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THE MADRAS CLINICAL JOURNAL



MONTHLY JOURNAL OF THE MADRAS STATE BRANCH INDIAN MEDICAL ASSOCIATION

Vol. I

FEBRUARY 1956

No. 2

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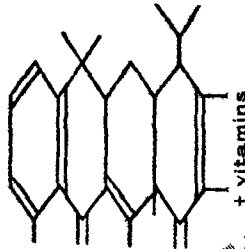
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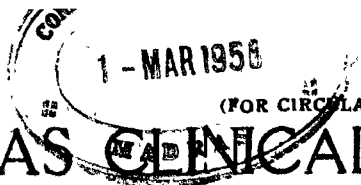
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TREATMENT IN DERMATOLOGY

By:

Dr. S. RAJAGOPALAN, L.M.S., Madras

I have a big field to cover. I know I will not be able to deal with all the Dermatological conditions. I am going to mention some points regarding the treatment in Dermatology, in general, and treatment in some of the Dermatological conditions, in particular.

To begin with the beginning, we all know the fundamental understanding about using lotions and creams for acute conditions, pastes for sub-acute conditions, and Ointments for Chronic conditions. I will never be tired of repeatedly mentioning the following points, though extraordinarily simple.

We must remember that a skin condition does not need as much Antiseptic precautions as a surgical condition. These precautions when taken, only help to aggravate the condition. It definitely hurts, to wash a skin lesion with Lysol or Dettol. It is an unnecessary and injurious practice to clean skin lesions extra frequently and thoroughly, with soap. This is only asking for trouble. I know of poor patients borrowing money to buy a cake of carbolic soap, to wash their skin conditions with. It is just "buying"

trouble. These Antiseptic measures are done with such good intentions by the patients, that they refuse to believe, that they could ever retard the healing, and they don't think it is necessary to tell the Doctor. That is why it is a useful and very necessary question, to ask the patient, what he is doing with himself. It is not uncommon to hear the patient say- he cleans the part with spirit to remove the old application, dips the part in a fairly strong Lysol bath, and gives it a good wash with carbolic soap, as a finishing touch !!

Next;-It is worth while to ascertain from the patient, when he puts the Ointment on, how long he keeps it on, and how he removes it. There is such a fondness for "Rubbing in the stuff" that the poor, almost imperceptible lesion starts weeping by the time this rubbing is over !

The Cream or Ointment must be applied thin and left over for at least six hours-it will be best, if it is left over-night. We should never think it is unnecessary to repeatedly tell the patient to be gentle about the cleaning in the morning. Dried-up areas must be soaked in oil or

warm water, and then cleaned. If you only get a chance to see the way the lesion is cleaned, in the morning, you almost feel like slapping the patient. In those two minutes, enough damage is done, not only to undo the overnight healing, but to delay the cure by a few days. I think I will sum it up by saying - skin lesion needs rest, needs to be severely left alone. This is more so because the majority of skin conditions you get, for treatment are suffering from over treatment. You never see a recent undisturbed lesion. Nobody comes to say 'I have got this from yesterday.' That is why there is always an inflamed stage to stem over in the treatment of most of the skin conditions. It is because of this I would emphasise on giving a cream on the first occasion. Cream to allay irritation, cream to allay inflammation, and cream on first occasion. If you don't know what to give - give a cream.

I am not exaggerating when I say that you do 80% good by asking the patient to stop what all he is doing - This plus, some soothing external application, and probably fomentations, do a world of good.

It is not sufficiently realised that looking after the general condition is an important part of the skin treatment. Sometimes it is the only thing necessary.

Treatment in Dermatology depends on the stage of irritation or inflammation of the condition, whatever the Diagnosis. You might have diagnosed ten cases as ten different things, but would have prescribed zinc Cream for all of them.

I think we have to just treat more cases - to settle down to using milder external applications, smaller doses of internal medicaments, and a very short list of medicaments.

In the treatment of Infants for any condition, maximum benefit in the quickest time is derived from constant looking after, to prevent scratching and to avoid hurting any part by any other means. Anything bland externally, plus fomentations, boric Baths or tub baths. Nearer the healing the parts could be bandaged lightly with cream, where possible, and the bandage changed every 6 hours.

I am afraid I am telling you all very elementary things. In a subject like Dermatology which is refreshingly vague, and where experimentation is rampant, it is so very easy to make a paper sound learned. You will have to be wading in the mire for a quite a few years, to realise the importance of these fundamentals.

It is unfortunate that for such a harrasing and all important symptom, Itching, the most economical remedy should be entirely within the reach of the patient. I am referring to Scratching. They forget that it is their leg, and if you are not on the look out, they may take up your hand to help, in the scratching.

Skin conditions, as somebody said, are benign to life and do not announce themselves in the clarion voice of death. This explains why, people are casual and callous about skin conditions. Skin as a living organ, is unique in the way it is placed. Though part of the general Physiological system, it protects the other organs from the environment, all the time being in contact with the latter. It is this contact with the environment that involves its putting up with, and adapting itself to, innumerable insults.

The hazards to which the skin is exposed, have been largely increased,

of late years, by the introduction of new chemical processes in industries, and of new drugs in medicine, and by the increased use of cosmetics.

Remedies are multiplying. There are any number of permutations and combinations. You really wish they were simpler. In the maze it is a pity we bypass the immense good that could be derived from the common simple thing. Will not one be laughed at, if one talked of a plain wet dressing with plain water.

Is it sufficiently realised that this is perhaps more efficacious, or most certainly less harmful, than the galore of fantasies in the market? How many of these patents contain a plain Zinc Cream? It is always a Sulpha or an Aneasthetic or Anti-pruritic or some other, if you will pardon me using the word, "masala" added to it.

That reminds me about the patents. I can't enumerate all of them. In the treatment for some of the conditions I am going to talk about, I would mention useful relevant patents. You must know why you like a patent, for what particular ingredient in it, and you must know for what condition you could use it and that at what stage. Patents, you prescribe for more than one reason. I am always for writing a prescription, but you could never get the "Get Up" of some of these patents. There are patents, very nicely got up, where you like the container more than the contained! I was always against the *same* patents claiming fantastic results for conditions very very *different*.

Four or five qualities make an application acceptable. Three of them denoted as S³ are stain, stink, and sting. I can't go into details and give you examples of these.

To these 3 qualities I would add efficiency, and cost.

We have now to think more of the relation between the Speciality and the rest of medicine. This has created an approach vast in extent, and difficult to completely regimentalise, if I may use the word. I would certainly quote Sir Russel Brain's Speech in the recent Congress in London. He says about the saying "Beauty is Skin deep," "I won't refute the statement, especially with so many Dermatologists in front of me." But he says he would certainly refute the statement that Dermatology is skin deep. A speciality which ranges from the viruses at one extreme, to the mind of man at the other, can be no superficial science. Surely we ought to regard a speciality, not as a circumscribed area of medicine, but as the whole of medicine seen from a particular view point.

A word about some of the new remedies, or shall I say! recent advances.

With the exception of Penicillin and Sulphonamides and perhaps some Fungicides, the practice of Dermatology cannot be said to have received much help over the last decade, by the introduction of new drugs to its armamentarium. Coal Tar, Calamine, Salicylic Acid, Phynol, Resorcinol and the salts of copper, mercury, Zinc and Lead, are as much in vogue to day, as they were many years ago. Moreover some of the newer drugs, although useful, lack that degree of specificity which we can attribute to the remedies in other branches of medicine, and the Clinician is still faced much too often with the obstinate skin condition. In dermatology, the work of the Bio-chemist has opened fresh fields for investigations. The last war has given great oppurtunities for nutritional

research. Skin Tuberculosis has been discussed in the recent Conference at London.

There are no remedies to mention, which could be called as Specifics for conditions, and which are really improvements on the existing reliable remedies.

