

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PROGRAMME

OF

The South Indian Medical Union

FOR OCTOBER 1932.

Monday, October 3

MEETING OF THE GOVERNING BODY

6-30 p.m.

Monday, October 10

CLINICAL MEETING

6-30 p.m.

Dr. C. R. Krishnaswami will read a paper on

"THE VEGETATIVE NERVOUS SYSTEM IN SURGERY."

BULLETIN
OF THE
SOUTH INDIAN MEDICAL ASSOCIATION.

SEPTEMBER 1932.

Revised Rules for the Honorary Scheme.

We invite the attention of our readers to the revised set of rules which have been laid down by the Government to govern the *honorary medical scheme*. The Government has practically accepted the recommendations of the Committee which considered this question last year. There is only one marked deviation from the Committee's report and that is in regard to the question of transfer of honorary medical officers in Madras city. They are liable to transfer at the discretion of the Government. This is a vexed question. The honorary officers as well as the profession outside have been definitely against such transfers. If such transfers be necessary they should never be against the wish of the officers affected.

The question of transfer of honorary medical men is likely to arise under two conditions. One would be when a new place is created in a hospital or when a place falls vacant by the retirement or resignation of an incumbent. The other occasion would be when a person is found unsuitable for the particular office he holds at the time. It is certainly essential that the Government should possess means for rectifying such defects. In such cases, we consider that it would be correct to allow the officer concerned to sever his connection with the institution.

It might happen that a medical officer who is not found suitable for one place may be fit for another office. In this case, he should resign from the former appointment and apply for the other place and take his chance with other applicants for the same.

In the other condition of a new appointment or the filling up of a vacancy, the best procedure would be to select from applicants for the particular office, the existing honorary officers being eligible to apply. We would earnestly commend these alternative procedures to the consideration of the Government. The transfer of an honorary officer from one institution to another against his desire is totally wrong and besides, the retention of this power gives no advantage to the Government.

There is another point in the revised rules to which we wish to draw the attention of our readers. Rule 6 begins thus: "Ordinarily an honorary medical officer will start from the lowest grade and gradually work up: but in exceptional cases and for special reasons the recommending authority may propose deviations from this course....."

We hope that such exceptional and special cases would be very rare. A strict adherence to this rule by the Government should ensure the selection of experienced and well tried medical men for the more responsible posts and would prevent unhealthy rivalry in the profession for honorary appointments.

The Honorary Medical Staff.

We have recently referred in these pages to some of the difficulties in the way of the independent medical profession. We have therein pointed out how the increasing association of practitioners with the working of the public hospitals would minimise those difficulties. It is therefore essential that the profession should do its utmost to make the honorary scheme a success. Those who have been associated with this scheme from its inception are well aware of the many hindrances that beset the path of the honorary medical officers. Some Government medical officers mistakenly look upon their honorary colleagues as rivals who have appeared on the scene to deprive them of their position and private practice. But increasing association with honorary men have helped many of them to

change their erroneous views. We understand that in the city of Madras and in some of the more important headquarters hospitals the relations between the two sets of workers are quite harmonious. There might still be some Government medical officers who are either too senior to be capable of correcting their views, or who have not yet come in contact with honorary men. The younger honorary officers who may chance to work with these men may experience some difficulties or inconveniences which might check their ardour for honorary work. These difficulties generally group round allocation of work, hours of attendance, and matter of prestige. Of the three, the hours of attendance should give the least trouble. We would advise our honorary friends to come to a definite understanding with the medical officers in charge of the hospitals about the time and keep to it invariably. The honorary men stand to gain by this arrangement. It is difficult for the honorary officer to attend the hospital in time, when he is called away from his residence on an urgent maternity work. A message left behind to inform the medical officer in charge as to the cause of absence should reasonably prevent complaints.

Allocation of work is really a difficult matter. No general rules could be usefully laid down as conditions vary in different places. There are Government medical officers who cheerfully divide the work equally and fairly with their honorary colleagues. There are others who grudgingly give away the most uninteresting portion of the work to the newly appointed men. Between these two limits there are interesting gradations. In many cases the young men feel that they are trifled with by the official in charge of the hospital and that insignificant work is allotted to them to humiliate them in the eyes of the public. It is difficult to say that the young men feel wrongly. We know of an instance where an honorary surgeon was detailed to look after a ward of over twenty beds with hardly any patients for almost a year. These beds were never better occupied even in other hands. We know of another instance where an honorary surgeon who was capable of very good surgery was detailed to look after a structure condemned for the use of so called chronic patients. Things have altered in recent years. But we give these instances to show that the young honorary officer is likely to meet with similar situations. They should look on the early years as testing time. They should patiently undertake the work allotted to them and then represent the true state of affairs to higher authorities. We are glad to know that most of the district medical officers now realize the initial difficulties of the honorary officers and are willing to deal fairly by them. Junior honorary medical officers who have difficulties and who find that they are not getting a fair deal in their institutions should acquaint the District Medical officers with their requirements in the usual way before they take the hasty step of resigning their appointments. They should resign only if their reasonable grievances are not set right by the Surgeon-General and the Government.

The question of prestige is really a question of personal relationship of the honorary and the Government Medical officers. The official is as likely to assume superior wisdom as the honorary worker is likely to sense insult in every little incident. We leave the official to be dealt with by the head of the department. But we would emphasize that the honorary medical officer has no prestige. He does not thrive on it. But he has privilege, the incomparably superior privilege to serve the poor and needy sick who crowd into hospitals and outside. If he uses this privilege well and wisely, he can let his Government colleague and his prestige alone.

We have written somewhat frankly and in detail. We do not intend this short article to be a sacred tablet for the guidance of the honorary medical officers. But we merely desire to indicate to our younger brethren where to look for help when they meet with difficulties. They might feel that we are calling on them to hold on to the honorary appointments in spite of indignities. We do not suggest anything of the kind. But we request them not to send in their resignation before they have fully endeavoured to have their reasonable grievances removed.

We consider the honorary scheme essential for the growth of the independent Medical profession and the profession has therefore the right to demand of its members that they should do their portion for the success of the scheme. Even more than the profession, the country requires the growth of the honorary scheme as it is at present essential for the expansion of medical relief. We are confident that the younger members of the profession would respond to the call cheerfully.

GOVERNMENT OF MADRAS

Local Self-Government Department

(Public Health)

G.O. No. 1610, P.H., 29th July 1932.

Honorary medical officers—Rules issued in G.O. No. 899, P.H., dated 11th April 1930, revised.

Order—No. 1610, P. H., dated 29th July 1932.

In G. O. No. 1705, P. H., dated 11th September 1931, the report of the Committee appointed to consider the question of revision of the rules relating to the appointment of honorary medical officers was published for general information. The Government have since considered the recommendations of the Committee and also the resolutions passed by the South Indian Medical Union and certain other associations thereon.

