SANGYAHARAN SHODH

Special Issue : Dedicated to Late Dr. S. B. Pande, Patron, AAIM

February 2007 Volume 10, Number 1

संज्ञाहरण शोध

An Official Journal of

BHARATIYA SANGYAHARAK ASSOCIATION

(Association of Anaesthetists of Indian Medicine)

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Chief Editor

Patron & Founder of Sangyaharan in Ayurved
Late Dr. S.B. Pande

OBITUARY

A.A.I.M. is deeply grieved on the sad demise of the patron and founder of Sangyaharan in Ayurved. May his soul rest into eternal peace.

- Dr. S.B. Pande, founder of Sangyaharan division in India, born on July 9, 1932 at Rangoon, the Capital city of Myanmar.
- Came India in 1941, during IInd World War on foot in three and a half months at his native place village Sukharipur, Bhabua (Bihar).
- He was arrested in 1942, during Quit India movement for three months at the age of ten years and was released on the ground of minor.
- Primary Education from Myanmar, Passed High School from Patna University (Bihar). Did I.Sc. from Central Hindu College (Kamachha). B.H.U.
- Admitted to ABMS course of B.H.U. During the course of medical education met the first prime Minister of India Pt. Jawahar Lal Nehru for the upliftment of the intergrated medical education in College of Ayurveda. B.H.U.
- Ph.D. degree awarded on his first Sangyaharan topic thesis, in the country.
- Appointed as Resident Anaesthetist, Department of Surgery. College of Medical Sciences. B.H.U. under Prof. P. Chandra D.A. (Lond.) FFARCS (Eng.), Head Div. Of Anaesthesiology and got the Golden Opportunity to work under his guidance for more than ten years.
- Appointed as Lecturer, Faculty of Indian Medicine, B.H.U. and founded a new Section of Sangyaharan single handed and continued the struggle for starting the Post Graduate degree course in Sangyaharan.
- M.D. (Sangyaharan) degree course started in year 1989. under his dynamic leadership.
- Ph.D. degree in Sangyaharan was also started due to his continuous pains taking efforts and Dr. D.N. Pande was awarded first Ph.D. degree in Sangyaharan in year 1990.
- Supervised more than two dozen PG students for M.D. and Ph.D. degree in Sangyaharan.
- Now the PG degree in Sangyaharan is recognized in the country by the Central government.
- Published more than half century original research papers in Indian and foreign Journals.
- Visited Nepal, Srilanka, Australia and Myanmar on academic tour.
- Retired as Reader and Incharge, Div. of Sangyaharan. B.H.U.
- Founder President and Patron of the AAIM and was the main driving force in its foundation.

Dedication

Late Dr. S.B. Pande

(July 9, 1933- Oct. 15, 2006)

This issue is dedicated to Late Dr. S.B. Pande, Founder President, Patron of A.A.I.M. and founder of Sangyaharan Specialty in Ayurveda.

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SANGYAHARAN SHODH

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EDITORIAL

The Association of Anesthesiologists of Indian medicine shocked due to untimely death of Dr. S.B. Pande, patron and founder president. This is a great loss which is not reversible to the Association and to the specialty. The Editorial Board decided to publish this special issue in the memory of Late Dr. S.B. Pande.

A memorial oration will be also organized on 6th-7th Feb. 2007 at the occasion of Xth National conference. The members of section of Sangyaharan decided to name the H.D.C.U. as Late Dr. S.B. Pande H.D.C.U.

In the editorial column of Sangyaharan Shodh I always tried to raise the voice for development of Sangyaharan incorporating all the updated knowledge and advancement. The persons who are not known to history of medicine or their heritage always raise their voice against Sangyaharan. To nourish their knowledge I am writing the history of Sangyaharan starting from Sushruta period till day.

Vision of Pt. Modem Mahon Malviya Ji:

Kashi, the learning seat of science and knowledge has full credit to start teaching and training of surgery in ancient Indian system of medicine. But the policy making machinery being in hands of some orthodox allopathic doctors created as lot of hurdles in the development of this science and the poor country population suffered a lot. The great visionary - Pt. Mahamana Madan Mohan Malaviya Ji felt this problem in the second decade of 20th century. He had the foresight to show the path of integration of ancient Indian values with the technological development of the west. Thus he started integrated system of medicine in the college of Ayurveda in B.H.U.

SANGYAHARAN (ANAESTHESIA) IN AYURVEDA

Ayurveda the science of life deals with the complete aspects of health of human being. References available in Vedas, Samhitas and many other texts reveal that many surgical operations were performed to treat the patients during ancient scientific era. Was it possible to perform any surgery without proper anesthesia? Sushruta, the father of surgery has mentioned many surgical operations in his text. He has also mentioned the drugs for anesthesia and pain management. If we look into the history of development of modern anaesthesia, the revolutionary changes came only after the use of herbal drugs in practice viz. Morphine and Curare etc.

Sangyaharan in B.H.U.:

A section of Ayurveda was established in B.H.U. under the Faculty of Oriental learning in 1920. Ayurvedic College in B.H.U., Varanasi was started in 1927. Anesthesia and Gynecology were the sections in the department of Surgery of Ayurvedic College. The Surgeons were Dr. P.J. Deshpande (I.M), Dr. Verma (M.M.), Dr. Lakhtakia (MM) and Dr. T.P. Srivastwa (MM). Dr. Lala was the anesthetist and Dr. Janki Bai was the Gynecologist. When medical college was established in year 1960 in the department of Surgery Dr. Louchtakia and Dr. T.P. Srivastwa were appointed as Surgeons whereas Dr. S.K. Basu M.B.B.S. (Cale) DA (Bambay), trained in vellure and England joined as full time anesthetist. Dr. P.S. Shankaran was the first Ayurvedic Anesthetist in the department. In the year 1962

Dr. P. Chandra MBBS (Lucknow), F.R.C.S. (UK) joined the department as Anesthestist. Dr. S.B. Pande ABMS and Dr. F.S. Gundeva ABMS were the Resident Anesthetists from Indian Medicine and Dr. Akram Lal MBBS D.A., M.D. (anesthetist) was Resident Anaesthetist from M.M. under Prof. P. Chandra and Dr. S.K. Basu.

Further, Prof. K. Pandey joined Anesthesia Section in the year 1966 and by Prof. P.D. Jain in 1965. Till 1977 section of Anasthesia was a part of Department of Surgery. Prof. K. Pandey became the I[st] Head of Department of Anesthesiology. Prof. P. Chandra left the department and settled in U.K. At this time Dr. S.K. Basu was Reader and Dr. P.K. Gupta, Dr. A. Lal, and Dr. Rajani Mishra were lectures. Further Dr. P.K. Gupta shifted to Shimla as Professor. Prof. S.K. Basu shifted to Imphal as Professor and Head in 1979. In the year 1988 Prof. K. Pande was retired. Dr. P.D. Jain was retired in the 1990 and Dr. A. Lal in 2001. Prof K. Pandey continued to participate actively in the department as Emeritus Professor. Dr. F.S. Gunderia continued as Resident Anesthetist till his retirement. In the mean time Dr. S.B. Pande was appointed as temporary lecturer and continued till 1984-85 in the same status. He associated with research work in the field of Anesthesia. The collaboration of both departments Shalya Shalakya and Anesthesia continued till 1995. This collaboration provided a very good research atmosphere and working condition which was unfortunately disrupted in the year 1995.

The founder and former Director I.M.S., B.H.U., Padmashree Prof. K.N. Udupa started collaborative teaching, training, research and patient care under one umbrella. He made some major efforts to explore a new scientific method of research to develop Ayurveda in a new shape. Prof. P. J. Deshpande established Shalya Shalakya as a new model and gave a name and fame in the world. On the same line Prof. P. Chandra, Prof. K. Pande Dept. of Anesthesiology thought and took an initiation to start research work on principles and drugs of Ayurveda in the field of Sangyaharan with collaboration of Dr. S.B. Pande, founder of Sangyaharan Section, Faculty of Ayurveda, I.M.S., BHU.

Problems of teaching and training of P.G. students of Shalya, Shalakya, Prasuti Tantra and Kaumarbhritya, Faculty of Ayurveda were felt by the senior faculty members Prof. L.M. Singh, Prof. P.V. Tiwari, Prof. G.C. Prasad and many others and an effort was made to start the Post graduate Degree course in Sangyaharan specialty. After the proper approval of Academic and Executive council of B.H.U. the course was started as a specialty in the Department of Shalya Shalakya, Faculty of Ayurveda, I.M.S., B.H.U. on 6[th] Feb. 1989. Further the faculty meeting held on 6.03.2006 approved **Sangyaharan Section** as a full fledged **Department** and further Academic Council Meeting dated 31.07.2006 also approved this Section as **Department.**

Sangyaharan At Pune:

Not only this, in early part of 1980, before the birth of CCIM, a P.G. Diploma course in Sangyaharan FFAM (Bombay) was started by Maharastra Faculty of Ayurveda Govt. of Maharastra. Prof. M.N. Chaudhary was the founder faculty to start the above course and Dr. S.B. Pande was actively attached in many aspects with Govt. of Maharastra since inception of this course.

Support of C.C.I.M. New Delhi:

Further a letter No. 4-12 / 98-99-PG (Misc.) 50 dated 24.3.1999, Secretary CCIM, New Delhi, was circulated to all state Secretaries, Directors, Deans of Faculties and Principals of Ayurvedic colleges of Indian medicine mentioning "Creation of one post of anaesthesiologist as Lecturer Sangyaharan in the Dept. of Shalya Shalakya / Prasutitantra / Kaumarbhritya in Ayurvedic Colleges with qualification of M.D. (Ay.) Sangyaharan". The Dept. of Shalya Shalakya faculty of Ayurveda, I.M.S., B.H.U. is the first institute in the country authorized by U.G.C. and the Govt. of India to run Post Graduate course in Sangyaharan specialty in Ayurveda. The course has been also bee included in the Gazette of Govt. of India dated 3rd Feb. 2005 as an P.G. specialty in Ayurveda.