One outstanding recent find, which is really the treatment of choice now for Pemphigus, is ACTH and Cortisone. This does not cure this condition. It certainly puts off the fatal end by some months or years. For all the other conditions A.C.T. H. or Cortisone would be just as good as any other. A. C. T. H. should be reserved for patients, who fail to respond to other types of treatment, because of the danger of complications from the hormone.

Pemphigus complicated by pregnancy is rare. The Corticoid output increases in the first and third trimester, and improvement in the Pemphigus during this period could be predicted. A drop in the endogenous cortical hormone in the second trimester could explain the exacerbation at this time. Similarly the exacerbation, which followed delivery, could have been due to the known drop in cortical hormone production after delivery.

The CORTISONE applications, plain and with an Antibiotic, have no particular advantage over the other remedies. One company uses Cortisone with Neomycin, and an other company uses Cortisone with Terramycin. Cortisone by itself, and in combination with the Antibiotic, could cause an Allergic Dermatitis. Cortisone applications are costly, and available in very small quantities.

Two or three conditions which need limited use of the Ointment, and for which this application may be

used are Anal Pruritus, Vulval Pruritus and what I have been calling as "Kammal Dermatitis" and "Kumkum" Dermatitis!!

The large expanse of ANTIBIOTIC and SULPHA DRUGS have a place in Dermatology during the inflamed stage of any condition. I have already mentioned that there is always an inflamed stage in all the conditions, and it is after getting over this we start the specific remedies. The inflammation is the same for all the conditions. Of the Sulphas and the Antibiotics, the safest and most convenient drug, which is also cheap, is Penicillin G Crystal. I would use the G Crystals dissolved in water, and give two lacs, twice a day, intramuscular, for one or two days. I would rather avoid the Procaine or Oil Penicillin.

Penicillin orally has not been as satisfactory as Aureomycin or Terramycin or the other Antibiotics that could be given orally. Without exception, they are all capable of causing a Dermatitis, or a disagreement in some way or an other. I will prefer for parenteral or oral administration an Antibiotic rather than a Sulpha Preparation. The variations are always there.

For external applications among the Sulphas and the Antibiotics, the most preferable, though it is not practicable to use it always, is Penicillin Spray, 1000 units in one c.c. The solution must be preserved after it is made. This solution could be sprayed two or three times during the day.

The Sulpha and the Antibiotic Ointments have no spectacular results, as applications for inflammations. Sometimes they flare it up and in an individual who is sensitive to the application, it is enough if even a half sq. inch area of the inflamed

skin is in contact with the application, to get a general Dermatitis overnight. The best treatment for an inflammation will be Zinc Cream, and in addition to this, the patient could get Vitamin C and an Antibiotic orally or parenterally. As I have mentioned before, unless one is against Injections, the best thing to do, would be parenteral Penicillin G Crystal dissolved in water.

It should not be forgotten, that in an Ointment the cause of the trouble need not necessarily be only the active ingredient, but it could be the vehicle. I am sure the bases used could be improved on.

ANTIHISTAMINES externally, orally and parenterally have a very limited curative action on skin condition. The oral and parenteral have probably the best effect in Urticaria. Unless very urgent there is no need to give Antihistamines parenterally. In the other Dermatoses, Antihistamines orally and parenterally have some effect in putting down the itching. It may be mentioned as a "non-Specific" effect. They do come in handy, sometimes in giving the patient better sleep, and more freedom from itching.

Antihistamine applications are no specifics for allergic inflammation, as is construed by many. You may choose an Antihistamine cream for its dainty get up, if the affected area is not very extensive. It is good as a soothing application not at the height of an inflammation, but only when the condition is healed to some extent.

The CHRYSAROBIN AND WHITFIELD OINTMENTS are still the best for Fungus. The organic acids which are available in the market, as Tinea-Fax containing Undecylenic Acid, and Purnatal containing propionic acids, are probably as good as whitfield.

Chrysarobin Ointment is still the best, provided it is used at the proper stage. Ointments are not meant for irritations or inflammations, much less a Chrysarobin Ointment. It is worthwhile to remember, when using Chrysarobin, that it hurts the eye extremely badly, and hence not be given for a face patch, and not to be prescribed for children. The latter could inadvertently hurt themselves. Chrysarobin is toxic, and could affect the kidney, and should be avoided if very extensive areas are affected.

Chrysarobin stains clothes leaving indelible marks. Lastly it is very important to remember that Chrysarobin could lend colours of its own to the hair. It is best to avoid for a scalp affection. I would always say, that it is a responsibility to treat a scalp, a bigger responsibility to treat a hairy scalp, and ten times more responsibility treating a lady's hairy scalp.

Things new have been suggested, to put in pigment, and to remove pigment. I must say a word about both. You all know how just a small achromic patch has disturbed the peace of so many families. If any misnomer has done havoc to society, it is the wrong name, "white leprosy" associated with Leucoderma. I always like to talk about this, I wont take your time now.

The Ammi Majus, with its components Xanthotoxin (Ammoidin) and imperatorin (Ammidin), is fairly promising to be a definite improvement on the existing remedy. As the French journals say, hair follicles, are first to repigment, usually. Repigmentation is just the same as in the embryo, in which the pigment appears initially in the hair cell, later it is produced by the Epithelial cell of the follicle, the basal layer of the Epidermis - and finally when

stimulation is strong enough, by the malpighian layer. New pigment may not be permanent. A number of writers believe, that this new pigment may be established by Majudin of Bergapten the third constituent of Ammi Majus. We have not tried the intradermal Injections. The intradermal injection technique is described by Dr. El Mofty in the last international Congress. The effectiveness of oral treatment have been confirmed by American Colleagues.

All in all, it can be said that even the qualified success of Xanthotoxin, justified the hope, that the era of almost complete frustration, in treating Vitiligo, may be approaching its end.

Management of Melamin Hyperpigmentation with Monobenzyle ether of Hydroquinone is still in the experimental stage.

The discrepancy between inflammatory and pigmentary response emphasises the fact that the mechanism, by which these treatments produce any effect, is not clearly understood.

One explanation is that, it is the combined effect of Sulphydriloxidation by 8 Methoxypsoralen, and of Ultra Violet stimulation of Melanocytes, which results in Melanin formations.

The recent reports about POLY UNSATURATED FATTY ACID F 99, in the treatment of Furunculosis, infantile Eczema, Adult Eczema, certain cases of Psoriasis, and Seborrhoea are very encouraging. It is a very rational and wholesome approach. Linoleic Acid is presented in a very pure form as Linacidin. The 100% purity counts in many respects. Linoleic Acid acts best in presence of Vitamin B6 and Calcium pantothenate.

The transformation of the fat in the Carbohydrates in the isolated Liver depended on the administration of Phosphotides which, the more Poly-saturated fatty Acids they contained, the more active they were. Poly unsaturated Fatty Acids play the principal part in the metabolic fat carbohydrate inter-relationship.

Breastmilk has higher percentage of Linoleic Acid than cow's milk. Breast fed infants suffer less from Infant Eczema. In Infant Eczema associated with digestive disorders, and specially in disorders of fat resorption, the body gradually becomes poorer in highly unsaturated fatty Acids. It is only active Linoleic Acid and Arachidonic Acids which exercise an efficient action on the skin and kidneys.

By completely eliminating the use of unsaturated Fatty Acids in the diet of rats, the following symptoms were noted:—scaly skin, Necrosis of the tail, slowing down of growth etc. even ending in death. These could be cured by Linoleic, Linolenic and Arachidonic Acids, contained in Oil of nuts, maize, poppy, soya, wheat germ, sesame.

Unsaturated Fatty Acids play a very important part in the general metabolism, but their main action has not yet been clearly defined.

It may be concluded by saying that the treatment of Eczemas, by unsaturated Fatty Acids undeniably represents a notable improvement on the usual therapeutics which has until now been quite disappointing. The specialised preparation Linacidin (Laboratory Pharmakon, Zurich) which contain a combination of Linoleic, linolenic and Arathidonic is a definite improvement on pure Linoleic Acids.