2. The rules relating to the appointment of honorary medical officers as revised and approved by the Government are appended to this order.

3. Separate orders will issue on the recommendation of the Committee in regard to the replacement of paid Government medical officers by honorary officers.

4. The Surgeon-General is requested to publish a general notification in the *Fort St. George Gazette* and in the more important daily newspapers of the Madras City announcing that honorary appointments will be made to all the Government hospitals in the Presidency and inviting applications before a certain date. He will then consider the applications and make recommendations in those cases in which honorary appointments are considered necessary and also suitable candidates are forthcoming.

(By order of the Government,
Ministry of Local Self-Government)

S. G. SENGODAIYAN,

Deputy Secretary to Government.

To the Surgeon-General.

,, Secretary, The South Indian Medical Union.

Press.

APPENDIX.

Rules relating to the appointment of honorary medical officers in Government hospitals in the Madras Presidency.

1. Honorary medical officers will be appointed to all Government hospitals in Madras City and to all Government headquarter hospitals. In the case of medical institutions at divisional centres, the appointment of honorary officers will ordinarily be restricted to those institutions where only one medical officer is employed. Appointments will be made by the Government on the recommendation of the Surgeon-General.

2. Whenever it is proposed to make an honorary appointment in any hospital, due publicity should be given.

to such proposal by publication in the notice board of the hospital concerned (and in the office of the District Medical Officer in the case of mufassal hospitals) and otherwise. Applications should at the same time be invited and out of those received the best should be recommended.

3. Medical officers desirous of honorary appointments in special subjects but who have not had the special training necessary to give them proficiency in that subject will be permitted to undergo training without payment of fees at one of the Government Medical Colleges or hospitals attached to a teaching institution for the period considered necessary by the Surgeon-General provided they execute a bond to serve the Government as honorary medical officers in that speciality for a minimum period of two years on completion of the training at a place to be agreed to beforehand by the applicant and the Surgeon-General. The officers will not be entitled to any travelling allowance for journeys which they may undertake in this connection.

4. Honorary officers with special qualifications will, as far as possible, be placed in independent charge of special departments, e.g., (i) eye, (ii) ear, nose, and throat, (iii) radiology, (iv) venereal diseases, etc., and given full scope to work up successful clinics.

5. *Designation.*—Honorary medical officers appointed to hospitals which are attached to teaching institution and to those which are not so attached will be designated as follows :—

(1) Clinical assistants.

(2) Honorary assistant surgeons or honorary assistant physicians.

(3) Honorary physicians or honorary surgeons. Honorary medical officers appointed for a speciality such as ophthalmology, ear, nose and throat work, pathology, radiology, venerology, dermatology, including leprosy work will be appointed to one of the above three grades with further indication as to their speciality.

6. Ordinarily an honorary medical officer will start from the lowest grade and gradually work up; but in exceptional cases and for special reasons the recommending authority may propose deviations from this course. Medical graduates who have served as house surgeons and house physicians and have been successful or may be successful in the competitive examination for Assistant Surgeons held in the year 1929 or subsequently will be permitted to commence service as an honorary assistant surgeon or assistant physician.

7. *Qualifications—A. Hospitals not attached to Teaching Institutions.*—A candidate for appointment as honorary surgeon and honorary physician in a hospital which is not attached to a teaching institution should satisfy one or more of the following requirements :—

(*a*) That he has held hospital or other appointments affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service rendered and has had actual recent practice in performing the service rendered or services of a similar character, or

(*b*) that he has had special academic or post-graduate study which comprises the service rendered ; and has actual recent practice as aforesaid, or

(*c*) that he is generally recognized by other practitioners in the area as having special proficiency and experience in a service which comprises the service rendered.

B. Hospitals attached to Teaching Institutions.—A candidate for appointment as clinical assistant in a hospital attached to a teaching institution should hold the degree of M.B.B.S., or its equivalent. A candidate possessing

the L.M.P. diploma or an equivalent qualification may however be appointed in exceptional cases as clinical assistant in a hospital attached to a teaching institution for licentiates or in a hospital for special subjects. A candidate for appointment as honorary assistant surgeon or honorary assistant physician should have previous service as a clinical assistant for a minimum period of two years from which one year may be deducted for service as a house surgeon or house physician. A candidate for appointment as honorary physician or surgeon should possess one of the following academic qualifications: M.D., M.S., M.R.C.P., F.R.C.S., F.C.O.G., or one of the special diplomas signifying skill in the speciality of his appointment. The age-limit for appointment is fixed at 60 years.

8. *Tenure of appointment.*—The minimum period that an honorary medical officer should spend as clinical assistant is two years and the maximum five years. If he has served as house surgeon or house physician in a hospital approved for the purpose by the Surgeon-General he will be allowed to shorten his period as clinical assistant by a maximum of one year. No period less than six months as a house surgeon or house physician will be counted towards the deduction of the period to be spent as clinical assistant. There will be no time-limit for the tenure of the other two grades of honorary appointments.

9. *Duties.*—Honorary officers should conform to the rules in force in the hospital in which they are working in so far as they relate to the care of patients.

10. Honorary surgeons and physicians will be placed in charge of a specified number of beds for surgical and medical cases respectively and they will be entirely responsible for the treatment and care of the patients in their charge. They should visit the patients in their charge daily or more than once daily should that be necessary except on Sundays and answer all emergent calls relating to these patients on Sundays. In the hospitals which are attached to teaching institutions, the honorary officers will be responsible for imparting clinical instruction to students in connection with the beds in their charge in accordance with such plans as may be laid down by the professor in charge of the medical or surgical unit or by the Superintendent of the hospital.

11. In the case of large hospitals, the honorary surgeon or physician will be given an assistant to help him, who may also be an honorary worker.

12. Honorary clinical assistants, honorary assistant surgeons and honorary assistant physicians will perform such duties as may be assigned to them. The allocation of their duties either in the in-patient or out-patient department or in both will be made by the Superintendent of the hospital in the case of hospitals in the Madras City and at the district headquarters and by the District Medical Officer in the case of other medical institutions at divisional centres. An appeal shall, however, lie to the Surgeon-General against the allocation so made.

13. *Hours of attendance.*—Honorary medical officers who have charge of hospital beds should attend the hospital daily except on Sundays. Those who have only out-patients in their charge may attend daily but need not attend after previous arrangement with the Superintendent of the hospital and the District Medical Officer more than three days a week. In the case of hospitals attached to teaching institutions the honorary officers should be present at the respective hospitals on such days and at such hours as may be necessary for the proper instruction of the students. In the case of other hospitals honorary medical officers should make their hospital visits during the recognized hospital hours.

14. Honorary clinical assistants, honorary assistant surgeons and honorary assistant physicians should attend the hospital at such hours as may be fixed by the Superintendent of the hospital in consultation with the honorary officer after obtaining the approval of the Surgeon-General.