A letter of secretary CCIM, File No. 28-5 /2004 – Ay. (MM) dated 19.5.2004 is self explanatory to practice Surgery, Gyane. and Obst. and Sangyaharan by the institutionally trained scholars.

The section of Sangyaharan was established with a motive to explore indigenous source of anesthetics having least of no side effects and to minimize the cost of anesthesia for the poor country people. For fulfillment of this objective proper teaching, training, research and patient care was framed by our learned faculty members. The faculties and post graduate scholars of Sangyaharan Dept. of Shalya Shalakya are making continuous efforts since last four decades in this direction. We are sure that we have achieved some thing original which can be the assets of our country. Thus the country can earn some foreign currency in this way

(Dr. D.N. Pande)
Chief Editor

APPEAL

All the life members who had already paid Rs. 500.00 as Life Membership fee are requested to send a DD of Rs. 500.00 in favour of A.A.I.M. payable at Varanasi for purchase of Land for office of Association (C.C.) at Varanasi.

The members who will donate Rs. 1001.00 or more will be presented a certificate and their name will be published in the Journal with their Photographs

Cardiac Arrest Following Spinal Anaesthesia

Dr. P.S. Pandey
B.A.M.S.(Gold Medalist), M.S. (Ay) Shalya -Sangyaharan, IMS, BHU,
Sangyaharan Specialist, Ashapur, Sarnath, Varanasi - 221007

The incidence of cardiac arrest during spinal anesthesia is not very common but it attracts the beginners for careful monitoring. Review of data from the American Society of Anesthesiologists (ASA) Closed Claim Project identified several cases of cardiac arrest during spinal anaesthesia. Since most of these cases- predated the routine use of Pulse oxymetry, many physicians believed that over sedation and unrecognized hypoventilation and hypoxia were the cause. However, in the years since, large prospective studies continue to report a relatively high as 1:1500. Many of the arrests were preceded by bradycardia and occurred in young healthy patients. The mortality rate has been reported to be high. A recent report on this problem has identified vagal response to a decreased preload to be a key factor and suggests that patients with high vagal tone are particularly at risk. Prophylactic volume expansion is recommended with vagolytic (atropine) treatment of bradycardia followed by ephedrine if necessary. A very large survey in France on regional anaesthesia gives an idea of the incidence of serious complications from spinal anesthesia (table-1).

TABLE-1

Technique	Cardiac arrest	Death	Seizure	Caudaequina syndrome	Paraplegia	Rediculopathy
Spinal (n=40,640)	26	6	0	5	0	19

Data from Auroy Y, et al : Serious complication related to regional Anaesthesia, results of a prospective survey in France. Anesthesiology, 1997;87: 479.

Sudden cardiac arrest during or otherwise an otherwise routine administration of Spinal Anaesthetic is an uncommon but catastrophic complication. The initial published report was closed claim analysis of 14 patients who experienced cardiac arrest during spinal Anaesthesia. The cases involved primarily young (average age 36 years), relatively healthy (ASA physical status – I, II) patients who were given appropriate dose of local Anaesthetic with the high level of block prior to arrest (T4 level). Sub clinical respiratory insufficiency with hypercarbia due to sedatives was thought to be a potential contributing factor. The average time from spinal administration to arrest was 36+/-18 minutes, and in all cases, arrest was preceded by gradual decline in heart rate and blood pressure to 20% below base line values. Just prior to arrest the most common signs were bradycardia, hypotension, and cynosis. Treatment consisted of ventilatory support, ephedrine, atropine, cardiopulmonary resuscitation (average duration 10.9 minutes) and finally epinephrine (on average given 5 minutes in to arrest period). Despite there interventions, 10 patients remained comatose and 4 regained consciousness with significant neurological deficits. A subsequent study concluded that arrests had little relationship to sedation but were more related to high vagal tone and

profound bradycardia. Most authorities have concluded that rapid, aggressive treatment of bradycardia and hypotension is essential in minimizing the risk of arrest. Early rapid reversal of volume deficits and prophylactic treatment of bradycardia with atropine may prevent a downward spiral. Stepwise doses of ephedrine should be given to treat hypotension. Moreover, practitioners should not hesitate to use epinephrine. Full resuscitation doses of atropine and epinephrine should be administered without any delay.

Reference:

1. Liu SS,Mc Donald SB : Current issues in Spinal Anaesthesia. Anesthesiology 2001 ; 94 : 888-906.
2. Palmer SK: What is the incidence of arrest and near arrest during spinal and epidural analgesia? Report of nine years experience in an academic group practice. Anesth Analg 2001;92:S 339.
3. Pembrook L : Unforseen, sudden cardic arrests continue in healthy patients. Anesthesiology News. 2000; 123-5.
4. Caplan RA, Ward RJ, Posner K et al: Unexpected cardiac arrest during Spinal Anesthesia : A closed claims analysis of predisposing factors. Anesthesiology 68:5, 1988.

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Legal Protection to Integrated Practitioners

Dr. D.N. Pande
Chief Editor, Sangyaharan Shodha,
Head, Department of Shalya Shalakya, Faculty of Ayurved, IMS, BHU,
VARANASI-221005

Day by day constrains of legal litigations on the Integrated practitioners framed by few members of Indian Medical Association here and there all over the country compel me to write this column. The column will be a regular feature of this Journal. The members of our different Associations –NIMA, Sushruta, Shalakya and others are requested to send copies of the G.O. and different Judgments of their known cases for publication in this column. In the first column I will produce Supreme Court decision and Andhra Pradesh High Court decision in favor of integrated practitioners. Gazette of Maha Rashtra Government and notification of CCIM is also included in this first column. As soon as I will able to get more information I will convey to our members for their ready references.

IN THE HIGH COURT OF JUDICATURE, ANDHRA PRADESH AT HYDERABAD
WEDENESDAY, THE NINETEENTH DAY OF APRIL TWO THOUSAND AND SIX
PRESENT
THE HON'BLE SN JUSTICE A. GOPAL REDDY

CRIMINAL REVISION CASE NO: 417 of 2002

Criminal Revision case under Section: 397 & 401 of Cr. P.c. against the Judgment in CRL.MP NO: 3771/2001 in C.C. NO: 1339/2000 dated 08/01/2002 on the file of the court of the Additional Judicial First Class Magistrate, Gudivada, Krishna District.

Between:

K. Nagaraju s/o K. Venkateswara Rao, R/o Gudivada, Krishna District. - ..... PETITIONER

AND

The State of A.P. Rep by Public Prosecutor High Court of A.P. Hyderabad. Respondents

The S.I. of Police, Gudivada, Itaram Police Station, Gudivada, Krishna District.

Counsel for the Petitioner: SN. MR. M. RAVINDRANATH REDDY

Counsel for the Respondents: The PUBLIC PROSECUTOR

The Court made the following Order:

THE HONOURABLE JUSTICE

A. GOPAL REDDY

Crl. R.C. No. 417 of 2002

ORDER

This Criminal Revision Case is directed against the order passed by the Additional Judicial First Class Magistrate, Gudivada in Crl. M.P. No. 3771 of 2001 in C.C. No. 1339 of 2000 dated 08-01-2002 where under the application filed by the petitioner/accused under Section 239 Cr. P.C. seeking discharge was dismissed.

Petitioner was charge sheeted for the offence under Sections 420, 336 IPC and Section 17 (4) of Indian Medicine Central Council Act, 1970 (for short 'the Central Act') alleging that accused who passed M.D. (Ayurvedic) from Banaras Hindu University, Banaras started Jeevan Eye Hospital in Eluru Road and Installed eye machinery. On reliable information L.W. 7 along with L.Ws. 18 to 20 and mediators- L.Ws. 15 and 16 visited the hospital of the petitioner and found that he is practicing as private medical practitioner doing eye surgeries and administering Allopathic medicines without registering as a private medical Practitioner under Section 17 of the Central Act, which is endanger to the human lives, thus liable for punishment under Sections 336, 420 IPC and Section 17 (4) of the Central Act. On being charge sheeted petitioner filed the above petition seeking for discharge contending that on his obtaining P.G. degree in Ayurveda by undergoing required study and training in Shalakya in the year 1992 under renowned professors of Banaras Hindu University and the said course is study of Ayurveda and modern system of medicine. As per the syllabus fixed by the University, it includes training in surgical procedure and also eligible to administer treatment in modern medicine. Thus he is entitled to give allopathic medicines and can conduct eye surgeries, as he is qualified practitioner. Further, in para-8 of Part-III Section 4 of Gazette of India dated 15-05-1995 it is published that in the specialties of Shalya, Shalakya and Prasuti Tantra, the practical training should aim in elicit knowledge on the investigative procedures, techniques and surgical performance so that the candidate is capable to undertake independent work in surgical procedures and their management in the respective specialties. When the Investigation Officer who approached the Banaras Hindu University whether the petitioner is competent to administer Allopathic medicines and having got written clarification, the same has not been filed before the Court. In view of the clarification petitioner has not committed any offence as alleged and the entire prosecution launched against him for the charges is groundless and he is liable to be discharged.

A counter affidavit has been filed stating that the accused has not registered either under the Indian Medical Central Council Act, 1970 or under the Indian Medical Counsil Act, 1956, therefore, the protection seeking by him under Section 17 (3)(B) of the Central Act do not have application.. As such he has to be prosecuted for which he was charged and as on the date of arrest he has not enrolled as Private Medical Practitioner in either of the above acts.