Allergies have increased because of the increase of cosmetics and make-ups. To treat these conditions you must know what all could cause an irritation, so that you may stop the provocation. The sensitisation could be from cosmetics, clothes, and jewellery.

Hair dyes could cause an irritation due to the presence of para Phenalene-Diamin and similar compounds. This dye is also the cause of the Dermatitis in the case of lip sticks, nail varnish and Kum Kum Dermatitis.

Permanent waving, and depilation, affect the hair badly. These attack the keratin chemically and break down Disulphide linkages.

Oxidation dyes and Alkalies hurt in some cases.

Photo Dynamic Substances like Eosin could cause an irritation in the case of lip sticks.

Rubber goods could cause a Dermatitis and depigmentation of a restricted area. The active agent at work being the Mono Benzyle, ether of Hydroquinone.

Plastics as a provocation can't be missed.

In all these cases you must try to prevent the contact and treat the irritation with a bland application. Plastics are becoming very popular. We won't be surprised if one of these days we will be served with plastic Jangaries, or Jillobies!

GRENZ RAY AND THORIUM may have a big future.

Grenz ray scores over XRay in two ways. The damage is less and the browning is deeper. It is more indi-

icated for delicate parts, like the lips and the glands.

Thorium if it is going to fulfill its claims, is going to be X Ray minus its bad effects. That will be very welcome indeed.

I would now mention the treatments for a few conditions:—

DERMATITIS. I am dealing with only treatment.

The general condition, teeth and throat are to be checked. Motion examined for ova, cysts and cells. For patients over 35 or 40 the urine to be examined. From the history, if we are lucky, we are able to know what the provocation is, and we stop it. We must know what all things could cause the trouble. Hurting may be of two kinds, the local damage done by a strong application or the general rebellion of the system due to the contact and absorption of the application. The general rebelling could be there, even after an Injection or after anything else taken orally.

The commonest offenders are the Sulpha drugs and it is always advisable to stop them altogether. The Antibiotics could cause a Dermatitis whether injected, injected or applied. The sequence of events in relation to the starting of the Dermatitis would help. It is useful to know a few other things that could cause the Dermatitis. Phenolthalein could cause a Dermatitis. Most of the laxatives contain it.

Other than the Antibiotics and Sulpha a few other external applications could hurt, example Acriflavine and Mercurochrome.

The allergic hurting is avoided by eliminating a few things as mentioned above.

It always helps to make the patient a Vegetarian for a few days, to hurry the cure. The usual things given at the height of a reaction are, Vitamin C, Calcium Gluconate and some Anti-histamines. Zinc Cream could be given for external application.

As I have mentioned earlier, parenteral Penicillin G Crystals dissolved in water seems to be the best, two lacs, twice a day, intramuscular for two days. We will be really unfortunate, if even this disagreed.

You can't treat an Allergy or Toxaemia without Vitamin C. I think it is the most reliable and efficient Vitamin, to combat the condition. A very efficient combination will be Calcium Gluconate, Glucose, and Vitamin C.

Vitamin K sometimes helps.

It is in the second stage when the patient is better, and when the inflammation is less, we switch on to Unguentum Hydrarg or a Lassars Paste, as external applications. It is at this stage that Milk, Autohaemotherapy or Lertigon injections, could be helpful. The above three injections are not to be used at the height of a reaction. All of them could cause reactions of their own. They are more meant to increase the resistance of the patient, and if not altogether to prevent a recurrence, at least to make it less severe, and few and far between.

Lertigon is Azo protein of P. D.

B. Complex injections sometimes start trouble because of the Anaesthetics in it or because of the Liver extract.

B/12 could cause a Dermatitis.

For external applications some combination of tar will be good.

Pics Liquid goes best with a paste and not with a cream or an Ointment, and the popular and efficient Lassars Paste will be the best base.

I always think it is necessary to mark out the treatment for a Dermatitis in two stages, if we have to do justice to the patient.

SCABIES is common.

It is important because it is common. A few points to remember in the treatment are:—

- (1) Preliminary scrub.
- (2) Sufficient quantity of Ointment.
- (3) Treat contacts, and prevent reinfection.

Things to be used:—

Unguentum Danish, is still one of the best. It must be given for a quiet condition with no irritation, or inflammation.

Unguentum Sulphuris - is also one of the best.

In the comparative study they had during the previous war Derrisroot was pronounced the cheapest and most efficient.

Benzyl Benzoas though popular has two disadvantages:—

- (1) Costly
- (2) could produce Dermatitis.

The acceptable combination of Benzyl Benzoas is a 25 to 30% water Emulsion.

A few new remedies deserve mention:—

- (1) Earax - Crotonyl N - Ethyl O Toluidine.

(2) Tetmosol - Tetra Ethyl Thiurium Monosulphide - 5% Emulsion in Oil.

These are very good. They could be used for children, and they have no bite about them.

(3) Neo-Scaboint - claimed as very good, and mentioned as "Kwell" (Hexa - Chloro Cyclo Hexane) I am not able to give any opinion, because I have not had sufficient quantity of the application to go through my trials.

INFANTS AND CHILDREN come for treatment for usually 5 conditions:— Scabies, Impetigo, Seborrhoeac Eczema, Infantile Eczema, and Nutritional Oedema. The last is definitely better looked after on the Medical side.

SCABIES AND IMPETIGO:— Either separately or together - Need to be looked after carefully. The inflammatory stage is looked after with Cream, Vitamin C and Penicillin (parenteral)

After the inflammation has subsided, Hydrarg Oxidi Flavi - 5 grains, in one Oz. of Zinc Cream is very useful.

B. P. Unguentum Hydrarg is also useful. A very good patent is Cusi Dermoses Anti-Impetiginous.

All the above things look after the Impetigo-part of it.

Eurax is a very good application for Scabies in children.

Unguentum Danish, if used must be diluted. - It could be mixed with an equal part of Unguentum Zinc.

The prevention of Re-infection, as you all know, is a bigger problem and that must be always borne in mind.

INFANTILE ECZEMA AND SEBORRHOEAC ECZEMA are very difficult conditions to bring under control.

Infantile Eczema is a wholly Allergic condition and Seborrhoeic Eczema is probably not so Allergic.

In treating infants and children—we have to give applications, internal medicines and injections, if any.

Apart from these, attention must be bestowed on correcting the diet of the infant, and if the child is getting mother's milk, the mother has to go on diet. Eledon Feeds sometime help. Changing to half cream milk is also sometimes helpful.

The usual things given are Vitamin C, Riboflavine & Nicotinamide, Vitamin K sometimes helps, more in the case of Infantile Eczema.

Vi-daylin - Abbott, are Paladac P.D - are found general tonics to give. Orange and Tomato juice are good additions, unless they themselves cause trouble, or disagree in some way.

Parenteral Penicillin will be the best for stemming over the inflammatory period. If anti-Biotic have to be given orally Aureomycin - Spersoids is good.

Zinc Cream both the formulae are good. Gention Violet - 1%. In water could be applied for raw areas, and over this the Zinc Cream could be applied.

When the condition is better, Eurax, Milkan Sulphur Lotion, and any of the Anti-Histamine creams are applications that could be used.

The best way of protecting from the scratching, would be to bandage the part as much as possible after liberal application of the cream.

If the patient could afford it, Cortril or Cortef Ointment could be used externally. I would certainly prefer the plain, without the Antibiotic.

Cortisone and A. C. T. H. orally or parenterally have no specific effect on these conditions. They should be

used only if the other remedies have failed.

Nearer the healing, Ultra Violet Baths help. The eyes must be well protected.