15. If for any reason the honorary officers are unable to attend during the prescribed hours they should inform the Superintendent or medical officer in charge in time to enable him to arrange for their work.

16. Honorary medical officers will issue the necessary certificates for patients under their treatment but should not except at the special request of the Superintendent or in his absence of the senior medical officer in charge deal with any cases in the in-patient or out-patient department other than those assigned to them or with the other miscellaneous work of the hospitals.

17. *Reports on officers.*—On the 31st January of each year, District Medical Officers and Superintendents of Presidency Hospitals should submit to the Surgeon-General in the form prescribed by him confidential reports on all honorary officers serving under them.

18. *Leave.*—Honorary medical officers may be granted casual leave up to fifteen days in a year by the Superintendents or medical officers in charge of the hospitals. They may be granted leave of absence other than casual leave by the Surgeon-General if he is satisfied that arrangements can be made for carrying on their duties without extra expenditure to Government. In such cases, the honorary officers will be considered to have a lien on their appointments during the period of leave and they will be allowed to rejoin their appointments on the expiry of the leave. If no such arrangements can be made, the honorary officers should be instructed to resign their appointments and fresh appointments should be made in their place.

19. *Transfer.*—Honorary medical officers in Madras City will be liable to transfer from one institution to another at the discretion of the Government.

20. *Termination of appointment.*—The appointments will be terminable by three months' notice in writing on either side.

21. *Re employment.*—Honorary officers re-employed after discharge will be re-accepted into their former rank.

22. *General rules.*—Honorary officers will be allowed the use of the respective hospital libraries and in the case of teaching institutions, of the libraries of the college or school attached to them.

23. They must abide by the Government rules in force in regard to the acceptance of fees from patients by the staff of the hospital.

24. The entire management and control of the hospital and the discipline of the staff are vested in the respective Superintendents or medical officers in charge. Honorary officers will be expected to observe all rules in force or issue from time to time and to report all instances of neglect or inattention or other breaches of discipline relating to their wards to the Superintendents or medical officers in charge who will deal with them. They may freely consult the Superintendents or medical officers in charge on any points in respect of which they consider the rules to admit of improvement but must abide by any decision the latter may arrive at.

The Superintendents and medical officers in charge of the hospitals should give full scope to the honorary workers and endeavour to make the scheme a success.

BULLETIN

OF THE

SOUTH INDIAN MEDICAL ASSOCIATION.

SEPTEMBER 1932.

Medical Education.

By Dr. T. Satakopan, M.D.

The present interest in the question of medical education in Madras that is evinced by medical men and the public is indeed very gratifying. General education, itself a vast problem has ever exercised the minds of man down the long centuries. The ideas about education, its objective and the methods adopted in imparting it have varied according to the changing vicissitudes of man. More so, the ideals and the methods of medical education. Discovery of new lands, opening up of uninhabited jungles, newer modes of transport, more ruthless methods of warfare, and the rapid fluctuation in the prosperity of countries, have all contributed to the many new problems of medical thought and skill. The methods and objectives of medical education necessarily change.

It is unnecessary to trace here the progress of medicine or the course of medical education in various countries or from ancient times. The main question that agitates the public mind here and elsewhere in India is whether there should be differing grades of medical education in this country. A careful study of the controversy reveals two useful facts. First, it is recognized almost universally that the initial minimum qualification for all medical practitioners should be of one standard. And secondly, it is unanimously agreed that the existing minimum standard is unsatisfactory and that it should be immediately very much improved. The emergence of these two facts makes the task of the educational reformer much easier. The present generation may not be aware of the difficulties that delayed this recognition. It is almost a quarter of a century since this view was pressed before the public with the characteristic vigour of the late Dr. T. M. Nair and his then enthusiastic associate Dr. U. Rama Rau. "The Antiseptic" of those days would bear testimony to this statement. Public opinion has progressed far since then. It now remains to decide as to what should be the minimum standard and as to what would be the best agency to look after medical education. The current views could be thus summarised. (1) All medical education should be of the present University standard and that it should be under the aegis of a University. (2) It should be of the University standard, but not necessarily under a University. (3) The standard should be high, but not of the University and that it should be outside a University. It is necessary to discuss the merits of the various views definitely and in detail.

Beginning with the last proposal, *viz.*, the lower than the University standard, those who know the temper and feeling of the qualified licentiates and the students of the various medical schools know only too well that this suggestion would be indignantly rejected by them. And that is as it should be. Apart from sentiment, public utility and safety demand that the practitioners of medicine in this country should be the highest possible trained and educated. In a land of scattered hamlets far away from railway stations and ill served by roads, the medical man settled in rural parts, if he is to be fully helpful to the poor people round about, should more and more rely on himself for all emergencies. He should be thoroughly equipped and resourceful to render relief and to investigate. His education and

training can therefore never be too high.

The second view, in relation to the first, might appear to be a distinction without difference. Those who are of the second view are serious. It should be examined very carefully. As far as one can see, the reasons that weigh with this group seem to be as follows. (1) The University insists on the Intermediate standard as the preliminary equipment for entering on the medical course. (2) This adds much to the expense of the course. (3) And the students are compelled to start their medical education at an unnecessarily higher age. (4) Academic influences are unnecessary. (5) The University is bureaucratic and tyrannous, whereas medical education should be controlled by democratic bodies. (6) If all medical education is under University control, it would be difficult to improve the status of the licentiates that are already qualified.

The first three objections can be discussed together. It is certainly true that the preliminary standard of the Intermediate course lengthens the education of the future medical man by two years and it adds to the expense. But as long as medical education is in the English language, this difficulty cannot be helped. But these are not unmixed evils. These two additional years of study increase the proficiency in English, and as the student gets a little better familiarity with the humanities, the medical man gains rather than loses in the long run. Better knowledge of the language helps him better to understand his books, helps his powers of expression and really helps him to pass his examinations more easily, thereby gaining what he might have lost earlier. Also, better knowledge of the language creates an interest in its literature and other cultural pursuits. Further, the extra knowledge he obtains in the preliminary sciences in the Intermediate classes, saves him some time during the medical course. Otherwise time would have to be found for these subjects in the medical curriculum itself.

As regards the question of age, it is held by some that it would be better to catch the students young as they come cut of the high schools at a more impressionable age and to take them to their medical education. But it has nowhere been suggested that the students who enter the Madras or Vizagapatam Medical College do not take to their studies with zeal and diligence, nor has it been proved that the pupils of the various medical schools are generally younger or are more zealous and diligent as a result of their entering on their medical career directly from the high school. The pupils enter the Medical schools when they are about eighteen or nineteen and leave them when about twenty-two or twenty-three years old. Many of them are much older when they pass out. The age conditions in the colleges are not very different.