The lower court after considering 161 Cr. P.C. statement of L.W.12, namely, Kancherla Seshaiah as stated that he took his 2nd daughter-Kancherala Sunitha – L.W.13 to the accused for treatment of eye ailment and he prescribed medicines and gave treatment for a period of 9 months; subsequently the ailment was increased and the entire eye ball was turned into white and also caused headache and eye balls were completely closed, then they approached the accused and questioned him about the eye ailment, who stated them with feeble words and cheated them; on their approaching another doctor-Paladugu Krishna Murthy who admonished L.W. 12 for prescribed medicines and after three months headache

was reduce. Further, L.W.14 who is running Sandhya Eye Hospital at Suryaraopet and who was also worked as Member of Ophthalmology Academy and subsequently elected as Secretary of the Academy. During their tenure in the Academy, Indian Council recognized Allopathic Degree holders M.S., D.O. and the specialists who are the members of the said society are eligible for membership and eye specialists are used to attend the meeting every month to exchange their knowledge. The petitioner/accused attended for lectures in the meeting and after completion of the meeting petitioner was asked to show the original certificates on which petitioner stated that at present he has not possessed the originals and he will send after going to Gudivada, Subsequently he did not attend any meeting. The 161 statements of witnesses who were examined during investigation disclose that petitioner/accused styled himself as eye specialist and spoiled their eye vision and as per the statement of L.W. 14 accused has no originals of his qualification for practicing Allopathy and to conduct surgery. Unless the petitioner registered himself in the State Register or Central Register as per Section 17(1) of the Central Act and in the absence of production of enrolment certificate of his practicing Indian medicine in surgery of eye and for conducting surgeries giving modern treatment, prima facie, committed an offence. Therefore, he is not entitled to be discharged and accordingly dismissed discharge application. Hence, the present revision.

Sri M. Ravindranath Reddy, learned counsel for the petitioner submits that all the certificates which were seized are made available before the Magistrate along with charge sheet which clearly establish that his enrolment in the Andhra Board for Ayurveda which is constituted under Andhra Pradesh (Andhra Area) Ayurvedic and Homeopathic Medical Practitioner Registration Act, 1956 (for short "the State Act") on 18-07-1988 and after such enrolment he studied M.D. in Ayurvedic Shalakya from Bananras Hindu University which has issued a certificate to the said effect and after completion of M.S. (Ayurvedic0 in the year 1992 he started eye hospital, therefore, he deemed to be a Registered Medical Practitioner under 17 of the Central Act. As per Section 2(j) of the Central Act "State Register of Indian Medicine" means a register or registers maintained under any law for the time being in force in any State regulating the registration of practitioners of Indian medicine. Once the State Act regulates such registration he is entitled to be protected under Section 17(3) (b) of the Central Act. The entire prosecution launched against the petitioner is groundless and the same is liable to quashed.

Learned Additional Public Prosecutor while refuting the same would contend that petitioner is at liberty to produce all such evidence before the Magistrate which is yet to be scrutinized by the Magistrate. Therefore, it is not desirable to discharge the accused unless sufficient opportunity is given to the prosecution to establish the guilt of the accused.

Before adverting to the above submissions it is relevant to note the list of documents, which were seized and produced along with charge sheet. The provisional certificate of BAMS issued by the Nagarjuna University dated 15-07-1900 certifying that the petitioner passed B.A.M.S. (Bachelor of Ayurvedic Medicine and Surgery) degree examination in October, 1987. The certificate of registration issued by the Registrar under the Andhra Board for Ayuurveda dated 18-71988 wherein it was certified that the petitioner has been registered as Medical Practitioner under clause-A in the register of Medical Practitioners maintained by the Andhra Board for Ayurveda, Hyderabad. The instructions to the said certificate disclose

the certificate is the property of the Board for Ayurveda and issued to Kalipindi Nagarju in accordance with Rule 4(a) of part-III of Andhra Ayurvedic and Homeopathic Medical Practitioners Registration Rules, 1959. The certificate issued by the Institute of Medical Science, Banaras Hindu University dated 04-08-92 certifying that he was student of 1989-92 joined M.D (Ay.) course which is recognized by the Central Council for Indian Medicine and obtained post Graduate degree in M.D. (Ayurveda) Shalakya and secured highest marks and during the period he worked as Honorary Registration the Department and attended Shalakya O.P.D., I.P.D. and emergency duties in S.S. Hospital, Banaras Hindu University and also participated in clinical services and attended modern medicine for the various subjects as mentioned in the certificate. The original provisional certificate issued by Banaras Hindu University certifying that the petitioner has passed M.D. (Ayr.) Shalakya in July, 1992 and certificate issued by the Institute of Medical Science, Banaras Hindu University, Department of Ophthamology certifying that he was deputed from the department of Shalya-Shalakya, I.M.S., Banaras Hindu University to the department of Ophthamology, I.M.S., Banaras Hindu University for his thesis under the supervision of J.C. Mathur, Professor and Head of Department of Ophthalmology and during the said period he regularly attended the OPD, performed duties in the indoor section of the department and gained proficiency in major and minor eye operation including micro surgery.

The submissions made by the learned counsel for the petitioner have to be considered in the light of various statutory provisions under the Central Act as well as State Act. Section 2(e) of the Central Act defines Indian Medicine which means the system of Indian medicine commonly known as Ashtang Ayurveda, Siddha or Unani Tibb whether supplemented or not by such modern advances as the Central Council may declare by notification from time to time. Section 2(j) defines 'State Register of Indian Medicine' which means a register or register maintain under any law for the time being in force in any State regulating the registration of practitioners of Indian medicine Section 17(1) of the Central Act prescribes the rights of persons possessing qualifications, which reads thus:

Subject to the other provisions contained in this act, any medical qualification included in the Second, third or Fourth Schedule shall be sufficient qualification for enrolment on any State register of Indian Medicine.

Sub-section (2), Which is crucial, reads as under:

1. Save as provided in section 28, no person other than a practitioner of Indian medicine who presses a recognized medical qualification and is enrolled on a State Register on the Central Register of Indian Medicine:
   (a) xxxxxx
   (b) Shall practice Indian medicine in any state.

Sub-section (3) (b) of Section 17 envisages as an exception, which reads as under:

2. Nothing contained in sub-section (2) shall affect.
   (a) xxxxxxxxx
   (b) the privileges (including the right to practice any system of medical) conferred by or under any law relating to registration of practitioners of Indian medicine for

the time being in force in any State on a practitioner of Indian Medicine enrolled on a State Register of Indian Medicine.

Sub-section (4) is a penal provision where any person who acts in contravention of any provision of any provision of sub-section (2) shall be punished with imprisonment for a termwhich may extend to one year, or with fine which may extend to one thousand rupees, or with both.

It is not in dispute that State Government has incorporated State Act to regulate the qualifications and to provide for the registration of practitioners of Ayurvedic and Homeopathic systems of medicine in the Andhra area of the State of Andhra Pradesh.

Section 2(i) of the state Act defines 'Ayurvedic system of medicine' which means Ayurvedic system including Sidha, Unani, Tibi and prakruti systems. Section 2(xiii) defines 'registered practitioner' which means a practitioner whose name is for the time being entered in the Register of practitioners.

Chapter IV Section 27 of the State Act deals with registration of practitioners, which reads as under: 27 (1) Every person-

(a) Who possess any degree, diploma, licensee, or certificate, conferred, granted or issued by a recognized institution specified in schedule I or by any other institution recognized under section 24.

(b) xxxxxxxx

(c) xxxxxxxx

(d) xxxxxxxx

(e) xxxxxxxx

Sub section (2) (a) of section 27 of the State Act envisages every person, whose name has been entered in the Register of practitioners shall be issued a certificate of registration in the prescribed form under the hand and seal of the Registrar. Section 39 of the State Act deals with penalty for practice by unregistered practitioners which reads thus:

(1) After the expiry of five years from the commencement of this Act, no person other than a registered practitioner shall practice the Ayurvedic system of medicine or the homeopathic system of medicine, or hold himself out, whether directly or by implication, as practicing, or as being prepared to practice such system.

(2) Any person who contravenes the provisions of sub-section (1), shall be punishable with imprisonment which may extend to three months or with fine which may extent to five hundred rupees or with both for the first contravention, and with imprisonment which may extent to six months or with fine which may extent to one thousand rupees or both for every subsequent contravention.

Section 42 of the State Act deals with taking cognizance of offences, which reads thus:

(1) xxxxxxxxxx

(2) No court shall take cognizance of any offence under this Act except on a complaint in writing of an officer empowered by the Government in this behalf.

Rules were framed under the State Act known as "The Andhra Ayurvedic and Homeopathic Medical Practitioners Registration Rules, 1959" (hereinafter called as "the

Rules). Part-III deals with Maintenance of Registers. Rule 4 envisages granting of certificate in Form VIII-A.

Though sub-section (2) of section 17 of the Central Act provides that no person other than a practitioner of Indian medicine who possesses a recognized medical qualification is entitled to practice, the said provision does not affect the right of practitioner of Indian Medicine enrolled on a State Register of Indian Medicine to practice Indian Medicine in any State.

The notification issued by the Central Council of Indian Medicine reads as under:

"No. 8.5/96.Ay. (MM) dated 30-10-1996

NOTIFICATION

As per provision under section 2 (1) of the Indian medicine Central Council Act, 1970 (48 of 1970) here by Central Council of Indian Medicine Notifies that Institutionally qualified practitioners of Indian Systems of Medicine (Ayurved Siddha & Unani) are eligible to practice Indian Systems of Medicine and Modern Medicine including Surgery. Gynecology and Obstetrics based on their training and teaching which are included in syllabi of via courses of ISM prescribed by C.C.I.M. after approval of the Govt. of India. The meaning of the word "Modern Medicine" (Advances) means advances made in various branches of Modern Scientific medicine, Clinical non-clinical bio-sciences also technological innovations made from time to time and notify that the courses and curriculum conducted and recognized by the Central Council of Indian medicine are supplemented with such modern advances.