Lastly a word about a few conditions which need a wider approach, and a very careful handling in the course of their treatment. Some of them border on the **PSYCHOSOMATIC TYPES** and necessitate a treatment regime bordering on Social Medicine. Some of the big writers label them as "Dangerous Diseases", to give more emphasis on the essentially sympathetic, kind and human approach, that should be the essence of the treatment. They are not dangerous to life, but they are dangerous because of the likelihood of producing a permanent dent in the future outlook of the patient, and in that way, have a very injurious and unhealthy influence on the patient's mind. The emphasis here is more on the psychological trauma, and the cosmetic disfiguration that the condition could result in, ending in the bad influences. These become more significant because the condition occurs in an adult and the seat of affection is the face. Adolescence is a very important stage when many systemic important reshufflings take place. You are at the junction of the main trunk roads. It is essential that you progress in the right direction.

I will refer to two conditions, **Chronic Seborrhoeic Dermatitis**, and **ACNE VULGARIS**. We have to remember the following things when we are treating a case:— The greatest predisposing factor for these two conditions is Adolescence. This is the important transition period at which there is such a reshuffling of the gland system, and any want of equilibrium in the Endocrine system influences the sebaceous secretion. Seborrhoea, Acne and Adolescence are great

friends. You may probably get Seborrhoea without Acne, but you very rarely get Acne without Seborrhoea. Because Seborrhoea affects the face, as a rule, and because Seborrhoea is commonest and virulent during Adolescence, I would emphasis as a rule, that a Doctor treating a face condition in the Adult should get into the habit of examining the scalp and treat it, if necessary. A cleaner scalp, ipso facto, a cleaner face. The treatment will not be complete if this is not done. A double emphasis if the patient is a girl. It often happens that the patient never complains of the scalp condition.

Adolescence, the important impressionable stage brings on another very important influence that could control the condition, and very often does—the psychic influence. Seborrhoea Dermatitis and Acne become more elusive to treatment, get an exacerbation frequently for no obvious provocation, because of the psychic influence which could set into action, any other influence to the patient's advantage or disadvantage, that the approach to a Seborrhoeic patient, in the course of a treatment become definitely elaborate. It is because of this, the treatment and management of a case is certainly a good deal more than an Ointment, Injection and internal tonics.

The mental reactions are very important. As a great Psychologist William James said "I would remind you to realise, to allow an emotion (wishful thinking or day dreams) to go untranslated into action is a form of emotional debauchery that leads to deterioration.

The skin condition could become a permanent obsession, and the self conscious, introspective, suspicious, shy individual full of an inferiority complex is either pulled out of the

mire or just allowed to be dragged in. It is because of this that the emphasis is on a kind 100% sympathetic human approach. Callousness and casualness will be cruel. If you would, please remember that this patient comes to our consulting room, looking up to you for relief. The trust in you is very genuine. To whatever degree we succeed in giving the relief, one thing we could certainly do, be kind to him. Get his confidence. Make him trust you. Once the trust and confidence are there, the proper co-operation follows and in these cases it is the proper co-operation that is the essence of successful treatment. He may have a number of wrong views and silly ideas. It will be well intentioned diplomacy to agree with him to start with. Get his confidence and once this is done it is easy to get the implicit obedience. Call him a fool, but not on the first day. He won't believe you, but a five days

later, you find he agrees with you. The indispensable requisites for a successful treatment for this or any condition will be kindness and a smile. I always used to remind people, that among the other things in the Doctor's kit, take your smile with you, and having taken it remember to wear it as often as possible!

ACNE. just a word about treatment. The essence of the treatment is better remembered probably this way. Acne is from the Greek terminology Acme. If you remember this for the time being, these four letters would denote the fundamentals to remember in the treatment. A for Aneamia, and Vitamin A; C for Vitamin C and Constipation; M for Massage, very mild gentle massage over the area which is supposed to give the flip to the sebacious musculature; and 'E' for exercise, mild open-air recreation. I can't go into details.

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DIAGNOSIS AND TREATMENT OF CORONARY THROMBOSIS

By

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INTRODUCTION:—

Angina pectoris was known to the clinicians ever since the classical description of the disease by HEBERDEN in 1768, but the first authentic report of coronary thrombosis came from the pen of HERRICK in 1912. So coronary thrombosis should be considered a modern disease. In recent years, it has been observed that the age incidence of this disease is coming down. Thus it is no longer a disease of the aged, but is likely to strike people of the younger age group as well. It is rare in women, and, if present, is generally associated with hypertension or diabetes.

CLINICAL FEATURES:—

Coronary thrombosis is characterised by (i) Pain (ii) shock (iii) signs of cardiac failure (iv) changes in temperature, leucocyte count, sedimentation rate and electrocardiogram.

(i) Pain is the most arresting and the cardinal symptom of coronary thrombosis. It is situated in the centre of the chest, behind the sternum. The pain comes on gradually and in a few hours it reaches a maximum. It is generally constricting in nature. Some patients describe it as "squeezing". Shooting stitching, burning and catching pains are seldom due to coronary thrombosis. The pain has a tendency to radiate to the upper extremities and may sometimes be referred to the lower jaw.

(Case Report):—A patient aged 32, well-built, was brought to the out-patient department with severe pain in his lower jaw and teeth. On close enquiry, it was found he had vague pains in his chest and left upper extremity. On examination, he was found to be cold and clammy and his blood pressure was low. This case might have gone to a dentist, and perhaps died in the dentist's chair. His E. C. G. showed evidence of posterior myocardial infarction.

The pain may sometimes last longer in which case the prognosis is said to be poor.

Sometimes, instead of pain there might be other symptoms, like distension of the abdomen. I want to draw the attention of my medical colleagues to the fact that a vague discomfort in the abdomen should not be casually passed off as 'gas' or flatulence, especially in patients past the age of 40. These cases require careful investigation. I have many proved cases of coronary thrombosis in my series, where the disease was ushered in by upper abdominal discomfort. In this connection, I repeat Broadbent's dictum, "whenever a patient complains of pain in the chest think of the abdomen and vice versa".

(ii) Shock is best defined in terms of systolic blood pressure. When the systolic blood pressure stays at or below 70 m.m. Hg. for more than $\frac{1}{2}$ hr., one is safe in diagnosing shock. The

extremities are cold, the pulse is fast and the patient may vomit. The shock is due to the hyposystole of the heart. There are many cases of coronary thrombosis in which there had been no appreciable fall of B.P. in the first 12-24 hrs.

(iii) **Signs of cardiac failure.** It is the left ventricle which fails first and the patient when first seen may be severely dyspnoeic and may be mistaken to be suffering from acute left ventricular failure, without appreciating the coronary mischief. Many cases are on record in which there was no praecordial pain, but which were associated with intense dyspnoea. Recently I had one such patient. He was aged about 55, was suffering from hypertension and was admitted with intense dyspnoea. So we thought he was suffering from acute left ventricular failure due to hypertension. In two or three days time he developed right sided hemiplegia. An E. C. G. showed the presence of extensive anterior myocardial infarction. The course of events in the case is as follows: Acute myocardial infarction produced left ventricular failure. At the same time, the intra-mural endocardium was involved, which favoured a thrombus formation. The thrombus got detached and infarcted the brain. Sometimes, in the elderly, a gradual congestive failure might be the first indication of coronary thrombosis. I know a patient in whom the catastrophe was heralded by giddiness. Yet another patient of mine was admitted in coma. So, though pain is the characteristic symptom complex of coronary thrombosis, one must be prepared to come across instances where pain in the chest might not be present at all.

(iv) **Changes in temperature:** Within 24-48 hrs. there is a rise of temperature. It seldom goes beyond 102° F, and does not last longer than a week. If

the temperature persists, it is in favour of some intercurrent infection, thrombophlebitis or pulmonary embolism.

Leucocyte count increases by the 3rd day and does not generally exceed 15,000 per c.m.m. This too comes back to normal by the end of a week.

Sedimentation rate begins to record a rise by the end of one week and stays elevated for nearly a month. The above changes are due to the absorption of protein into the system from the infarcted area.