There are a few who consider that the academic atmosphere of a University is unnecessary for the future practitioner. They hold that University education is apt to make medical students scholars and thinkers. They consider this inimical to quick decision and prompt action, and hence disadvantageous to medical men who should be extremely practical and should be able to decide and to act in sudden emergencies. This view is superficial and mistaken and is generally held by people who have not unfortunately had the advantage of a University education. Among the various schools of Medicine, the British and the Continental schools particularly the German, are considered to typify the two views on medical education. The British in their various Royal Colleges

aim at producing practitioners who are efficient in looking after the sick population; while on the Continent the aim is to produce scientific investigators and men devoted to medical research. But whatever the methods adopted, the vast majority of medical men finally settle down to practise medicine, to relieve the ailing and to repair the injured. Nevertheless, about 15 to 25% of those who qualify for medicine are available in those countries to devote themselves chiefly or entirely to research in the wards and laboratories. In India and particularly in Madras, the total number of qualified medical men is small. It is difficult to hope for a marked increase in that number in the near future. And if it is attempted to have two classes of medical men within that small number, one for general practice and another for research, the number of successful investigators would be very small indeed. Further the idea that there could be two distinct sets of medical men, one for research and the other for practice is rapidly fading. A casual acquaintance with the history of medicine, both ancient and modern, reveals that the best investigators were men whose skill in healing attracted to them great multitudes from near and far. After an unfortunate lapse, the truth has been refound that the enthusiastic and skilful practitioner is the most proper person for carrying on research. It is therefore essential that the training of medical men in this country should aim at combining both these qualities in them. This could be better achieved if the students are brought up in an academic atmosphere.

It is a very general belief among medical men that the University of Madras is tyrannous and bureaucratic. It is alleged that those who guide and practically control the University in the department of Medicine do not appear to have any useful policy. As at present constituted, those who shape medical education are said to form a ring jealously guarding it against strangers, But here, it is as well to remind the critics that the Faculty of Medicine and the Board of Studies in Medicine have each a non-official or two on them, though it be meant as garnish for the dish. These Bodies are constituted almost entirely by the professors and lecturers of the Madras Medical College. They are all of them in the services of the Government and in unequal official positions. It is very likely that the official superiors and the more influential among them dictate the policy for the others to follow without much question. It is also probable that the official bickerings and jealousies might be reflected in the activities of these University Boards. But, if as is complained, the university is unreasonable and autocratic, it is still a semi-autonomous institution, with a great deal of freedom from official control. And if such a body is not said to be amenable to public opinion, it is rather unreasonable to hope that a Board constituted directly under State control would be any more responsive to such opinion. The attitude of the official ridden University should indeed be a warning! A forceful president of the College Board or of the Board of Examiners might conceivably be a more mischievous tyrant than the most autocratic University Body.

The question of improving the knowledge and status of the qualified Licentiate is an important one. The existence of the inferiorly trained medical men is said to clog the progress of the science and profession of medicine in this country. Among others, this feeling of inferiority has been one of the main causes for the present demand for raising the standard of education. It should be acknowledged that none has been so keen and insistent on this need than the noble band of men and women who have

suffered from the handicap and unmerited indignities incidental to the possession of inferior diplomas and equipment. One might feel to be as competent as any other practitioner. One might be a more successful practitioner than many of his University brethren. It might also be that one's services are in greater demand by the people amidst whom one lives. But despite these evidences of professional competency and success in life, if one does not get the regard and approbation of the learned and the thoughtful of the society, one does feel greatly hurt. It is this feeling that is at the bottom of the present demand for improved education. The All-India Medical Bill that is now in the making, the non-recognition of their diploma in other countries and the distinction that is in many places made between the licentiate and the graduate in Medicine have together made this demand urgent. The licentiates therefore seek for measures which would help them quickly to escape from this undesirable situation, In the interests of the unity and dignity of the profession, and even more, to enable the country to have a more effective service of medical relief, this desire of the licentiates should be fully and immediately satisfied. Valuable time has been lost and the progress that would attend the efforts of a united profession has not been realized. No efforts would therefore be too much if this necessary object could be achieved very early. But rectification of the past should not victimize the future. And if this be the main reason for the desire to organize medical education outside the sphere of the university, then it is an untenable argument.

The arguments of those who advocate that all medical education should be of a uniform initial qualifying standard remain to be examined. Medical education in all countries except Great Britain and Ireland is in association with Universities. It is only in the latter countries that it is also carried on by other bodies besides the Universities. And even here, we have reasons to believe that any extension of medical education outside the Universities would be strictly discountenanced. It would not be amiss to remind our readers of the causes for the existence of these multiple bodies in the United Kingdom. The various Royal Colleges of Physicians and Surgeons are ancient. They have been in existence long before the Universities were created. Oxford and Cambridge might probably be exceptions. It is the ancient and high tradition attached to these institutions that make their diplomas so valuable in English speaking countries. Since there is no such hoary tradition associated with the licensing boards in this province, there is no point in attempting to introduce almost meaningless college diplomas here. Granting of these diplomas and the creation of such Boards might enable a few individuals to satisfy their vanity, but from the point of improving the standard of medical education and relief, it would be a waste and a failure.

The present standard set by the local University is considered to be about the minimum needed to train suitable and reasonably efficient practitioners. And any medical school which might be newly created or which might desire to improve its existing standard of education should necessarily aim at the standard of the Madras University. And if such a school happens to be within the area served by the University, it might as well get affiliated to the latter. In the case of schools which may be near other Universities, they might be affiliated to the respective Universities. Such affiliation would cost no more to the State than if the schools were controlled by any newly constituted board of studies and examiners. On the other

hand, a certain amount of saving could be expected.

When all medical education is established on University basis, all medical men begin their career with identical training and qualification. This initial equality of equipment and allegiance to a common institution is the best foundation for building up a tradition of which the future profession could be proud. Those who contend that equality of training and qualification need not necessarly be under the aegis of the University would appear to forget one of the most common failings of human nature. Whatever might be the case in other countries, University qualification is here looked upon as the highest in all branches of learning. When an institution fights shy of affiliation to the university, it is bound to be looked upon as inferior and so its diplomas. In this province, some of the recent departments of education which were at first content to award their own diplomas, are now affiliated to the university, thereby proving that the University awards are considered superior to college diplomas even in technical or professional departments such as agriculture, commerce and economics.

Medicine is of the learned professions and as one of the former principals of the Madras Medical College put it, it is easily the noblest of professions. It is so, because those who practise it are not only learned in the science and art of the profession, but are also cultured to a great degree. As one of the greatest of its professors said exactly a generation ago, " In no profession does culture count for so much as in medicine, and no man needs it more than the general practitioner working among all sorts and conditions of men."....." The wider and freer a man's general education the better practitioner is he likely to be, particularly among the higher classes to whom the reassurance and sympathy of a cultivated gentleman may mean much more than pills and potions." And mindful of the familiar critic, he said " for men who do the hard general practices among the poor and in rough agricultural regions, culture is very essential. It is the antiseptic which may prevent the infection and may keep a man sweet and whole amid the most debasing surroundings." Our Universities are not yet famous for their cultural activities. But in the recent years they have been striving in this direction. Should the future practitioners of medicine be denied even the little that these Universities are capable of imparting ?