Further it is calcified that the rights of practitioners of Indian Systems of Medicine practice modern scientific system of Medicine (Allopathic Medicine) are protected under Section 17 (3) (b) of I.M.C.C. Act. 1970.

Sd

xxxxx

(R.K. JAIN)

REGISTRAR – CUM – SECRETARY

CENTRAL COUNCIL OF INDIAN MEDICNE

Once the petitioner enrolled as a Medical Practitioner under the State Act to which a certificate No. 19897 dated 18-07-1988 was issued by the registrar, Andhra Board for Ayurveda under Clause-A, the allegation that the petitioner contravened provisions of Section 17 of the Central Act without registering as Private Medical Practitioner he is not competent to do eye surgeries and administer allopathic medicines is contrary to provisions of sub-section (3) of Section 17. Once he is registered under the State Act the prohibition contemplated under Section 17 (2)(a) will be redundant. Once it is clarified by the Registrar, CCIM through notification, referred to above the right of practitioners of Indian Systems of Medicine to Practice Modern Scientific Systems of Medicine (Allopathic Medicine) are protected under section 17 (3)(b) of the central Act, petitioner has not contravened any of the provisions of the Central Act, Since he is entitled to practice in Modern Scientific System of Medicine once he got himself registered under the state Act.

In view of the same, the charge, which is framed against the petitioner, is groundless,. The learned magistrate without considering the Registration Certificate issued under the state Act dated 18-07-1988 and the original provisional certificate issued by the Nagarjuna University dated 15-07-1968 erroneously held that the petitioner did not produce any enrolment certificate which are required under section 17(2) the central Act for practicing Indian Medicine and conducting eye surgeries and accordingly dismissed the I.A. Once the charge framed against the petitioner is groundless, it is the right of the accused to get himself discharged from all the charges.

In view of the same, the impugned order passed by the magistrate is aside and Criminal Revision is allowed. Petitioner is discharged of all the charges.

Sd
P. KRISHNA MURTHY
DEPUTY REGISTRAR

// TRUE COPY //

SECTION OFFICER

One fair copy to the Honourable Mr. Justice A. GOPAL REDDY
(For his Lordships kind Perusal)

To,

1. The Additional Judicial First Class Magistrate, Gudivada Krishna District. (with records)
2. The Station House Officer, Ittaram Police Station Gudivada Krishna District.
3. 8 L.R. Copies.
4. The Under Secretary, Union of India, Ministry of Law, Justice and Company Affairs, New Delhi.
5. The Secretary, A.P. Advocates Association Library, High Court Buildings, Hyderabad.
6. Two CCs to the Additional Prosecutor High Court Buildings Hyderabad.
7. Two CD Copies.
8. 1 CC to Sri. M.R. Ravindranath Reddy, Advocate (opuc)

HIGH COURT

DATED: 19-04-2006

ORDER

Crl. R.C. No. 417 of 2002.

Allowing the Crl. R.C. Sd/xxxxx Dated: 29-04-2006

II III. क्र. २३२ रजिस्टर्ड नं एम एच/वाय–साउथ/२०

सत्यमेव जयते

महाराष्ट्रशासन राजपत्र

असाधारण

प्राधिकृत प्रकाशन

बुधवार, नोव्हेबर २५, १९९२ / अग्रहायण ४, शके १९१४

स्वतंत्र संकलन म्हणून फाईल करण्यासाठी या भागाला वेगळे पृष्ठ क्रमांक दिले आहेत

भाग चार – ब

महाराष्ट्र शासनाने महाराष्ट्र अधिनियमांमध्ये तयार केलेले (भाग एक, एक– अ आणि एक–क यांमध्ये प्रसिद्ध केलेले नियम व आदेश यांच्याव्यतिरिक्त) नियम आदेश

MEDICAL EDUCATION AND DRUGS DEPARTMENT

Matralaya, Mumbai 400032, dated the 25th November 1992

MAHARASHTRA MEDICAL PRACTIONERS ACT. 1961

No. CIM. 1091/CR-179/91 (Part V) ACT - In exercise of the powers conferred by the proviso to section 33, read with clause (fa) of section 2 of the Maharashtra Medical Practioners Act. 1961 (XXVIII of 1961) (here matter referred to as "the said Act) the Government of Maharashtra hereby directs that the Ayurvedic Practitioners enrolled on the State Register of Practitioners of Indian Medicine holding qualification specified in Parts A. B and A-1 of the Schedule appended to the said Act, shall be eligible to practice the modern system of medicine which is known as allopathic system of medicine to the extent of the training they received in that system.

By order and in the name of the Governor of Maharashtra.

SHEELA KARNANI
Section Officer

CENTRAL COUNCIL OF INDIAN MEDICINE

INSTITUTIONAL AREA JANAKPURI, NEW DELHI- 110058

No. 85/96-Ay (MM) Dated: 30.10.96

NOTIFICATION

As per provision under section 2 (1) of the Indian medicine Central Council Act, 1970 (48 of 1970) here by Central Council of Indian Medicine Notifies that Institutionally qualified practitioners of Indian Systems of Medicine (Ayurved Siddha & Unani) are eligible to practice Indian Systems of Medicine and Modern Medicine including Surgery. Gynecology and Obstetrics based on their training and teaching which are included in syllabi of via courses of ISM prescribed by C.C.I.M. after approval of the Govt. of India. The meaning of the word "Modern Medicine" (Advances) means advances made in various branches of Modern Scientific medicine, Clinical non-clinical bio-sciences also technological innovations made from time to time and notify that the courses and curriculum conducted and recognized by the Central Council of Indian medicine are supplemented with such modern advances. Further it is calcified that the rights of practitioners of Indian Systems of Medicine practice modern scientific system of Medicine (Allopathic Medicine) are protected under Section 17 (3) (b) of I.M.C.C. Act. 1970.

(R.K. JAIN)
REGISTRAR – CUM – SECRETARY
CENTRAL COUNCIL OF INDIAN MEDICNE

CENTRAL COUNCIL OF INDIAN MEDICINE

Institutional Area Janakpuri,
NEW DELHI- 110058

NOTIFICATION

Dated: 19.5.2004

F.No. 28-5/2004-Ay. (MM)

In exercise of the power conferred by 2 (1) (e) of the Indian Medicine Central Council Act, 1970 hereby Central Council of Indian Medicine notify that: -

The Indian medicine Central Council Act, 1970 is very clear with regard to definition of Indian Systems of Medicine of which reads as follows:-

"Indian Medicine" means the system of Indian Medicine commonly known as Ashtang Ayurveda, Siddha or Unani Tibb whether supplemented or not by such modern advances as the Central council may declare by notification from time to time.

To clarify the word "Modern Advances" the Council at its meeting held on 23rd March 2003 has passed the resolution and defined Indian Medicine as under:-

"This meeting of Central Council hereby unanimously resolved that in clause (e) of Sub-section 2 (1) of the IMCC Act, 1970, the word 'Modern Advances' be read as advances made in the various branches of Modern Scientific medicine in all its branches of internal medicine., surgery, gynecology and obstetrics, anesthesiology, diagnostic procedures and other technological innovation made from time to time and declare that the courses and curriculum conducted and recognized by the Central Council of Indian Medicine are supplemented with such modern advances."

It is further clarified that the rights of practitioners of Indian Systems of Medicine are protected under Indian Medicine Central Council Act, 1970 under section 17 (3)(B) which states as under:-

"Nothing contained in Sub-section (2) shall affect privileges (including the right to practice any system of medicine) conferred by or under any law relating to registration of practitioners of Indian Medicine for the time being in force in any State of a practitioners of Indian Medicine enrolled on a State Register of Indian Medicine."

The Government of India from time and again have asked the Council to improve the syllabus by including subjects with regard to National Programmes like National Malaria eradication programme, TB, Leprosy, Family Welfare Programme, RCH Programme immunization Programme, Aids, Cancer etc. and accordingly the Council has strengthened the Syllabus of all the system of Medicine.

The institutionally qualified practitioners of Ayurveda, Siddha, Unani Tibb are eligible to practice respective System with modern Scientific medicine including Surgery and Gynecology obstetrics. Anesthesiology, ENT, Ophthalmology etc. based on the training and teaching.

(PR SHARMA)
SECRETARY

Secretary : 5610978
Office : 5599464

CENTRAL COUNCIL OF INDIAN MEDICINE

Institutional Area, Janakpuri
NEW DELHI- 110058

No. 8-5/98-Ay. (MM)

To,

All members of Central Council of Indian Medicine

Sub: Judgement of the Supreme Court-reg.

Sir,

I am directed to forward herewith the Judgement of Hon'ble supreme Court in regard to right to practice of modern medicine by the practitioners of Indian Systems of Medicine for your kind perusal.

Yours faithfully

(PR. SHARMA)

SECRETARY

Kalra * 241298

D. No. 29/87/Sec.X
SUPREME COURT OF INDIA
NEW DELHI
DATE: 15TH OCTOBER, 1998

FROM: ASSISTANT REGISTRAR (JUDL.)

To,

1. The Secretary to the Government of Punjab, Department of Health, CHANDIGARH.
2. The Director ,Health Service, Govt. of Punjab, CHANDIGARH.
3. The Chairman/Registrar, The Board of Ayurervedic & Unani Systems of Medicine, Punjab
   SCO, 823-24, Sector 22 A, CHANDIGARH.
4. Honorary General Secretary,Dr. JJ Sood ,Indian Medical Association, IMA House, Indraprastha Marg, NEW DELHI
5. General Secretary, All India Ayurvedic Congress , Dhanwantri Bhawan,Punjabi Bagh,
   Road No. 66, NEW DELHI – 110026
6. The Director of Ayurved & Unani Systems of Medicine, CHANDIGARH

WRIT PETITION (CIVIL) NOS. 5 OF 1987, 1082 OF 1988, 359 OF 1991 AND 423 OF 1997.