Changes in E. C. G. are very characteristic. The introduction of unipolar leads has been particularly helpful. If the multiple chest and limb leads show a normal configuration repeatedly, one is justified in excluding grave myocardial ischaemia. The usual changes in the E. C. G. in myocardial infarction are (a) an abnormal Q wave (b) elevation of ST. segment and (c) inversion of the T wave. When those changes are present in V3 and V4, antero-septal infarction is said to be present. When there is extensive anterior infarction these changes are seen in V1 to V6. High lateral infarction produces changes in AVL, whereas in posterior myocardial infarction the changes are present in AVF.

CLINICAL EXAMINATION shows that the pulse is fast and the extremities cold, for the first few hours. The pulse can be very slow, when there is complete heart block, or very fast when there is ventricular tachycardia. Both these conditions are of grave prognostic significance. Sometimes the pulse is likely to be irregular due to auricular fibrillation. Examination of the heart may show a gallop rhythm. Pericardial rub appears only after 36 hrs. of infarction, and that too only in anterior myocardial

infarction. Arrhythmias and change in cardiac rate will be obvious on auscultation. Bases of the lungs may show congestion and the liver may be tender, if there is congestive cardiac failure.

DIFFERENTIAL DIAGNOSIS: All causes of praecordial pain come into differential diagnosis. Functional pain has to be carefully separated from this condition. Patients with functional pain are neurotics and the pain is situated in the inframammary region. The pain has not the characteristic features of coronary thrombosis and all the laboratory findings are normal.

Dissecting aneurism produces severe tearing pain in the chest and may simulate coronary thrombosis. This occurs in elderly patients who are hypertensives. The pain radiates to the face, and from there down the back to the lower extremities. Within a few hours, a rough diastolic murmur may be detected in the aortic area or the pulse in one or other major peripheral arteries may disappear. X-ray might show double contour in the vessel area.

Pulmonary embolism: deserves careful differentiation. It occurs in patients who have been confined to bed for sometime, whereas coronary thrombosis occurs in healthy individuals who are active and moving about. Pulmonary embolism is generally preceded by the presence of phlebo-thrombosis in the lower extremities. The pain in pulmonary embolism is sudden and maximum from the beginning, whereas the pain in coronary thrombosis takes time to develop. Dyspnoea and cyanosis are commoner with pulmonary embolism. The E. C. G. in pulmonary embolism may simulate posterior myocardial infarction, but AVF is generally normal.

Spontaneous pneumothorax, cholecystitis, mesenteric embolism and acute haemorrhagic pancreatitis have to be differentiated from coronary thrombosis.

TREATMENT: depends on (i) giving maximum rest to the patient and to his heart till the scar has become firm and strong (ii) combating pain, shock and cardiac failure (iii) treating the complications as and when they arise.

Rest: is essential to reduce the cardiac load. The patient should be put to bed and nursed in the most comfortable position possible. The use of pillows is not prohibited. The patient may be allowed a com-mode if he finds the use of a bed pan difficult. It has been found that it takes 6 weeks for the scar in the myocardium to become firm and hence a minimum of 6 weeks bed-rest should be insisted upon. After six weeks the patient is allowed out of bed, and gradually one tries to find out the cardiac reserve. If there are no untoward symptoms, the patient is allowed to resume his duties after six months. One should appreciate the fact that prolonged rest in bed may prove to be positively harmful, especially in the elderly. So early ambulation in keeping with the cardiac condition should be insisted upon.

(ii) **Pain** should be controlled as quickly and as efficiently as possible. In my experience, there is no drug as dependable as morphia and it should be given in $\frac{1}{2}$ gr. doses which may be repeated every sixth hour. The usual route is the subcutaneous or, rarely, deep intramuscular. Some use 1/100 gr. of atropine along with morphia with the idea of blocking the vagus. They feel that atropine will prevent the coronary spasm and pulmonary oedema. It is doubtful

whether the vagus has any control over the coronary arteries and whether atropine will prevent pulmonary oedema. On the other hand, atropine is sure to induce tachycardia and hence may actually be harmful.

When once the pain is controlled, it is better to keep the patient on sedatives by giving 1 grain of phenobarbitone twice a day for the first week. If the pain is not controlled, oxygen administration under pressure, along with morphia, might produce favourable results.

If shock persists for more than a few hours, attempts should be made to elevate the blood pressure. I believe administration of 1 cc. of nor-adrenaline in 200 cc. of glucose intravenously is very helpful. A word of warning about intravenous therapy is essential here. If the circulation is loaded too suddenly by intravenous transfusions in the presence of coronary thrombosis, pulmonary oedema is certain to result.

Acute pulmonary oedema should be treated by morphia (in the doses mentioned above) by oxygen administration and intravenous administration of aminophylline. Aminophylline should be injected very slowly to avoid complications.

If congestive cardiac failure sets in early, the patient should be treated with mercurial injections and should be put on a salt-free diet. The place of digitalis in cardiac failure occurring in the course of recent myocardial infarction is debated.

Place of anti-coagulant therapy: Reports from America and Great Britain testify to the fact that the mortality in coronary thrombosis can be reduced by 50% by the institution of anti-coagulant therapy. Cases of coronary thrombosis can be divided

into "good risks" and "bad risks". Good risks are those patients whose general condition is good.

Bad risks are those in whom

- (1) pain lasts longer than 5 hours
- (2) shock persists
- (3) congestive cardiac failure appears early, and
- (4) arrhythmias and embolic phenomena are manifest.

All are agreed that these "bad risk" patients should be given the benefit of anti-coagulant therapy. One starts with 20,000 units of Heparin intravenously daily, in divided doses during the first two days. Simultaneously, 900-1200 mgms. of Tromexan is given orally daily. On the 3rd day a prothrombin estimation is made. The ideal is to keep the prothrombin time around 35 seconds. If on the third day the pro-thrombin time is below 35 seconds, the same dosage, i.e., 900 mgms, is maintained till the prothrombin time reaches 35 seconds. Later on, the dosage should be cautiously and carefully adjusted so that there is no wide fluctuation in the prothrombin time. This regime should be maintained for 3 weeks. Patients under this treatment should have their urine examined daily for microscopic haematuria. In my experience, anti-coagulants are not so dangerous as one is led to believe.

Diet. Patients suffering from coronary thrombosis must be put on liquid diet for the first one week. In the absence of complications biscuits, eggs and custard may be added to this food. By the sixth week the patient begins to take his normal food, but in reduced quantities. If basal crepitations are present, it is advisable to restrict salt in the diet.

Treatment of complications: In the first week the likely complications are congestive cardiac failure and ventricular tachycardia. The treatment of congestive cardiac failure has already been discussed. Ventricular tachycardia is a dangerous complication. It should be treated with procaine-amide, either orally or intravenously, depending upon the general condition of the patient. This treatment should be taken only when electrocardiographic control is available. Embolism is unlikely to take place in the presence of anti-coagulant therapy.

GENERAL ADVICE: A patient who had an attack of coronary thrombosis should be told the gravity of the disease, without making him a neurotic. Any predisposing factors, like hypertension and diabetes, should be carefully treated. 95% of all cases of coronary thrombosis are due to coronary atheroma, and atheroma is due to an upset in the lipoid metabolism. How far lipotropic factors, like Choline, will help to prevent the progress of coronary atheroma, time alone can say.

ANNOUNCEMENT

MEDICAL BULLETIN OF 5th ISSUE OF OCTOBER 1955.

200 copies of the Medical Bulletin, fifth issue, of October 1955, have been received from the Director of Medical Services, Madras, and are ready for supply to the members of the Indian Medical Association. The Government have recently permitted the supply of the Medical Bulletin to Registered Private Medical Practitioners also provided they register their names for the supply of the issue with the Honorary Secretary, Madras State Branch, Indian Medical Association. Hence the members of the medical profession, both members and non-members of the Indian Medical Association, who are desirous of having a copy of the fifth issue of the Medical Bulletin of October 1955 may send a requisition for the same to the Honorary Secretary, Indian Medical Association, Madras State Branch, No. 6, Rajabhadhar Mudaliar Road, Thyagarayanagar, Madras 17, enclosing SIX ANNAS postage stamps towards the cost of each copy of the Bulletin required inclusive of postage and incidental charges. 34 copies of third issue and 153 copies of fourth issue of the Medical Bulletin are also available at the same rate for those who wish to have them.