There is all around us the tragic evidence of what happens to medicine when its practice is confined to those who are devoid of learning and culture. The degenerate state of " indigenous " medicine is a menacing reproach. Hindu and Arabic Medicines were famous in their days. But when under most unfortunate conditions, their profession and practice were taken up by uncultured and often unlettered men, what a state medicine has come to ! Shall we repeat that mistake ?

Otitis Media.*

Anatomy, Pathology, Signs, Symptoms and Differential Diagnosis.

M. Sanjeeva Rao, M.B. & B.S.—

Otitis media, or middle-ear inflammation deserves much more prominence and closer attention than it has hitherto received at the hands of the medical profession on account of

(1) Frequency of its incidence.

(2) Numerous and often dangerous complications that it may give rise to.

* Papers read before the South Indian Medical Union, Sepetmber 1932.

(3) Great tendency to chronicity with difficulties of cure and functional recovery, if neglected.

(4) Complete success of the methods of treatment if diagnosed early and treated promptly.

(5) Impairment of hearing which is bound to affect the subject adversely in the struggle for existence, *e.g.*, doctors, shorthand writers, actors, etc.

(6) Possibility of its acting as a focus of infection.

The middle-ear is a tiny cavity in the temporal bone, communicating through the eustachian tube with the naso-pharynx and through the aditus with the antrum and mastoid air cells. These together constitute the middle-ear cleft *i.e.*, Eustachian tube, tympanum, aditus, antrum and air cells and develop from the visceral pouch of the embryo. Like the paranasal air sinuses it commences as a small out-growing bud of mucosa from the nasopharynx and grows into the foetal connective tissue of the temporal bone, expanding backwards and lining the middle-ear cleft and covering the tympanic ossicles and chorda tympani nerve with mucous membrane. In reacting to inflammation also the middle-ear cleft closely resembles the paranasal sinuses.

The surgical importance of inflammation in this region can be vividly realized if we recall the important structures surrounding it. To mention a few, we have (1) above, the dura mater covering the temporal lobe of the brain, separated by a thin plate of bone —Tegmen Tympani. (2) The Jugular Bulb is separated from its floor by a very thin partition of bone—easily absorbable under inflammatory conditions; and what is worse still, these two bony partitions may present congenital dehiscences. (3) Again the labyrinth on the medial wall may be invaded via the oval or round windows or thin plates of bone covering lateral semi-circular canal or promontory. These easily give way for instance under the pressure of cholesteatomatus masses. (4) Posteriorly the signoid sinus is separated by a thin plate of bone called the sinus plate from the mastoid air cells. (5) The facial nerve embedded in the postero-medial aspect is poorly protected and more liable to injury in chronic suppurations.

Aetiology.—For all practical purposes the infection is from the nose and throat, *e.g.*, either

(1) *Acute Rhino-pharyngitis*—following a simple cold or that occurring at the onset of infectious fevers, *e.g.*, Influenza, Smallpox, Diptheria, Tonsillitis, etc., or after operations about the nose and throat or by vigorous blowing of the nose during an attack of cold.

(2) *Chronic Rhino-pharyngitis.*—Commonest being that due to tonsils and adenoids in children. In adults it may be due to sinusitis, deflected septa, new growths, or tubercle or syphilis etc., etc.

Bacteriology.—In uncomplicated cases the infecting organisms are of the same strain as that of the nasopharynx, *e.g.*, staphylococci aureus or albus, streptococci—often hæmolytic variety, pneumococcus, influenza bacillus or tubercle etc. But this picture may be very much complicated by instillatin of all sorts of dirty oils and drops or stuffing the ear with some rag—certainly not an uncommon picture among the ignorant classes.

Pathology, Signs and Symptoms.—When the middle-ear is getting invaded by spread of infection from the naso-pharynx the Eustachian tube is usually involved first though it is possible to directly infect the middle-ear without such involvement, *e.g*, in blowing the nose and directly carrying septic material to middle-ear. In other cases the pro-

gress of the infection is rapid and salpingitis (inflammation of Eustachian tube) is not recognised as such.

Salpingitis.—During this stage, patient usually complains of pain radiating to the ear or cracking pain in the ear during swallowing, slight deafness or stuffy fealing in the ear. Drumhead is usually normal on otoscopy or may be slightly indrawn and successful rhinoscopy reveals a glazed, red and swollen pharyngeal orifice of the eustachian tube with probably a pellet of mucus. The nasopharyngeal picture will obviously reflect the causal condition. Pathologically there is an acute inflammation of the mucous membrane of the Eustachian tube.

Accute Otitis Media.—Salpingitis may resolve or may spread to the middle-ear. The accute otitis media may be catarrhal or purulent depending on the nature of the secretion serous or purulent. Whether the inflammation be catarrhal or suppurative the symptoms vary only in degree.

Symptoms.—(1) *Pain* usually worse at night. In purulent cases pain is very severe and confined to the depths of the ear or radiates over the temple or backways to occiput or to frontal region. It is intensified by anything which increases intra-tympanic pressure, *e.g.* sneering, coughing, etc., and is usually not relieved till the fluid is got rid of by absorption, paracentesis or perforation of drumhead. In acute purulent cases there is usually some " mastoid tenderness " due to catarrhal inflammation of antral mucosa. But this is of no serious significance as the bone is not involved and subsides in the treatment of the main disease.

(2) *Deafness.*—Variable depending usually upon the amount of fluid or infiltration of mucosa. *Tinnitus* and *Autophony* are also sometimes present.

(3) *Fever.*—In adults there is usually no fever or below 100°F. In children however the temparature may shoot up to 102 or 103 and the child repeatedly put its hand to its ear or bore its ear against the pillow. In some cases there may be symptoms strongly suggestive of meningitis, *e.g.*, vomiting, convulsions, positive Kernig and Babinski signs etc. In these cases lumbar puncture shows normal fluid, the appearance of the tympanic membrane gives the clue and paracentesis is followed by prompt relief of symptoms.

Signs.—In mild catarrhal cases there may be only in drawing of membrane on otoscopy or injection round the handle of malleus or of whole membrane. When there is serous exudation into the tympanum the drum appears dull or sometimes has a definite yellow tinge. When the fluid completely fills the tympanum, the drum appears as if a drop of oil has been spread on its surface or if only partly filled the upper wavy margin of the fluid may be recognisable through the translucent membrane.

In frankly purulent cases, there is radial injection of the drum vessels and later the whole membrane becomes uniformly red and bulges. Failing to resolve a yellow spot appears at the point where perforation is imminent. Often this spot can be seen pulsating by transmitted pulsation.