(Under Article 32 the Constitution of India)

Brij Mohan & Ors. Etc. etc. ..... Petitioners

Vs.

State of Punjab & Ors. .....Respondents

Sir,

I am directed to forward herewith for your information and necessary action a certified copy of the Judgment of this Court dated the 8.10.98 passed in the matters above mentioned.

Please acknowledge receipt.

Yours faithfully

Sd/-

ASSISTANT REGISTRAR (JUDL.)

IN THE SUPREME COURT OF INDIA
CIVIL APPELIATE JURSDICTION
CIVIL APPEAL NO. 89 OF 1987

Dr. Mukhtiar Chand & Others ..... **Appellants/Petitioners**

Vs.

The State of Punjab & Others ..... **Respondents**

WITH

(C.A. No. 836/87,WP (C) No. 5/87, 1082/88, 359/91, S.L.P. (C) No. 8422/95, WP (C) No. 423/97 & SLP (C) No. 4009/98).

JUDGEMENT

QUADRI, J.

These cases raise questions of general importance and practical significance – questions relating not only to the right to practice medical profession but also to the right to life, which includes health and well being of person. The controversy in these cases was triggered off by the issuance of declaration by the State Government under clause (iii) of Rule 2(ee) of the Drugs and Cosmetics Rules 1945 (for short, the Drugs Rules') which

Page 2.

defines "Registered Medical Practitioner". Under such declarations, notifies Vaidys/Hakims claim right to prescribe Allopathic drugs covered by the Indian Drugs and Cosmetics Act, 1940 (for short 'the Drugs Act'). Furthermore, Vaids/Hakims who have obtained degrees in integrated courses claim right to practice allopathic system of medicine.

In exercise of the power under clause (iii) of Rule 2(ee), the State of Punjab issued Notification No. 9874-IHBTT-67/34526 Dated 29TH October, 1967 declaring all the Vaids/Hakims who had been registered under the East Punjab Ayurvedic & Unani Practitioners Act, 1949 and the PEPSU Ayurvedic and Unani Practitioners Act, 2008 BK and the Punjab Ayurved and Unani Practitioners Act, 1963 as persons practicing Modern Systems of Medicine for purposes of the Drugs Act. One Dr. Sarwan Singh Dardi who was medical practitioner, registered with the Board of Ayurvedic and Unani System of Medicines, Punjab, and who was practicing modern system of medicines, was served with an order of the District Drugs Inspector, Hosharpur, prohibiting him from keeping in his possession any allopathic drug for administration to patients and further issuing general direction to the chemists not to issue allopathic drugs to any patient on the prescription of the said doctor. That action of the Inspector was questioned by Dr. Dardi

Page No. 3.

In the Punjab & Haryana High Court in CWP No. 2204 of 1986. He claimed that he was covered by the said notification and was entitled to prescribe allopathic medicine to his patients and store such drugs for their treatment (hereinafter referred to as Dardi's cas). A Division Bench of the Punjab & Haryana High Court, by judgment dated September 17, 1986 held that the said notification was ultra vires the provisions of Sub-clause (iii) of Clause (ee) of Rule 2 of the Drugs Rules and also contrary to the Provisions of Indian Medical Council Act, 1956 and accordingly dismissed his writ petition.

Writ petitions filed in the High Court of Punjab and Haryana for a mandamus restraining the authorities concerned from interfering with their right to prescribe medicines falling under the Drugs Act on the strength of such notifications were also dismissed by the High Court and the aggrieved persons have filed appeals before us by special leave.

Writ Petitions are filed in this Court by various persons claiming that they are registered medical practitioners within the meaning of the said notification and are entitled to practice 'modern scientific system of medicine.' It may be noticed here that the petitioners in WP No. 1082/88 and 359/91 were registered by Ayurvedic and Unani

Page No. 4.

Medical Council in the State of Bihar. The petitioner in WP No. 423/97 holds degree of BAMS from the Maharishi Dayanand University, Rohtak. He asscrts that on the basis of said degree he is entitled to practice 'modern scientific system of medicine.'

On the same subject cases came up before Rajasthan High Court. The Jodhpur Branch of Indian Medical Association filed Civil Writ Petition No. 1777/82 in the High Court of Rajasthan seeking a declaration that Rule 2(ee) (iii) of the Drugs Rules and the Circular No. 26(24) M.E. Group-I) 82 issued by the Government of Rajasthan on July 26, 1982, were void and ultra vires the provisions of the Drugs Act and the Indian Mecal Council Act, 1956. By judgment dated September 29, 1994, a Division Bench of the Rajasthan High Court held that the said rule was without any legislative competence and consequentially the notification was illegal and void. The correctness of the said judgment has been assailed by the Private Medical Practitioners Association of India (which represents the beneficiaries of a similar circular issued by the Government of Rajasthan) in S.L.P. No. 8422 of 1995. On the strength of the aforesaid judgment of the Division Bench, another writ petition filed by M/s. Chandasi Private Medical

Page No. 5.

Practitioners Sansthan, a registered society, was also dismissed. That judgment is also challenged by filing a Special Leave Petition.

We heard all the said civil appeal, special leave petitions and writ petitions together, as the question involved in all the cases is common.

Mr. DD Thakur, learned senior counsel appearing for the appellants-petitioners in the appeals and special leave petitions, has argued that the ground on which the Punjab & Haryana High Court dismissed Dr. Dardi's writ petition are not applicable to the appellants-petitioners and without noticing the difference the Division Bench denied relief to them so the judgments under appeal are unsustainable in law. The rule in questions, submits the learned senior

counse, was framed under the Drugs Act having regard to the factual position that the qualified allopathic doctor are not available in the rural areas and that persons like the appellants-petitioners have been catering to the medical needs of the residents of such areas, as such the rule is in public interest. The rule, it is argued, cannot be said to be illegal for want of legislative competence as Section 33 of the Drug Act confers very wide powers on the Central Government to frame rules. As the class of medical practitioners postulated by clause (iii) of the rule,

Page No. 6.

Can properly be identified by the State Governments , they are empowered to declare, by general or specific order, such class and the notifications issued by various State Governments are well within the ambit of the rule. In any event, urged the learned counsel, the High Court ought not to have dismissed the writ petition in limine and that it ought to have gone into the merits of the case of the petitioners on the basis of the qualifications possessed by them and allowed them to prescribe allopathic medicines as registered medical practitioners.

Mr. KTS Tulsi, learned senior counsel, supported the notification issued by the State Government and submitted that had the State Government so desired it would have withdrawn the notification but the very fact that it had not done so, would show that the registered medical practitioners have been rendering yeoman service to the citizens, hence, the notification must be given full effect.

Mr. Indra Jaising, learned senior counsel, adopted the arguments of Mr. Thakur in general, but focused on the plea that since integrated courses in Ayurvedic medical education comprises of various topics under modern medicine and when such persons have put in considerable years of practice covering such topics also, and infraction of their right to prescribe medicines which may fall under the Drugs Act would very adversely affect the areas where they are mostly serving now.

Mr. PC Jain, learned senior counsel appearing for petitioners in Writ Petition No. 423 of 1997, while supporting the contention of Mr. Thakur, highlighted that the right of practitioners of Indian Medicine to practice modern scientific system of Medicine (Allopathic Medicine) is protected under Section 17 (3)(b) of Indian Medicine Central Council Act, 1970.

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Mr.Kirit N.Raval, learned Additional Solicitor General appearing for the Central Government, has submitted that the Central Government is maintaining equal distance from both the contenders, namely, the doctors of modern scientific medicine (allopathic) and the qualified Vaid/Hakims of Indian Medicine; though the Central Government had taken the plea in the High Court that practice in allopathic medicine should not be allowed by non-allopathic doctors and in that he would support the view taken by the High Courts of Rajasthan and Punjab & Haryana regarding validity of rule 2(ee)(iii) and the notifications issued thereunder, he, would, however, add that as a matter of fact many Ayurvedic Vaids and Unani Hakims are prescribing allopathic drugs and that the Central Government will abide by the decision of this Court. Here we are constrained to observe that the stand taken by the Central Government show utter bewilderment in as much as

Page No. 8.

The authority which framed rule is not interested in supporting the legality and the validity of the rule nor does it want to do away with the rule whole heartedly.

Mr. KS Bhati, learned counsel appearing for the State of Rajasthan, in his arguments strongly supported the judgment of the Rajasthan High Court under appeal.

Mr. HM Singh appearing for the State of Punjab also supports the judgment of Punjab and Haryana High Court and went further and submitted that the rule itself was invalid a strange plea by the state Government indeed. –

Mr. Devendr Singh appearing for Respondent No. 1 in Special Leave Petition (C) No. 8422 of 1995 also maintained the arguments of Mr. Bhati.

Mr. Ranjit Kumar who appeared for allopathic doctors, vehemently contended that non allopathic doctor could not be permitted to prescribe allopathic medicines; he supported the grounds on which the Rajasthan High Court had struck down the rule and also the interpretation placed by the Punjab & Haryanan High Court on the Said rule. His alternative submission is that even if Vaids/Hakims are held to the within the ambit of clause (iii), after the enactment of Section 15(2)(b) of the Medical Council Act and the Indian Medicine Central Council Act, 1970 that clause ceased to be operative.