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R. SANKARAN, L.M.P.,
Honorary Secretary, Madras State Branch.

OPHTHALMIC EMERGENCIES IN GENERAL PRACTICE

By:

Dr. T. V. RANGANATHAN, M.B.B.S., L.O., TIRUCHY.

Whenever a general practitioner sees an eye case the natural tendency for him is to tell the patient to go to the nearest eye specialist. There is an inherent fear complex in the average general practitioner that if anything goes wrong, the eye will go blind. The end result of this fear complex is the eye especially in acute conditions does not get the proper immediate treatment it ought to receive before it reaches an eye specialist. Hence it is I ventured to put this article before you more to stimulate your interest, for, in acute conditions or an emergency in the eye early attention means so much in saving the sight in many cases.

Only certain of the ophthalmic emergencies affecting the anterior segment of the eye alone is dealt with. As in all other branches of medicine, a proper, careful and methodical examination of an eye is essential to arrive at a correct diagnosis and the main points in the external examination of an eye are as follows:—

A gross proptosis or protrusion of the eye ball or a marked squint often strikes the observers' eyes. But to proceed methodically you examine the lids and the palpebral aperture - is it normal on both sides.—do the eye lids close normally.—is the eye lid thickened as in trachoma, are the eye lids swollen - is there any stye or cystic swelling near the lid margins, — are there any dried up secretions in the lid margin, — are the eye lashes normal, or anything turned inwards or outwards. Next examine the conjunctiva, any congestion present. You note the nature of congestion, is it peripheral or peri-corneal, are there any phlyctenu-

les, evert the upper lid and examine the tarsal conjunctive for any foreign bodies or follicular appearance or searing, then examine the upper and lower fornices.

Examine the cornea, any foreign body or ulceration or opacity - general lusture of the cornea etc. The anterior chamber,—its depth - any hypopyon or Hyphaema present - next examine the Iris,—is it healthy, — are the markings on the iris clear,—examine the pupil, its size, shape and reaction and compare it with the other side.

Lastly and most important you must always examine the lachrymal sac for any regurgitation, denoting chronic dacryocystitis.

1. STYE. A stye is an acute suppurative inflammation of the glands of Zeiss. There is pain, tenderness, redness and swelling of the affected area. In an early case you find on the lid margin a small raised red area which is very tender and you also find the corresponding eye lash sticking out. In some cases, you can pull out the eye lash and let out the pus. In severe cases there is such a lot of cellulitis that both the eye lids get swollen up and oedematous and even the conjunctiva over the corresponding area is chemosed. It might simulate a retro-bulbar inflammation. But the absence of proptosis in a case of stye differentiates it from a retro-bulbar inflammation.

Treatment. Hot fomentation, Sulphanamides by mouth and keep the

* Lecture delivered at the Tiruchy Branch of I. M. A. on 23-7-55.

area perfectly clean. There is no need to apply Penicillin or any other antibiotic eye ointment, because it cannot have any action. Later on after the styte has opened out, you may apply some ointment, like Irgafen eye ointment or any other sulfa drug ointment or Sod. Sulphacetamide drops. But to apply Penicillin ointment or any other antibiotic to the eye in an early case of styte is like applying Penicillin ointment to a boil and dressing it before it has burst. Of course, in very severe cases where the attending cellulitis is very severe, Penicillin injection may be given. After the acute attack subsides you look for the cause of styte.

2. ACUTE DACRYOCYSTITIS. Again patient might come to you with a swelling at the inner angle of the eye, fever and complaining of intense pain. On examination you find that the maximum tenderness is at the site of the lacrymal sac area and there is a history of epiphora. Diagnosis acute Dacryocystitis. Of course at this stage, you cannot press on the lacrymal sac area to find out whether there is regurgitation or not because it is already inflamed and tender and any rough handling will only disperse the infected material. Treatment is the same as what you will do when you treat a boil or acute inflammation in any other part of the body. Hot fomentation and sulfa drugs orally and in some severe cases Penicillin injection in adequate doses are given. Wait till the natural barriers form and the pus to get localised. Then you incise and let out the pus and the healing occurs in no time. In acute dacryocystitis you do the same thing and when you incise it, the incision about $\frac{1}{2}$ inch long should be made just below the medial palpebral ligament and along the inferior orbital margin, and the incision should be sufficiently deep to let out the pus from the Lacrymal sac.

In some cases the inflammation has so much ulcerated the sac walls that in the process of healing after the incision scar tissues forms and obliterates the sac space leading to a spontaneous healing of the Chr. Dacryocystitis or as often occurs a sinus is left behind at site of the original incision and you will have to do an extirpation of lacrymal sac at a later stage.

3. HERPES. Next we will consider another type of emergency. The patient presents with acute pain in or around the eye and sometimes with headache on that side. You examine the eye and find nothing abnormal. No styte. No acute Dacryocystitis. Conjunctiva, cornea and Iris appears normal. Probably the cause is extra orbital. You examine the teeth. Here I wish to stress that there are quite a few cases of root abscess of a tooth giving rise to varied types of headache. The patient very seldom complains about this bad tooth. Only an X-Ray might reveal the root abscess and then the extraction of the corresponding tooth and healing of the abscess cavity gives permanent relief to that patient. Or you might find nothing wrong with the teeth. You examine the sinuses. It may be a case of sinusitis. Here the history in some cases will be of help. A typical history of a sinus headache will be that the patient gets the headache just as he gets up from his bed in the morning and the intensity of the headache becomes severe as the day progresses and by evening the headache is better. With this sort of typical history and when you find the sinuses hazy and the patient gives a history of cold along with his headache, you refer the patient to the E. N. T. specialist for further examination and treatment. But in some cases you might find the teeth and sinuses alright. You are unable

to diagnose the cause of the headache. You probably think that it is due to indigestion or a bilious headache. You give him a good dose of analgesic like Aspirin. The patient is satisfied and goes home but his headache persists and the next morning he finds fine crops of vesicles on that side. So when a patient presents with one sided headache with no previous history of such headaches and you are unable to find a cause, you think of Herpes. In an early case of Herpes there are only three things that can give one a lead. One is that the headache is of the nature of burning sensation in the skin and secondly in fair individuals. You will be able to note that the skin is redder on the affected side and this redness is limited exactly by the mid-line, and thirdly in some cases you will be able to demonstrate that there is hyperaesthesia of the skin on the affected side. After the vesicles have come out and when you find the distribution characteristic the diagnosis of the case is easy.

Treatment. Pitruatin and Dihydro Ergotamin Tartarate injection are still the sheet anchor. Vitamin B 1 parenterally and locally anaesthetic ointments like Xylocain ointment will be of use. But since the course of herpes is varied and since the eye ball also gets involved with iridocyclitis and corneal ulcers it is better to send the case on to the Eye specialist. Moreover the treatment of Post Herpetic neuralgia always gives a headache more to the doctor than to the patient and so it is safe to pass the baby on to somebody else.

Prognosis in Herpes :— Occuring in the aged say after 50 or 60 years it always heralds the impending death usually within a period of 3 to 5 years. Death being due to some other inter-current illness. That has been my experience.

4. KERATOMALACIA AND GONOCOCCAL OPHTHALMIA. Keratomalacia is an emergency in every sense of the word. Most of us are general practitioners and we often treat undernourished infants for chronic diarrhoea. But how often do we realise that those cases will be leading to an acute Vitamin A & D deficiency. Usually these infants are motherless or have had no mother's milk and there is no one in the family to look after the babies. One day the same infant might be brought to you with the complaint that it has not opened its eyes for two or three days. You open out the eyes and see the cornea dry and lusturless, conjunctiva smoky and dry and all the signs of advancing K. M. You may find the cornea ulcerated. Even at this stage there is still some chance to save the babies eyes. But if allowed to progress you might find the cornea completely dissolved as it were, over-night with no hope of any recovery.