After perforation and discharge of contents it is usually necessary to syringe the ear to view the drumhead. The perforation can then be made out or a small bead of pus escaping from it can be seen.

The pathological changes are the same as those of the mucosa elsewhere, *e.g.*, either catarrhal inflammation with injection of the superficial vessels and sero-sanguinous discharge or those of purulent inflammation with leucocytic infiltration of the submucosa, swelling and exfoliation of epithelium, with

muco-purulent and purulent discharge, etc.

Chronic otitis media.—In unfavourable cases, *e.g.*, very debilitated patients with poor resisting power, or sometimes in otitis media following asthenic fevers like influenza, whooping cough, small-pox, typhoid, etc., or if badly treated in the previous stages or in cases of tubercular infection, the inflammation tends to become chronic. It also tends to become chronic if drainage is not free or if the causal condition persists, *e.g.*, tonsils and adenoids.

The chief signs and symptoms are:—

(1) *Discharge from the ear* may be very slight as to escape notice, or plentiful and muco-purulent or purulent, foetid or otherwise.

(2) *Impairment of hearing* depending upon the amount of damage to the essential tympanic structures, and more especially on the amount of sclerosis round the oval or round windows interfering with their mobility.

(3) *Perforation of the Tympanic Membranes.*—Variable in size and position, from a pinpoint up to total destruction of drumhead.

(4) *Tinnitus* is not an uncommon symptom.

(5) *Pain* is rather rare and when it does occur is of serious significance. Usually the drainage is defective and it points to the onset of serious intracranial complications.

Vertigo may be due to syringing the ear in some cases. But when occurring apart from it is usually due to erosion of lateral semicircular canal or possibly pressure on the stapes also.

Signs.—The ear has usually to be syringed to obtain a clear view of the drumhead. On otoscopy perforations varying from very small pinpoints up to total destruction of drumhead may be seen. Sometimes the membrane may be hidden by polypi or cholesteatoma. Perforations are usually single. It is sometimes multiplied in tuberculosis. In perforation of the Shrapnell's membrane there is usually disease of the attic with caries of the head of incus. The remaining portion of the membrane may be reddish or merely swollen or thickened.

Differential Diagnosis.—The only conditions arising for differential diagnosis are:

(1) Otitis media with or without mastoiditis.

(2) Otitis externa with or without retro-auricular cellulitis.

While in the vast majority of cases the differential diagnosis is easy, we do come across certain cases where the diagnosis is extremely difficult. It must also be remembered that the two conditions are often co-existent. The points that will help us in differential diagnosis are,

(1) *Discharge* in external otitis is thick and scanty. In otitis media profuse and muco-purulent.

(2) *Pain.*—In external otitis the pain is usually elicited by pressure on tragus or manipulation of auricle or pressure below ear lobe.

In otitis media it is increased by sneezing, coughing, etc.

In mastoiditis it is more deep seated and present on pressure over mastoid antrum or posterior border of mastoid or its tip.

(3) Hearing is more impaired in otitis media.

(4) Whistling or bubbling sound may be heard in otitis media if middle ear is inflated.

(5) Finally a good radiograph of the mastoid will show in mastoiditis, cloudi-

ness over the area with the cellular outlines indefinite and blurred, whereas in external otitis the picture will be normal.

C. V. C. Rao (Diploma of Vienna)—

After the elaborate and detailed paper read by my colleague Dr. Sanjeeva Rao, I know there should be no difficulty to diagnose "Otitis Media". Still I very much desire to mention a few points bearing on the diagnosis.

Otitis Media is either acute or chronic. Again acute otitis is either purulent or non-purulent. Earache with constitutional disturbances, redness, swelling and bulging of the membrane, though common in both types of acute attacks, the severity of these signs and symptoms will enable any one to diagnose a purulent otitis media.

Differential diagnosis.—The chief diseases, likely to be confused with, are Myringitis and Furunclosis of ear. It is not very easy to distinguish an acute attack from Myringitis as the latter accompanies the former also. The chief symptom is presence of deafness which is absent in myringitis. But in all these doubtful cases an early paracentesis is the safe method, instead of waiting for the diagnosis. Furunclosis of ear can easily simulate "acute otitis" especially when it is attended with swelling and oedema of mastoid region. But in Furuncle the swelling is limited to meatal wall external to isthmus while in middle-ear suppuration, the swelling extends to the supero-posterior wall and roof of meatus extending directly to the drum. If one can manage to get a glimpse of the drum with fine speculum in Furunclosis one finds the drum and malleus normal. Other diagnostic points are—pulling of external ear produces pain in Furuncle but nil in otitis media while pressure on mastoid produces pain in otitis media.

The diagnosis of "otitis media" is not really very difficult in adults but it is invariably overlooked in children due to the inability of the child to complain. In fact so many deaths in children are due to complications arising out of undiagnosed "otitis" which are put down as due to some fever of unknown cause, etc. Hence it cannot be too strongly insisted upon that a routine examination of the ear should be made in all cases of sick children. The otoscope is as essential as stethoscope in pediatric practice. If you find a sick child lying always on one side, suspect ear trouble.

Chronic otitis media though easy to be diagnosed, the treatment side of it is generally very much liable to be neglected by the doctor as well as the patient, as it does not invariably produce painful and distressing symptoms. But it is necessary to be guarded against this silent disease since the complications it may give rise to, are very serious and mostly fatal. In all cases of acute otitis, never omit to closely question the patient to get out from him, whether it is an acute exacerbation of a chronic complaint or just the first attack. If it is the former, it invariably portends some complications.

Complications.—The complications of otitis media are due to extension of infection from the middle-ear to the labyrinth, to the cranial contents or to the soft parts of the neck. It will not be possible for me here, to mention the diagnosis of various complications. I shall therefore mention only the various complications. Complications can broadly be divided into intracranial and extracranial.

(1) *Intracranial, middle fossa.* Brain abscess. (2) *Posterior fossa.* Cerebellar abscess. (3) *Meninges*—Meningitis.

Extracranial (1) Sinus thrombosis, if lateral sinus is affected (2) Mastoiditis

and mastoid abscess when infection is spread to mastoid cells (3) When inner ear is affected, Labyrinthitis (4) When infection spreads to soft tissues of neck, we have what is called a descending abscess or pterygo-maxillary and pharyngeal abscesses.

Facial paresis and paralysis of the sixth nerve are also not infrequent. Locally one may find granulations polypi and cholesteomata. These complications can occur both in acute and chronic otitis media.

Thus it is clear that grave complications can arise from that innocent looking and sometimes painless "otitis media." It is unnecessary for me to emphasize on the gravity of the prognosis in these cases. But the prognosis need not always be bad, if an early diagnosis is made and the necessary operation performed. If every practitioner realizes the importance of early care of these cases and enlightens his patients on the possible dangers and risk to his life, there is no doubt that the mortality in our country can be reduced to a great extent. I mention this not out of my personal experience but from the experiences of my professors in Vienna.