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On the submissions made by the learned counsel for the parties, the questions, which fall for determination, are:

1. Whether Rule 2 (ee)(iii) of the Drugs rule is bad for want of legislative competence; and are the impugned notifications issued by the State Governments, under clause (iii) of the said rule, declaring the categories of persons who were practicing modern system of medicine invalid in law.
2. What is the impact of Indian Medical Council Act, 1956 and Indian Medicine Central Council Act, 1970 on rule 2(ee)(iii) of the Drugs Rules and the notifications issued thereunder/ and
3. Whether the persons who have qualified the integrated courses in Ayurved and Unani from various universities are entitled to practice in and prescribe allopathic medicines,

Before adverting these questions, it would be use full to notice various systems of medicine in vogue in India and the statutes regulating them.

The systems of medicine generally prevalent in India are Ayurveda, Siddha, Unani, Allopathic and Homoeopathic. In Ayurveda, Siddha and Unani systems and treatment is based on the harmony of the four humors where as in allopathic system of medicine.

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Treatment of discuses is given by the use of a drug which produces a reaction that itself neutralizes the disease. In Homocopathy, treatment is provided by the likes.

Of the medial systems that are in vogue in India. Ayurveda had its origin in 5000 BC and is being practiced throughout India but Siddha is practiced in the Tamil –speaking areas of South India. These systems differ very little both in theory and practice. The Unani system dates back to 460-370 BC but that had come to be practiced in India in the 10th Century AD

(Park's Textbook of Preventive and Social Medicine, 15th Edn. pp.1 & 2). Allopathic medicine is comparatively recent and had its origin in the 19th century.

Noticing that for practicing allopathic system of medicines the degrees and diplomas were being issued by private institutions to untrained or insufficiently trained persons and some of them were colorable imitations of those issued by recognized Universities and corporation which was resulting in unqualified persons posing to the public as possessing qualifications in medicine and surgery which they did not possess. The Indian Medical Degrees Act, 1916 (for short '1916 Act') was enacted to ban conferring of degrees or issuing of certificates, licenses etc. to practice western medical science, by persons or authorities other than those specified in the Schedule and notified by State Governments.

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The Western medical science was defined to mean the western methods of allopathic medicine; obstetrics and surgery; the Homeopathic Ayurvedic and Unani system of medicine were excluded from its purview. The next Central legislation on the subject is Indian Medical Council Act, 1933 (for short '1933 Act'). This 1933 enactment was introduced to constitute a Medial Council in India in order to establish a uniform minimum standard of higher qualifications in medicine for all the erstwhile provinces. Section 2 (d) of that Act defines the word "medicine" to mean "modern scientific medicine" which connotes allopathic medicine) including surgery and obstetrics, but excluding veterinary medicine and surgery. Although Homeopathic, Ayurvedic or Unani system was not expressly excluded from the definition, yet a perusal of the Schedule makes it abundantly clear that those system of medicines were not within the scope of that Act.

It may be noted that since 'legal, medical and other professions' it Item 26 of List III (Concurrent List) of Seventh Schedule to our constitution, both the State Legislatures and the Parliament have enacted on the subject of medical profession. Now all these systems of medicine are governed by Central Acts. The Indian Medical Council Act, 1956 (which

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Has repealed 1933 Act) regulates modern system of medicine; the Indian Medicine Central Council Act, 1970 regulates Indian Medicine and the Homeopathic Central Council Act, 1973 regulates practice of Homeopathic medicine. Here we are not concerned with Homeopaths; in regard to practice of allopathic medicine by a homeopath, this Court concluded thus, in Poonam Verma vs. Ashwin Patel (1996) 4 SCC 332:

"A person who does not have knowledge of a particular system of medicine but practices in that system is a quack and a mere pretender to medical knowledge or skill, or to put it differently a charlatan."

The erstwhile provinces were had thereafter the present States are also having their own legislation with regard to medical practitioners in different systems (Indian Medicine as well as allopathic) and are maintaining registers of medical practitioners in those systems. They are too many to enlist them here lest this judgment will be needlessly burdened. However, we shall presently refer to the relevant Acts of the State to which the appeals relate.

The Drugs Act was enacted with a view to regulate the import, manufacture, distribution and sale of drugs to curb the evil of adulteration of drugs and production of spurious and sub-standard drugs which were posing serious threat to the health of community. The amended definition of 'Drug' in clause (b) of Section (3) in the drugs Act is inclusive and comprehensive but it does not include 'Ayurvedic, Siddha or Unani' drug. Indeed, at

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The time of its enactment in 1940, it was not intended to apply to such drugs. It is only by Act 13 of 1964 that those drugs are also brought within the purview of the Drugs Act by including their definition in clause (a) of Section 3 and Chapter IV A in the Act.

Section 33 which falls in Chapter IV of the drugs Act, empowers the Central Government to make rules for the purpose of giving effect to the provisions of Chapter IV which deals with manufacture, sale and distribution of drugs and cosmetics, sub-section (2) of Section 33 enumerates many subjects in clauses (a) to (g0 in respect of which rules may be made. Section 33 A says that Chapter IV shall not, except as provided in the Act apply to Ayurvedic, Siddha or Unani drugs. On December 21,1945, in exercise of the powers conferred under Section 33, the Central Government framed the Drugs Rules. Rule 2 contains the definition of the terms and expressions used in the Rules. Rule 2(ee) , which was inserted by so 1196 dated April 9, 1960 with effect from May 14, 1960, defines the expression "registered medical practitioner".

For purposes of the Pharmacy Act, 1948, the expression 'medical practitioner' is defined

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By substituting Section 2(f) therein with effect from 1.5.1960. Section 2(f) of Pharmacy Act and Rule 2(ee) of the Drug Rules are identical.

Clause (i) to (iii) of Rule 2(ee) are relevant for our purpose and they read as under:-

"2(ee). Registered medical practitioner means a 'person'

(i) Holding a qualification granted by an authority specified or notified under Section 3 of the Indian Medical Degrees Act, 1916 (7 of 1916), or specified in the Schedules to the Indian medical Council Act, 1956 (102 of 1956); or

(ii) Registered or eligible for registration in a medical register of a State meant for the registration of persons practicing the modern scientific system of medicine (excluding the Homeopathic system of medicine); or

(iii) Registered in a medical register (other than a register for the registration of Homeopathic practitioners) of a State who although not falling within sub-clause

(i) or sub-clause (ii) is declared by general or special order made by the State Government in this behalf as a person practicing the modern scientific system of medicine for the purposes of this Act.

(iv) and (v) **********"

(They are omitted, as they are not material for this batch of cases).

A plain reading of clauses, extracted above, shows that ambit of clause (iii) must necessarily exclude those who would fall under the first two clauses. There is no controversy that categories (i) and (ii) relate to practitioners of allopathic medicines.

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Hence, the third category falling under clause (iii) on which Vaids/Hakims (non-allopathic doctors) base their claim may be analysed here (a) It takes in persons who are registered in a medical register of State (It may be noticed here that such a register should not be meant for registration of Homeopathic practitioners but it need not be register meant for registration of persons practicing modern system of medicine), (b) such persons do not fall within catergory (i) or category (ii) of clause (ee), a noted above; (c) they must be declared as persons practicing modern system of medicine by general or special order made by the State Government in that behalf; and (d) such a declaration would operate only for purposes of the Drugs Act and the Rules made thereunder.

The learned counsel argued at length on the question whether clause (iii) is also intended for left out qualified allopathic doctors. But if that interpretation is accepted, the said clause will become redundant as admittedly clauses (i) and (ii) exhaust all categories of practitioners entitled to practice in allopathic medicine. It was conceded at the end of the day and, in our view rightly, that the clause takes in medical practitioners other than qualified practitioners entitled to practice allopathic medicine. And as practitioners of

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Homeopathic medicine are specifically exclude, it becomes evident that this category comprises of practitioners who are enrolled in medical register of a State and though not answering the description of clauses (i) and (ii), are de facto practicing modern system of medicine (allopathic) and those facts are declared by the State Government concerned. By this sub-clause, a de facto practitioner of modern scientific medicine (allopathic) is recognized as registered medical practitioner and is enable to prescribe drugs covered by the Drugs Act.

This being the content of clause (iii) of Rule 2(ee), we shall now turn to the question of validity of the said clause and the circular/notifications issued thereunder by the State Governments. Letter No. 26 (240M.E. (Group-1) 82 dated July 27, 1982 was issued by the Rajasthan Government, communicating the approval of recommendations subject to the conditions specified therein for purposes of issuing the notification under clause (iii) (herein referred to as 'circular') and the notification No. 9874-IIBII-67/34526 dated October 29, 1967 was issued by the Punjab Government in exercise of powers confereed under the said clause.

The learned counsel appearing for allopathic doctors and their association supported the view of the Rajasthan High Court that the rule is bad for want of legislative competence. We are afraid, we cannot accede to this contention. Section 33 of the Drugs Act confers

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Wide power on the Central Government to make rules. Section 33, in so far as it is relevant, is reproduced hereunder:-

"22. Power of Central government to make rules:--

1. The Central Government may after consultation with, or on the recommendation of the Board and after previous publication by notification in the Official Gazette, make rules for the purpose of giving effect to provisions of this Chapter:

   Provided that consultation with the Board may be dispensed with if the Central Government is of opinion that circumstances have arisen which render it necessary to

make rules without such consultation, but in such a case the Board shall be consulted within six months of the making of the rules and the Central Government shall take into consideration any suggestions which the Board may make in relation to the amendment of the said rules.

2. Without prejudice to generality of the foregoing power, such rule may --

(a) to (d) *** *** ***

(c) Prescribe the forms of licenses for the manufacture for the sale and for the distribution, for the sale and for the distribution f drugs of any specified drug or class of drugs or of cosmetics or any specified cosmetic or class of cosmetics, the form of application for such licenses, the conditions subject to which such licenses may be issued the qualifications of such authority and the fees payable therefore and provide for the cancellation or suspension of such licenses in any case where any provision of this chapter or the rules made thereunder is contravened or any of the conditions subject to wich

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They are issued is not complied with;

(f) to (p) *** *** ***

(q) provide for the exemption conditionally or otherwise from all or any of the provisions of this chapter or the rules made thereunder, of any specified drug or class of cosmetics."