Treatment. (1) In every case of chronic diarrhoea in an infant think of Vitamin A & D deficiency as a probable cause and treat for that deficiency. Giving Cod-Liver Oil or Vitamin A & D drugs by mouth, often aggravates the diarrhoea. So better give Vitamin A by injection (2) In advanced K. M. cases where a major part of the cornea is healthy Vit. A injection 100,000 units daily till the eye condition improves. Then a maintenance dose to be continued. Cod-Liver Oil drops and antibiotic eye ointments. Sulfa or antibiotics orally to check the diarrhoea and improve the nutrition by other methods.

Gonococcal Ophthalmia is also an emergency. Because though it is only a simple conjunctivitis the Gonococcus can penetrate an intact healthy cornea and cause havoc in the deeper tissues of the eye. Hence the emer-

gency. Gonococcal conjunctivitis is common in new born babies the infection being from the mother. Ophthalmic neonatorum is often Gonococcal. In adults it occurs usually in males. The lids become enormously swollen and tense pus freely flows out of the palpebral aperture. The most important point in diagnosis is the coincidence of Gonococcal Urethritis. The most important point in prognosis is the condition of the other eye. Because these patients often consider the Gonococcal Ophthalmia as simple acute catarrhal conjunctivitis they start treating it with house remedies or more enlightend patients treat it with Argryol or Silver Nitrate drops. And in a matter of a day or two the Gonococcus invades the cornea producing corneal ulcer. Perforation occurs and the eye is irretrivably lost. If you can save the other eye atleast you must be happy.

Treatment: Penicillin eye drops (2 lakshs of Crystallin Penicillin dissolved in 20 c.c. of distilled water) and Penicillin injections are good, keep the eyes clean and install a few drops of Penicillin drops every 5 minutes till the acute condition subsidies. You can apply it every half hour or, one hour later as the condition subsidies.

5. ACUTE CATARRHAL CONJUNCTIVITIS, ACUTE IRITS AND ACUTE GLAUCOMA. In all these three conditions redness of eyes is the prominent sign and pain in the eyes and headache the prominent symptom. A detailed consideration of these three conditions is important because very often a patient with redness of eyes goes to his family physician first for relief of his condition, And here one must be fully conversant with the three conditions to avoid dangerous

mistakes. For if you go on treating a case of Iritis as conjunctives with Argryol or even with the new anti-biotic eye ointments the patient will ultimately find that his vision is irrecoverably lost. Or if you wrongly diagnose a case of acute Glaucoma as Aceo start applying Argryol drops. You will be making the condition worse for every hour of delay in a case of acute Glaucoma adds to the permanent impairment of vision. Early and proper energetic treatment is of the greatest importance in saving the vision, in a case of acute Glaucoma. Conjunctivitis is a simple disease and rarely does it cause serious damage to the eye - usually bilateral with a feeling of grittiness in the eye (as though sand has got into the eyes) - There is copious muco-purulent discharge and intense congestion of the eyes. In Iritis there is severe dull pain in the eye-headache on that side-watering of eyes and the congestion in the eye is peri-corneal or circum corneal congestion of the anterior ciliary vessels. The absence of muco purulent discharge - no history of sticking of the lids in the morning and the peculiar changes in the Iris and pupil in a case of Iritis often distinguishes it from A. C. C. O.

In acute Glaucoma the onset usually sudden-there may be a history of high fever preceeding the attack-there is acute pain in the eye and headache - it is usually accompanied by gastro intestinal disturbance like Nausea and vomitting. The conjunctiva is congested anterior chamber is shallow-Pupil is dilated oval and reacts sluggishly to light or does not react at all.

The following table gives the chief differentiating points in the three conditions.

	A. C. C. O.	IRITIS	GLAUCOMA
Age	Usually children	Adults	Usually aged.
One or both eyes	Usually bilateral	Usually unilateral	Usually unilateral
Pain	Gritty feeling	Dull pain	Intense pain
Headache	Usually absent	Present	Severe
Discharge	Copious Muco- purulent	Serous or watery	Watery or nil
Onset	Gradual	Sudden	Sudden
General distur- bance	Nil	Nil	Accompanied by gastro intestinal disturbance
Lids	Dried up discharge on the lid margins and the muco- purulent discharge is flowing out	Nil	Nil
Congestion	Intense peripher- al congestion in the conjunctiva	Cirum-corneal con- gestion which is deep under the conjunctiva,	Slight indefinite congestion
Cornea	Clear in uncompli- cated cases	Clear in early cases	Loss of lusture or gloss of the cornea
Arterior chamber	Normal	Normal in early cases	A. C. Shallow
Iris	Markings normal	Muddy	Normal
Pupil	Normal in size and shape	Contracted and pupillary margin irregular	Dilated and oval
Pupil reaction	Brisk	No reaction or sluggish	No reaction or sluggish
Posterior synechiae	Absent	Present	Absent

Tension	Normal	Usually normal	Raised
Treatment	Wash Silver Nitrate 2% drops to be used to brush the upper tarsal conjunctiva. Argyrol 20% and 2-B drops. Sulfa ointments or anti- biotic ointments. No hot fomenta- tion	Atropine and treat the cause of Iritis (usually Syphilis)	Escrine $\frac{1}{2}$ % drops Purgatives Morphia and operative treatment

Though the differentiating points are so many yet there are a few cases which baffle even the most experienced Ophthalmologists. Hence it is that in all cases where you are in doubt you refer the cases to the nearest eye specialist.

INJURIES AND F. B. IN THE EYE. A contusion or black eye - first you advise a cold compress and later on hot fomentation to absorb the Haematoma. But now one injection Hyaluronidase subcutaneously at the site of the contusion resolves the haematoma dramatically. Cuts in eye lids - horizontal cuts of the lids i.e., cuts in the plane of the orbicularis oculi muscle and parallel to it - You need not stitch them up. A clean sterile dressing or in the case of small cut even Tincture Benzoin sealing is enough because it heals up with very little scar formation and the deformity is often very negligible. But in cuts involving the tarsus or the lid margins and in vertical cuts you must suture them and see that the lid margins are in proper apposition. In children it may even be necessary to give a general anaesthesia to ensure proper apposition of the cut edges.

Regarding F. B. in eye you all know the advise that one should not rub the eye as it might drive the F.B. further

inwards and damage the conjunctiva or cornea. The F. B. often gets lodged in the sub tarsal sulcus so evert the upper lid and remove the F. B. from the sulcus. If of course it is stuck up to the cornea, you use a local anaesthesia like cocain 4% Anethain $\frac{1}{2}$ % or Pantocain $\frac{1}{2}$ to 1% and remove the F. B. with the point of sterile hypodermic needle or a corneal spud. If you have damaged the cornea to any great extent in the process of removal, apply some antiseptic drops and bandage the eye for a day or two. But before you attempt to remove the F. B. always make sure that there is no regurgitation from the Lacrymal sac. Because any latest chronic Dacryocystitis will infect the corneal wound and lead to sepsis of the eye ball. Also routine instillation of Atropin after removal of F. B. from the cornea is unnecessary. It only gives a discomfort to the patient for some days. Next in all cases where you find the eye ball injured - a perforating injury or a severe blast injury with prolapse of Iris or other contents of eye ball all you can do is to clean the eye (not wash) and bandage the eye and send the case to the nearest eye specialist. You may with advantage apply Cortisone eye ointment and dress the eye. I don't mean to say that the specialist can do very much more than removing such eyes, but it is possible there may be cases where something useful can be done.

In cases of irritants falling into the eye like acid or alkalis or as often occurs lime (Sunnambu) falling into the eye, the best you can do to wash the eye well with clean water and so dilute or remove the irritant and apply some bland anti-septic oily drops or ointment.

Only some of the common emergencies have been dealt with. It is mainly intended to stimulate ones interest on the need to give timely treatment in acute condition of the eye.