World renowned Otologistis like professors Ruttin and Neuman used to take pride, that general knowledge of Otology among the profession in Vienna is so well spread, that hardly a week passes without some life being just saved, because the case was diagnosed just in time for operation, before a fatal complication developed. They could quote us histories of hundreds of such cases.

M. R. Bail, L.M. & S.—

PROGNOSIS AND TREATMENT.

Acute catarrhal otitis media.—In early cases, and those due to adenoids, is good. It is not favourable in those cases, in which air douches do not improve the hearing, and in those, that recur frequently, giving rise to chronic adhesive process.

Treatment. — Prophylactic.—The unhealthy adenoid growths of children should be attended to, and their general health improved. Frequent attacks of cold should be avoided. The nasopharynx, in acute infectious diseases, should receive careful attention, by way of mild antiseptic douches and gargles.

Curative.—If the condition of the nose and throat permits, the fist step is to get rid of the fluid in the tympanum by politzerisation. This can be done every second day till the exudate ceases to appear. Massage of mastoid process is of doubtful value. Leeches or fly blisters are used with advantage in front, behind or below the ear. Under this treatment if the exudate does not diminish even after about a week, one thinks of paracentesis, immediately followed by politzerisation to drive the fluid from the tympanum. If the fluid is thick, suction can be applied with a Seigles speculum. Fluid in the meatus is mopped up and a little cotton wool worn in the ear. There is a great tendency for the perforation to close; this is avoided by the patient performing Valsalva's experiment 3 or 4 times a day, while the daily politzerisation and mastoid massage should not be stopped till the fluid ceases to accumulate. Inspite of this, if the perforation closes, the membrane can be incised once again. If even after a month, a cure is not affected under the above treatment, then, the causal condition in the nasopharynx, probably adenoid vegetations, should receive attention.

Acute purulent otitis media.—The prognosis is mostly good, both as regards hearing and stoppage of discharge. In mild cases without perforation, a complete cure can be expect-

ed But in cases of perforation, and especially those associated with exanthemata, it is not so favourable. In a few cases, complications are set up, which may prove fatal.

Treatment.—In mild cases, the patient should have rest in bed, bowels opened by calomel and saline. Pain is relieved by glycerine carbolic with cocaine or laudanum. Dry fomentations, *e.g.*, hot salt bags, are advised. When inflammation has subsided, a course of inflation with catheter or politzer bag, should be given to hasten return of hearing.

In severer cases of inflammation. when perforation is imminent, paracentesis is done, especially if the pain is severe as to rob the patient's night sleep, or if the drumhead is bulging—external meatus is cleaned with spirit or tincture of iodine, and an incision is made, with a tenotomy knife in a speculam, into the bulging part of the membrane from behind, above downwards and forwards, throughout the thickness of the membrane, under ethyl chloride. At first blood stained serum is seen; later discharge of pus relieves the pain.

When the ear begins to discharge through a natural perforation or after paracentesis, two methods of treatment are employed, viz., (1) *dry method* in which a piece of sterile ribbon gauze is inserted into the external meatus, with sterile forceps, and changed as often as it gets saturated with pus, *or* (2) *the wet method*, in which the ear is syringed with warm boric lotion or saline, every 2 or 3 hours, if the discharge is plenty, and less frequently, as the discharge diminishes. After syringing, it is dried with a cotton mop, and a cotton plug is lightly placed.

Vaccines are useful in subacute cases, which tend to become chronic. The ear is syringed with saline and dried. A pledget of cotton wool with rectified spirit is placed in external meatus for five minutes. A platinum loop is introduced into the tympanum through this perforation, and the secretion is transferred to a blood ascitic agar plate, or when operating in acute mastoiditis, the pus from the mastoid can be collected to prepare a vaccine, which hastens the cessation of aural discharge, and promotes healing of wound. Vaccines are said to be specially useful in purulent otitis media of infancy.

After inflammation in membrane has subsided, systematic inflation is carried out, if hearing does not improve rapidly. The causal adenoid growths are attended to. This can be done along with paracentesis under ethyl-chloride. It is necessary to ensure that the discharge has completely stopped by an otoscopic examination, and not to rely on symptoms alone, lest it should pass on to chronic otorrhea, with its attendant disabilities.

In cases, where copious discharge persists, deafness marked, perforation small, and all the above measures fail to cure within a reasonable period of time, draining through the mastoid, by opening the antrum should not be delayed. This procedure is called the Schwartz's or the classical or the simple.

Mastoid operation.—The other indications for this operation are :—(1) pain and mastoid tenderness for 2 or 3 days after paracentesis (2) fever above 100 and rapid pulse in adults (3) copious pulsating purulent discharge quickly refilling meatus, showing widespread infection of mastoid cells (4) sagging of meatal wall, subperiosteal oedema and Bisold's abscess (5) facial paralysis with tender mastoid (6) labyrinthine and intracranial complications.

Technique.—The skin around mastoid is shaved and painted with picric or iodine. Auricle is held forwards and an incision made through skin ¼" behind retro auricular fold down to the bone, and beyond the tip of mastoid. The periosteum is separated exposing the cortex up to posterior root of zygoma, suprameatal spine and tip of mastoid. With gouge cuts from behind forwards and inwards the cortex is removed exposing the tympanic antrum about ½" deep, behind the suprameatal spine.

All the diseased cells are searched and gouged away. In cases where the temperature was above 100, the dura matter of middle fossa of skull and of sigmoid sinus is exposed, and even the tip of mastoid removed to provide free drainage at the lower end, and especially, where the cells extend down to the tip. The cavity is swabbed with H_2O_2, syringed with warm saline, and lightly packed with indoform gauze which protudes at the lower end of the wound, while the upper ¾ is stitched up. External meatus is lightly packed with iodoform gauze, and the usual dressings applied. After a successful Schwartz's operation, the temperature is expected to remain normal, showing that the suppuration in the tympanic cavity is passing away, in which case the gauze plug in the external meatus is dry. Under these conditions, the dressings are changed after the 5th day, when the stitches are removed. If the tympanic discharge has not ceased the wound is not allowed to heal quickly by changing the dressings. Antogenous vaccines are used at this stage. Some surgeons advocate, what is known as the blood-clot method, in which, the cavity after being dried, is filled with Bipp, and the wound stitched throughout. This method could be used with advantage in late cases, *i.e.*, of more than six weeks' duration. In early cases, the former is better and it is safer to drain at the lower end.