Sub-section (1) of Section 33 of the Drugs Act empowers the Central Government to make rules for purposes of giving effect to the provisions of chapter IV which deal with manufacture, sale and distribution of drugs and cosmetics. This is a general power of great amplitude. Without prejudice to the generality of the power in sub-section (1), specific topics are itemized in sub-section (20, in clauses (a) to (q), in respect to which rules may be made by the Central Government. Among them sub-clause (e) realest to be power to prescribe the forms of licenses for the manufacture for sale, or for distribution, for the sale and for the distribution of drugs, or any specified drugs or classes of drugs or of cosmetics or of any specified cosmetics or any class of cosmetics, the form of application for such licenses, the condition subject to which such licenses may be issued, the authority empowered to issue the same, the qualification for such authority, etc. Section 18 which falls in Chapter IV, specifically deals with prohibition for manufacture and of certain drugs and cosmetics. Rule 65 provides conditions of license to sell,

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Stock or exhibit or offer for sale or distribute for wholesale, retail etc. Various sub-rules of the said rule contain as condition of license that the supply of drugs should be on the prescription of a 'registered medical practitioner' (See Conditions Nos. 2, 3 (1), 5(1), 9 and 9 (a)).

From the above discussion what emerges is that drugs can be sold or supplied by pharmacist or druggist only on the prescription of a 'registered medical practitioner' who can also store them for treatment of his patients. It has, therefore, became necessary for the rule-making authority to define the expression 'registered medical practitioner' for the purposes of the Act and the Rules. Rule 2 (ee) does no more than defining that expression, which is within the

scope of section 33(1) as well as 33(2) (e). Therefore, it cannot be said that the rule making authority was lacking legislative competence to make rule 2(ee). The High Court misdirected itself by looking to the provisions of Section 6 and 12 which do not contain the rule-making power. It is only section 33, which contains the rule-making power. The High Court has also erred in searching for a power to frame rules for the registration of medical practitioners: obviously such a power is not conferred under the Act. The rule veritably does not deal with registration of the medical

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Practitioner. It only defines the expression 'registered medical practitioners' by specifying the categories of medical practitioners, which fall within the definition for purposes of the Drugs Act and the Drugs Rules. For the aforementioned reasons, we are unable to sustain the view taken by the High Court of Rajasthan that impugned Rule 2(ee)(iii) suffers from the vice of lack of legislative competence and is ultra vires the Drugs Act.

Now coming to the notification issued by the Punjab Government on October 29, 1967 and the Circular issued by the Rajasthan Government on July 26, 1982, refereed to above, it has already been pointed out that for purposes of clause (ii) of Rule 2(ee) what is required is not the qualification in modern scientific system of medicine but a declaration by a State Government that a person is practicing modern scientific system and that he is registered in medical register of the State (other than a register for registration of Homeopathic practitioner). A notification can be faulted with only if those requirements are not satisfied. The Punjab and Haryana High Court proceeded with an assumed intention of rule-making authority that it could not be within its conception to bring Vaid/Hakims, the practitioners of Ayurveda (Indian System of Medicine), within the purview of the said expression and that it could have only envisaged registration of

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Medical practitioner of modern scientific system holding qualifications mentioned in clauses (i) and eligible for registration under clause (ii) and on that basis held the said notification was ultra vires the rules.

From what has been discussed above, we are unable to uphold the view of the Punjab and Haryana High Court.

We have perused the above said notifications issued by the State Governments and we find that they are well within the confiner of clause (iii) of rule 2(ee). Therefore, we conclude that the said circular and the notification issued by the said State Governments declaring the categories of Vaids/Hakims who were practicing modern system of medicine and were registered in the State Medical Register, are valid in law.

Points 2 and 3 have some over lapping so it will be convenient to discuss them together. The right to practice any profession or to carry on any occupation trade or business is no doubt a fundamental right guaranteed under Article 19(1)(g) of the Constitution of India. But that right is subject to any law relating to the professional or technical necessary for practicing any profession or carrying on any occupation or trade or business enacted under clause 6 of article 19. The regulatory measures on the exercise of this right

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Both with regard to standard of professional qualifications and professional conduct have been applied keeping in view not only the right of the medical practitioners but also the right to life and proper health care of persons who need medical care and treatment. There can, therefore, be no compromise on the professional standards of medical practitioners. With regard to ensuring professional standards required to practice allopathic medicine the 1956 Act was passed which deals also with reconstitution of he Medical Council of India and maintenance of a Indian Medical Register. Thus, for the first time an Indian Medical Register for the whole of India come to be maintained from 1956. In the 1956 Act, Section 2(f) defines "medicine" to mean 'modern scientific medicine' in all its branches and includes surgery and obstetrics, but does not include veterinary medicine and surgery and the expression 'recognized medical qualification' is defined in Section 2(h) to mean any of the medical qualifications include in the Schedules to the Act.

Three more expressions in the 1956 Act have to be noticed here. But before we do so, it must be noted here that the object and reasons of the 1956 Act took note of the fact that there are local Acts in theStated providing for State Medical Council and maintenance of

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State Medical Registers for registration of qualified practitioner in western medical science or modern scientific medicine, that is, allopathic medicine. Now, reverting to the expressions in 1956 Act, they are: "State Medical Council" defined in Section 2(j) as a medical council constituted under any law for the time being in force in any State regulating the registration of practitioners of medicine; State Medical Register" defined in Section 2(k) to mean a register maintained under any law for the time being in force in any State regulating the registration of practitioners of medicine and 'Indian Medical Register' to mean the medical register maintained by the Council. The 1956 Act provides for the recognition of medical qualifications granted by Universities or medical institutions in and outside India, which are specified in the Schedules. Section 15 which is relevant, was in the following terms when the said Act was passed in 1956:

"15. Subjectto the other provisions contained in this Act, the medial

Qualifications included in the Schedules shall be sufficient qualification for

Enrolment on any State Medial Register".

It laid down that the qualifications included in the Schedules should be sufficient qualification for enrolment on any State Medical Register. It be pointed out here that in none of Schedules the qualifications of integrated course figure, consequently

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By virtue of these section persons holding degrees in integrated courses cannot be registered on any State Medical Register.

By Act 24 of 1964, Section 15 of the 1956 Act was modified by keeping the existing section as sub-section (1) and adding two more, sub-section (2) and (3), which read thus:

> "(2). Save as provided in Section 2, no person other than a medical practitioner enrolled on a State Medical Register-

(a) shall hold office as physician or surgeon or any other office (by whatever designation called) in Government or in any institution maintained by a lecal or other authority.

(b) Shall practice medicine in any State;

(c) Shall be entitled to sign or authenticate a medical or fitness certificate or any other certificate required by any law to be signed or authenticated by a duly qualified medical practitioner.

(d) Shall be entitled to give evidence at any inquest or in any Court of Law as an expert under Section 45 of the Evidence Act, 1872 or on any matter relating to medicine.

(3). Any person who acts in contravention of any provision of sub-section (2) shall be punished with imprisonment for a term which may extend to one year, or with fine which may extend to one thousand rupees, or with both."

For the present discussion, the germane provision is Section 15(2)(b) of the 1956 Act

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Which prohibits all persons from practicing modern scientific medicine in all its branches in any State except a medical practitioner enrolled on a State Medical Register. There are two types of registration as for the State Medical Register is concerned. The first is under Section 25, provisional registration for the purposes of training in the approved institution and the second is registration under section 15(1). The third category of registration is in the 'India Medical Register', which the Council is enjoined to maintain under Section 21 for which recognized medical qualification is a pre-requisite. The privileges of persons who are enrolled on the Indian Medical Register are mentioned in Section 27 and include right to practice as medical practitioner in any part of India. 'State Medical Register' in contra-distinction to 'Indian Medical Register', is maintained by the State Medical Council which is not constituted under 1956 Act but is constituted under any law for the time being in force in any State; so also a State Medical Register is maintained not under 1956 Act but under any law for the time being in force in any State regulating the registration of practitioners of medicine. It is thus possible that in any State, the law relating to registration of practitioner sof modern scientific medicine may enable a person to be enrolled on the basis of the qualifications other than the recognized medical

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Qualification' which is a pre-requisite only for being enrolled on Indian Medical Register. But not for registration in a state Medical Register. Even under the 1956 Act, 'recognized medical qualification' is sufficient for that purpose. That does not mean that it is indispensably essential. Persons holding 'recognized medical qualification' cannot be denied registration in any State Medical Register. However a person registered in a State Medical Register cannot be enrolled on Indian Medical register unless he possesses 'recognized medical qualification'. This follows from a combined reading of Sections 15(1,) 21(1) and 23. So by virtue of such qualification as prescribed in a State Act and on being registered in a State Medical Register, a person will be entitled to practice allopathic medicine under Section 15(2)(b0 of the 1956 Act.

In the above view of the mater, we are unable to agree with the following observations of this Court in **AK Sabhapathy vs. State of Kerala** (1992) Suppl. (3) SCC 147:

> "These provisions contemplate that a person can practice in allopathic system of medicine in a State or in the country only if he possesses a recognized medical qualification. Permitting a person who does not possess the recognized medical qualification in the allopathic system of medicine would be in direct conflict with

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> the provisions of the Central Act."

