Medicine in Ancient India

SIR,—Two years ago there was a symposium under the auspices of the National Institute of Sciences of India on the history of sciences, including medicine, of ancient India.

The following quotations from my paper with S. N. Pandeya¹ regarding the importance of theoretical and of practical training in medical education in ancient India will, I am sure, be of interest to your readers:

1. "The student who obtains his knowledge only from books is like an ass with a burden of sandalwood, for he knows the weight but not the value thereof."²

2. "He who is versed only in books, but not skilled in practice, gets alarmed and confused, like a coward in the battlefield when confronting active disease."³

3. "He who is skilled in practice but is audacious and ignorant of the theory of science, does not receive approval of the learned men and receives capital punishment from the king."⁴

4. "Both these groups of persons (items 2 and 3) are lacking in dexterity and inept in the discharge of their duties, for they know only half the science and are like birds with one wing only."⁵—I am, etc.,

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REFERENCES

- ¹ Misra, S. S., and Pandeya, S. N., in *The History of Sciences in India*, 1963, p. 198. National Institute of Sciences of India.
- ² *Susruta, Sutrasthanam*, chapter 1, verses 3-4.
- ³ *Ibid.*, chapter 3, verse 48.
- ⁴ *Ibid.*, chapter 3, verse 49.
- ⁵ *Ibid.*, chapter 3, verse 50.

Desensitization for Dapsone Dermatitis

SIR,—I have read with much interest Dr. S. G. Browne's comprehensive and well-documented article on this subject (September 14, p. 664). I have used this method, oral administration of dilute solutions of solapson ("sulphetrone"), in many cases of lepra reaction precipitated by sulphone treatment, as well as the less common allergic drug dermatitis. It was originally suggested to me by Dr. E. J. Currant about 1955. I used a different dose schedule from Dr. Browne's, which I think may be worth reporting.

As solapson is unstable in dilute solution I prepared the dilutions once a week from 50% stock solution. The dilutions were 10%, 1%, and 0.1%. Starting with 0.1% solution I gave daily doses by mouth of 1 ml., increasing by 1 ml. each day up to 9 ml. Then 1 ml. of 1% solution was given and similarly increased, leading in turn to 10% solution in similar doses. When 5 ml. is reached, containing 0.5 g. of solapson, tablets may be substituted and gradually increased up to therapeutic doses. By this very gradual increase a slight reaction can be detected, in which event the treatment is stopped until the

reaction has subsided and started again at half the last dose.

This method proved very effective both in lepra reactions and in dapsone dermatitis. Patients have different degrees of allergic sensitivity. I think this method is more flexible and can be more readily adjusted to the individual. Some patients can be rapidly desensitized; others may take a very long time; but some cases of progressive lepra reaction, which appears to be intolerant of any treatment, get symptomatic relief on sub-therapeutic doses.—I am, etc.,

H. JOCELYN SMYLY.

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Tranlycypromine and Convulsions

SIR,—The incidence of convulsions associated with treatment by tranlycypromine is, I understand, not high. Within the last two years, however, out of a total of about 20 patients treated with normal doses of this drug I have had two who developed temporary epilepsy whilst under treatment. Both have been free from attacks since the treatment was withdrawn, and one of them has not had any anticonvulsant drugs for four months.

The importance of this observation is that one should bear this drug in mind as a possible cause of new cases of epilepsy. In this way some patients may be spared the unnecessary investigations, anticonvulsive drugs, loss of driving licence, and other inconveniences associated with this condition, when a simple withdrawal of the tablets may solve the problem.

It may be worthy of note also that one of these patients had only one major convulsion, and volunteered the information that after this event she began to feel better and her depression lifted—a new type of convulsive therapy!—I am, etc.,

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The Title of "Dr."

SIR,—I read with interest Mr. David H. Patey's letter (August 17, p. 447) on the subject of the title of "Dr." His suggestion that the Association approach the Press Council in an effort to get the press to refrain from using the title "Dr." when referring to laymen who are practising medicine in any of its branches is an excellent one. However, even if successful, it could only have a temporary and interim effect. Surely what is actually required is a private Bill before Parliament to exclude all people in this country who are entitled to use a foreign doctorate of any description from doing so if they are in any way connected with the practice of medicine, so that members of the public may know clearly who holds a registered British medical qualification. Such a Bill would, of course, require very careful construction, and it might be that the B.M.A. or the General Medical Council would have to maintain a register of non-British medical

qualifications that are acceptable for use in this country as distinct from those foreign qualifications which enable a practitioner to get on to the *Medical Register*. Otherwise many fully qualified medical practitioners with foreign degrees might be unnecessarily hampered in their work and status, a situation one would wish to avoid at all costs.

Another and perhaps a simpler and better method and one which I would personally commend is that all registered medical practitioners should use the title of "M.D.," as is the case in America, where the system works most satisfactorily. It only needs a lead from the Association.—I am, etc.,

LIONEL M. GREEN.

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Chronic Pneumonitis and Asbestosis

SIR,—In a letter (January 12, p. 123) Professor J. G. Thomson discussed the "new pulmonary condition, basal asbestosis," which he had described in a paper¹ then in press.

Professor Thomson's diagnosis of basal asbestosis seems to depend upon the recognition of a limited slight chronic interstitial pneumonitis in conjunction with finding one or several isolated asbestos bodies in the lung juice. However, various degrees of chronic interstitial pneumonitis which are not necessarily limited to the basal portions of the lungs, of unknown aetiology, and not associated with asbestos bodies, are common findings in unselected necropsied hospital deaths,² particularly if the silver impregnation technique for reticulin is routinely employed in the study of the lung sections.

There can be no disagreement with Professor Thomson's statement that the presence of asbestos bodies in the lung merely indicates exposure to asbestos fibres and not the existence of asbestosis. When numerous asbestos bodies are regularly found in conjunction with a diffuse chronic interstitial pneumonitis, the probability that the two findings are related would appear to be overwhelming. When, however, only one or two asbestos bodies can be found and the association with chronic pneumonitis is infrequent, there would appear to be a *possibility* that the pneumonitis is non-specific and the asbestos body a fortuitous finding. This possibility could become a strong probability if it can be ascertained that the person in whom this lesion is found had no significant exposure to asbestos dust. In view of the commonness of chronic interstitial pneumonitis of some degree in the lungs of adults, particularly in the older age groups, it may be wise to adopt a conservative attitude regarding the significance of isolated rare asbestos bodies in the lungs.

Professor Thomson's assumption that the very small amount of asbestos dust which may be found in urban air is sufficient to produce "basal asbestosis" raises the question, "How much asbestos dust