Chronic Purulent otitis media—Prognosis.—The presence of a chronic middle-ear suppuration is a potent source of risk. At any time intracranial complications may set in. This danger is commoner in infancy and early adult life. It is more frequent in poorer classes, as a discharge from the ear is neglected as a trivial matter. Ear discharges, subsequent to exanthemata, are more prone to develop cranial complications. Perforations on the Sharpnell's membrane showing attic suppuration, or on posterior superior quardrant showing caries of incus, suppuration of tympic antrum, probably with erosion of the walls by cholesteotoma, are looked upon as more serious, than those on the anterior part of drumhead indicating a tubo tympanic infection calling for the treatment of nasopharynx, or on the posterior inferior quardrant, suggesting a suppuration of the lower part of tympanic cavity. In the latter cases, cranial complications are rarely met with.

Treatment :—The routine treatment consists in allowing 10 to 15 drops of hydrogen peroxide in the affected ear for about 5 minutes till it stops bubbling. It is then syringed with warm boric lotion in a brass syringe, dried with strile cotton wool, and inflated by Politzer method. The meatus is again mopped with cotton wool, and finally, about 10 drops of boric alcohol (10 gr. to oz. 1) is instilled and a cotton plug placed. The treatment is repeated 2 or 3 times a day according to the amount of discharge.

If this procedure does not succeed in a reasonable period, then intra-tympanic syringing could be tried under reflected light. Different writers have used various solutions. After cleaning the meatus, 10 drops of Calot's solution are instilled and forced into the deeper

parts by tragal pressure; till the patient feels the solution in the naso-pharynx or 1% solution of picric acid in 70% alcohol or a watery solution of hydrarg. perchlor (1 in 1000) with equal quantity of glycerine several times a day or anæsthetic ether. If after 3 weeks' treatment, no improvement is seen, then a radical mastoid is advisible.

If the secretion is mucopurulent syringing the middle ear through the Eustachian tube will be efficient. An ordinary catheter is passed through the tube, and inflated with air, to ensure its position. An ear syringe with boric lotion is fitted into the catheter, and the tympanic cavity washed, some of the fluid escaping through the perforation into the external meatus. Again air is injected. Finally, 2 to 10% solution of argyrol is sent through the catheter, and blown up the tube with a Politzer bag.

The same treatment could be tried the other way as well. External meatus is cleaned by syringing in the usual way. The syringe is fitted with a bulbous nozle, so that it fits the meatus well and the tympanic cavity is washed into the nasopharynx with a fistula bag in the meatus, the passages are dried, and finally argyrol is instilled into the meatus, and driven through the tube in the same way.

If the discharge is foetid, either a 40% formaldehyde (*i.e.*, 20 drops in oz. 1 of boiling water), or creolin 1% or hydrarg. perchlor 1 in 3000 could be used for syringing.

Instead of the wet method of syringing, some otologists advocate the dry method, by which the aural discharge is mopped up with cotton wool and boric alcohol (10 gr. to oz. 1) instilled.

In cases of large perforation with scanty discharge, after syringing and drying the ear, boric acid or aristol, or orthoform or xeroform powders are insufflated, to from a thin film on the perforation and membrane.

When sepsis is confined to more of tympanum (*i.e.*, not in the attic or antrum) and when the perforation is large enough, to allow the solution to enter the middle ear, zinc ionisisation is useful (*i.e.*, zinc sulphate 75 gr., glycerine oz. 2 water 35 oz.) with an equal quantity of hot water. After syringing with boric lotion, and drying the ear, it is filled with the solution, and the positive electrode, a zinc wire in vulcanite speculam, is placed in the meatus, the indifferent electrode being placed over the arm or leg, on a towel wet with saline. 3 or 4 m. a. are slowly let in for 10 min., and diminished to zero, before the speculam is removed. If the suppuration does not yield within 2 or 3 sittings, it is useless to continue.

When the suppuration has stopped, and the perforation dry, a pledget of cotton is worn, to avoid water getting into the ear during a bath, lest the inflammation should recur. Sea bath is also avoided. To induce healing, and cicatrisation of the perforation, a few surgeons have advocated the painting of trichlor-acetic acid, or Tr. Ferriperchlor or $AgNO_3$.

After the discharge has ceased completely, the impairment of hearing can be remedied by an artificial drum. The simplest method is to take some cotton, and make it into the shape of a pear, and moisten in liquid paraffin or boroglyceride. It is then placed against the perforation, with an aural forceps. In the beginning, it is placed for an hour or two, and later, throughout the day, being removed only at night. A fresh one is placed the next day. After some time, the patient himself can do

it. If suppuration recurs, this should he discontinued at once.

By conservative treatment, *i.e.*, drops, syringing, etc., if efficiently carried out, about 50 per cent of the cure can be obtained. Another 25 per cent may need special method, *viz.*, intratympanic or Eustachian syringing or ionisisation. The remaining 25 per cent require a radical mastoid or the modified radical operation.

The radical operation consists in converting the complicated middle-ear spaces, into a common cavity communicating with external meatus. The procedure is more or less same as Schwartz; but here, the outer wall of the aditus, called the bridge, and the incus and malleus if present are removed; the auditory tube and tympanic cavity scraped carefully.

Tuberculous otitis media.—By way of prophylaxis, in this type, very common among children, mention must be made of pure milk supply, along with fresh air and nutritious food. The curative treatment, in this chronic variety, is as before, with the addition, that an early radical mastoid is advisible, the condition of the patient pemitting, try Pfannelstill's method, sodium iodide is administered in increasing doses, and the operation cavity is plugged with gauze soaked in H_2O_2 daily, to liberate nascent iodine. After treatment should be in a sanatoriam.

Syphilitic otitis media.—The local conservative treatment does not differ from other chronic varieties of otitis. The results of constitutional antisyphilitic treatments are not encouraging. For the congenital type, antenatal antisyphilitic treatment, is said to give better results, than the subsequent mercury inunction with administration of potassium iodide. Injections of Hg. followed by salvarsan, pilocarpine injections, administration of thyroid extract with Hg, and potassium iodide, are some of the other lines of treatment, that could be tried. Yet, the resulting deafness, in a long standing case, has little chance of recovery; while, early cases may improve under the above methods. In adults, salvarsan alone is not only not efficacious, but said to be dangerous, as a source of ear trouble. Hg is always combined with it. Yet both Hg and As. are not supposed to pass the choroid plexus, and hence, the cerebro spinal fluid. Probably, Bismuth preparations, are of little more use.

UNION NOTES.

The ordinary clinical meeting of the Union for the month of September was held as usual at 32, Broadway, at 6-30 p. m. when Dr. M. Sanjiva Rao opened the discussion of the evening by reading a paper on " Otitis Media". Drs. C. V. C. Rao and Bail followed with papers respectively on the " Complications " and " Prognosis and Treatment " of the same condition. As pointed out on a previous occasion a team of speakers on a subject enables the subject to be dealt with in an exhaustive manner. A number of the members took part in the discussion.

The number of applications for membership till now received, will be put forward for election on Monday the 3rd of October before the meeting of the Governing Body of the Union.

The Secretaries make an appeal to all the members who are in arrears of subscription kindly to pay up the dues as early as possible.