ASSOCIATION NEWS

COIMBATORE BRANCH

A meeting of the Coimbatore District Medical Association was held in the Association premises at 6 p. m. on Tuesday the 24th January 1956.

The Vice-President, Dr. Y. P. Vasudevan, M.B.B.S., B.S.Sc., presided.

Dr. S. T. Achar, M.D., F.R.C.P., Professor of Pediatrics, Madras Medical College, Madras delivered a talk on "The importance of knowledge about children in Health and disease to the General Practitioner."

TIRUCHY BRANCH

The following clinical meetings were held on 4th, and 18th February 1956 in the premises of the Medical Association Buildings, Salai Road, Woraiyur, Tiruchy under the presidentship of Dr. V. Enok, M.B.B.S., L.M., D.G.O., Z.G.O. Dr. N. S. Narasimha Iyer, F.R.C.S. Dr. K. C. Nambiar, F.R.C.S, and Dr. Mrs. Indira Ramamoorthy, M.D., M.R.C.O.G., addressed the members on "Treatment of Fractures in outlying stations", "Role of General Practitioner in the field of surgery", and "A few advances in Obstetrics and Gynaecology" respectively.

REVIEW

LYMPHOGRANULOMA VENEREUM

By:

R. V. RAJAM AND P. N. RENGIAH

Monograph series No. 1, Supplement to Indian Journal of Dermatology
& Venerology, Bombay.

Publishers: Medical Digest, Bombay.

A survey of limited but representative contemporary medical literature of the past one decade reveals that the problem of Lymphogranuloma Venereum, (L. G. V.) has received but scant attention. It is perhaps this cavalier treatment meted out to this growing subject that prompted the authors of this excellent and exhaustive monograph on the subject, to deplore, and very rightly too, that "In the medical administration reports of several States in the Indian Union, L. G. V. does not find a separate column but is dumped into the common catch basket under the heading 'other venereal diseases.' And yet, L. G. V., in its fully developed stage could be as gruesome a spectacle and as tough a proposition as any other that we know of.

The authors give an account of the geographical distribution of the disease, but point out that this could not be taken as a correct statement of facts, for, investigations have not yet been carried far enough into many countries and cities in an extended manner. That, if it is looked for, a greater and wider prevalence may be revealed is exemplified by Koch et al (1949) who carried out the Frei and Compliment Fixation tests on a group of patients who had general symptoms of other venereal diseases, and found that a significant number among them gave a positive result. This would surely go to support the appeal of the authors for a greater

awareness of this disease which begins as a rather simple insidious adenitis, and which, when neglected, may assume proportions which would require the combined efforts of Venerologist, Ophthalmologist, Surgeon, Gynaecologist and Physician to effect anything approaching a cure. Even the word 'cure' in this condition has to be used with reservations in as much as very distressing and remote complications have been reported even after the clinical healing of the lesion. In common with Syphilis and Tuberculosis, there appears to be no site of the body which cannot be affected, and no circumstances in which it cannot be expected. The case cited by the authors (page 21) illustrates that the disease is not dependant on situations or circumstances.

The authors have naturally taken great pains to enumerate the protean manifestations of the disease and the means of differentiating them from other conditions simulating them. These manifestations range from an affection of the skin to meningeal involvement, and the treatment accordingly varies from simple procedures to a colostomy. A distinctly alarming angle on these manifestations and their implications is provided by Pund and Lacy (1951) who carried out the relevant serological and other tests on a series of 85 cases of cancer of the penis, vulva and the anorectum, and found that 36% of them gave a positive result for L. G. V.

They are apparently so impressed with the figure that they advocate the consideration of L. G. V. as a pre-cancerous lesion and press for the consideration of L. G. V. as having a cancerous predisposition.

The monograph has stressed the diagnostic and therapeutic difficulties in a condition like L. G. V. which may co-exist, —by no means peacefully,— with one or more of the other venereal diseases like Syphilis, Chancroid, Gonorrhoea and Donovanosis. This makes the problem a multidagnostic one demanding poly-pharmaceutical measures. Kornblith (1951) found that a second venereal disease coexisted with L. G. V. in over 50% of the cases under his observation. This seems to be the generally accepted opinion and Koch et al (1949) advocate that every case with indication of disease of the inguinal lymph glands should have the specific tests performed, for it is accepted on proof that the patient stands a good chance of early and complete cure if spotted in the early stages, while, with chronicity, the chances recede.

The far-reaching effects of the disease and the variegated extragenital manifestations of the condition are very impressively mentioned. The range and severity of these manifestations and the difficulties in the way of satisfactory treatment make the authors reiterate the need for catching these cases 'young'. The surgical manifestations are also well narrated, ample stress being laid on the anorectal syndrome. The extent of surgical intervention that may be called for in severe cases of anorectal strictures of an intractable type is also mentioned by Schmid (1950) who describes cases where the transverse colon had to be drawn down to replace an extirpated rectum.

The section on Diagnostic tests and technique is very comprehensive and is quite in line with general uniform excellence of the thesis. It is no great consolation to know that even after the apparent healing of the lesions clinically such reactions as the Frei test persist for long periods, implying the need for caution in pronouncing cures. If the Frei reaction persists for a long time, it appears that the attendant hyperproteinaemia and hyperglobulinaemia persist much longer with a depressed A/G ratio. It would therefore appear that the potential danger of complication and remote effects, and, perhaps, the risk of relapses should always be kept in mind as long as a depressed A/G ratio and hyperglobulinaemia persist. By the same token, it would be logical to assume that the reversal of these biochemical abnormalities should be, in the present state of our knowledge, taken as the ultimate criterion of cure.

The marked change in the therapeutic attitude to this disease and the evolution that has taken place in its treatment during the past ten years are mentioned briefly, and one gathers the impression, that, subject to resistance problems, sulpha drugs should be the first line of therapeutic defence. The antibiotics are exhibited when the sulpha drugs are innocuous or when resistance to them develops. The authors feel that there is little to choose between the various broad spectrum antibiotics since all of them act to a more or less degree, though Wammock and her associates (1950) claim beneficial results from intensive aureomycin therapy with daily manual dilatation of the rectum. They also feel that procedures like colostomy could be entirely avoided under this regimen.

No discussion of any disease entity is ever complete without a mention

of the preventive aspect of it. The monograph provides a brief but cogent mention of these measures not only from the Public Health point of view, but also from the legislator's viewpoint in an attempt at limiting the spread of the infection. This is justly so, since we know that the spread of infection is by infective coitus and only drastic legislation and rigorous social propaganda and education can cope with the preventive problems. It is perhaps of interest to note that the female victim of the disease runs a more prolonged and chronic course than the male. (Costello and D'Avanzo, 1952) One does not like to speculate whether this is due to an alleged fact that "the female of the species is more india-rubbery than the male," but the fact carries enough weight to stress the importance of limiting the spread of infection by restrictive legislation on 'sexual promiscuity and prostitution'.

The monograph serves the purpose which all good monographs are expected to do,—the highlighting of the salient points of a single disease entity. The meticulously thorough manner in which the subject has been dealt with bespeaks arduous work, and if this publication would create a sense of awareness among its readers of, not only the existence of this fell disease, but also of its farflung repercussions, one feels that the authors would have been amply rewarded for their labours. The authors's appeal for more intensive attention to the condition especially in this part of the country which is included in the endemic areas, will surely receive ample support from the profession. Surely, no more effective step to eradicate a menace like L.G.V. can be taken than by placing it high on a high priority list. This complete monograph under review has amply and ably accomplished it.

M. S. NARAYANAN.

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Maharashtra Medical Journal Volume No. 2 No. 11—Feb 1956. Poona.

Managing Editor.

REVIEW

This volume contains useful articles in the nature of symposium on Sterility in the male and female. It contains articles on Peptic Ulcer again in the nature of a symposium by reputable doctors. The issue is recommended to be read by one and all in the profession.

Editor.

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