We have perused the Bombay Medical Act, 1912, Bihar Act, 1916, Punjab Medical registration Act, 1916, Rajasthan Medical Act, 1952 and Maharashtra Medical Council Act, 1965 which regulate maintenance of registers of medical practitioners and the entitlement to practice allopathic medicine. Under those Acts State Medial Registers are maintained. Section 7(3) of the Bombay Act of 1912, enabled the Provincial Government, after conculting the State medical Council, to permit the registration of any person who was actually practicing medicine in Bombay Presidency

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Before 25th June 1912; this seems to be the only case of registration without requisite qualification. Further persons possessing Ayurvidya Visharad of the Tilak Maharashtra vidyapeeth of Poona, obtained during the years 1921-1935 (which was included in the Schedule to that Act on 31st September, 1938 pursuant to Notification No. 3020/33 dated 12.9.1939) were entitled to be registered in the State Medical Register; this is the only Ayurvedic qualification on the basis of which persons were eligible to be registered on the State Medical Register in Maharashtra; further with regard to rural area, the prohibition to practice in any village in the rural area **prior to 1912.** None of the petitioners has claimed benefit of these exceptions. We could not find any other provisions which enables a person, other than those possessing qualification prescribed in the Schedules to the Act, to be registered on the state Medical Register to practice allopathic medicine. So it can be observed that if any State law relating to registration of Medical practitioners permits practice of allopathic medicine on the basis of degree in integrated medicines, the bar in Section 15(2) (b) of the 1956 Act will n to apply.

Rule 2(ee), as noted above, has been inserted in the Drugs Rules with effect from May 14, 1060. Section 15 of the 1956 Act, as it then stood, only provided that the medical qualifications in the Schedule shall be sufficient qualification for enrolment on any State medical register and so there was no inconsistency between the Section and the Rule when it was brought into force. But after sub-section (2) of Section 15 was inserted in the 1956 Act, with effect from 15.09.1964, which , inter alia, provides that no person' other than a medical practitioner enrolled on a 'State Medical register' shall practice modern scientific medicine in any State, the right of non-allopathic doctors to prescribe drugs by virtue of the declaration issued under the said Drugs Rules, by implication, got

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obliterated. However, this does not debar them from prescribing or administering allopathic drugs sold across the counter for common ailment.

Here it may be necessary to refer to the development of law with regard to Indian Medicine. In pre-constitutional era each province of India was having its own enactment. Regulating the registration and practice in Indian Medicine like – Uttar Pradesh Indian Medicine Act , 1939, the Punjab Ayurvedic and Unani Practitioners Act. 1949 etc. After coming to force of the Constitution, many State legislation were enacted to regulate the practice of Indian medicine, Ayurvedic and Unani like Punjab Ayurvedic and Unani Practitioner Act, 1963 etc. however, on the model of 1956 Act, the Parliament enacted the Indian Medicine Central Council Act, 1970 (for short '1970 Act') . The schemes and provisions of 1970 Act and 1956 Act are analogous. 'Indian Medicine' is defined in Section 2(e) of the Act to mean the system of Indian Medicine commonly known as Astang Ayurveda, Siddha or Unani Tibb whether supplemented or not by such modern advances as the Central Council may declare by notification from time to time. In Section 2(j) the expression "State Register of Indian Medicine" is defined to mean a register or registers maintained under any law for the time being in force in any State regulating the registration of practitioners of Indian Medicine. The Act contemplates

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having separate Committees for Ayurvedic, Siddha and Unani Medicine. Section 17 enables, inter alia, the persons who possess medical qualifications mentioned in the Second, Third or fourth schedule to be enrolled on any State Register of Indian Medicine. A perusal of the Second, Third and Fourth Schedules shows that they contain both integrated medicine as well as other qualifications. So a holder of degree in integrated medicine is entitled to be enrolled under Section 17 of 1970 Act. Section 22 authorizes the Central Council to prescribe the minimum standards of education in Indian Medicine required for granting recognized medical qualifications by Universities, Boards or medical institution in India. The Central Council is enjoined to maintain Central Register of Indian Medicine containing the particulars mentioned therein and Section 25 lays down procedure for registration in the central Register of Indian Medicine. The counterpart of Section 15 of 1956 Act is Section 17 of 1970 Act. We shall quote it here:

> "17. (1) Subject to the other provisions contained in this Act, any medical qualification include in the Second, third or Fourth Schedule shall be sufficient qualification for enrolment on any State Register of Indian medicine.
>
> (2) Save as provide in section 28, no person other than a practitioner of Indian

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> Medicine who possesses a recognized medical qualification and is enrolled on a State Register or the central Register of Indian Medicine –
>
> (a) shall hold office as Vaid, Siddha, Hakim or Physician or any other office (by whatever designation called) in Government or in any institution maintained by a local or other authority;
>
> (b) shall practice Indian Medicine in any State;
>
> (c) shall be entitled to sign or authenticate a medical or fitness certificate or any other certificate required by an law to be signed or authenticated by duly qualified medical practitioner;

(d) shall be entitled to give evidence at any inquest or in any Court of Law as an expert under Section 45 of the Indian Evidence Act, 1872, on any matter relating to Indian Medicine.

(3) Nothing contained in sub-section (2) shall effect –

(a) the right of a practitioner of Indian Medicine enrolled on a State Register of Indian Medicine to practice Indian Medicine in any State merely on the ground that, on the commencement of this Act, he does not possess a recognized medical qualification;

(b) the privileges (including the right to practice any system of medicine) conferred by or under any law relating to registration of practitioners of Indian Medicine for the time being in force in any State on a practitioners of Indian Medicine enrolled on a State Register of Indian Medicine;

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(c) the right of person to Indian Medicine in a State in which, on the commencement of this Act, a State Register of Indian Medicine is not maintained if, on such commencement, he has been practicing Indian Medicine for not less than five years;

(d) the rights conferred by or under the Indian Medical Council Act, 1956 (including the right to practice medicine as defined in clause (f) of Section 2 of the said Act, on persons possessing any qualifications include in the Schedules to the said Act.

(4) Any person who acts in contravention of any provision of sub-section (2) shall be punished with imprisonment for a term which may extend to one year, or with fine which may extend to one thousand rupees, or with both."

A perusal of the provisions extracted above shows that sub-section (1) prescribes qualifications considered sufficient for enrolment on any State Register of Indian Medicine . Sub-section (2) ordains that all persons except those who possess a recognized medical qualification and are enrolled on a State Register or the Central Register of Indian medicine, are prohibited, from doing any of the acts mentioned in Clause (a) to (d) of that sub-section. Sub-section (30, however, carves out an exception to the prohibition contained in sub-section (2). Clause (a0 thereof saves the right to practice of any medical practitioner of Indian Medicine who was not having recognized medical qualification the date of the commencement of 1970 Act but who was enrolled on a State Register to

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practice that system of medicine; clause (b0 protects the privileges which include the right to practive <u>any system of medicine which was conferred by or under any law relating to registration of practitioner of Indian medicine for the time being in force in any State</u> on a practitioner of Indian Medicine who was enrolled on a State Register of Indian Medicine; Clause (e) saves the right of person to practice Indian Medicine in a State in which no State Register of Indian Medicine was maintained at the commencement of that Act provided he has been practicing in the Indian Medicine for not less than five years before the commencement of the Act and Clause (d) protects the rights conferred by or under the 1956 Act including the right to practice modern medicine possessing any qualification included in that Act. In other words, under clauses (d) the right to practice modern scientific medicine in all it branches is confined to only such persons who possess any qualification included in the

Schedules to 1956 Act. In view of this conclusion it matter little if the practitioners registered under 1970 Act are being involved in various programs or given postings in hospitals of allopathic; medicine and the like.

It will be appropriate to notice that 1970 Act also maintains similar distinction between

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State register of Indian Medicine and Central register of Indian medicine. Whereas the State Register of Indian Medicine is maintained under any law for the time being in force in any State regulating the registration of practitioners of Indian Medicine, the Central Register of Indian Medicine has to be maintained by the Central Council under Section 23 of that Act. For a person to be registered on the Central Register, Section 25 enjoins that registrar should be satisfied that the persons concerned was eligible under that Act for such registration. Keeping his position in mind, if we read Section 17(3) (b0, it becomes clear that the privileges which include the right to practice any system of medicine conferred by or under any law relating to registration of practitioners of Indian medicine for the time being in force in any State on a practitioner of Indian Medicine enrolled on a State register of Indian Medicine, is not affected by the prohibition contained in sub-section (2) of Section 17.

To ascertain if any State law confers 'the right to practice any system, we have perused Bombay Medical Practitioners Act, 1938 Rajasthan Indian Medicine Act, 1953 and Maharashtra Medical Practitioners Act, 1961 which deals with registration of practitioners of Indian Medicine in those States. The requirement as to registration was also contemplated under Pepsu Ayurvedic & Practitioners Act, 2008 B.K. (No. XII

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of 2008 BK) and East Punjab Ayurvedic & Unani practitioners Act, 1949 as well as under Punab Ayurvedic and Unani Practitioners Act, 1963 which repealed the said two Act. This 1963 Act prescribes qualifications as specified in the Schedule for the purpose of registration as a registered practicenor. In the said Act of 1963 also, there is an express provision prohibiting a person other than registered practitioners, as defined therein to practice or hold out whether directly or by implication as practicing or being prepared to practice Ayuvedic Systemor Unani system. Section 16(3) of the Pepsu Ayurvedic or Unani practitioners Act, 2008 B.K. enjoins that no Vaids/Hakims shall be registered under the Act if the Registrar is satisfied that such a person is found to practice any other system of medicine for which he did not hold any certificate or diploma. But we could not lay our hands on any provision in the said State Acts under which the right to practice any system of medicine is conferred on practitioners of Indian Medicine registered under those Acts.

Nevertheless, Ms. Indira Jaising asserted that the prohibition contained in Section 15(2) and the punishment provide in Section 15(3) of the 1956 Act would apply only to persons practicing allopathic system of medicine without obtaining the registration but

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does not apply to practitioners of Indian Medicine. This submission is too board to merit acceptance. It may be pointed out first that the Act regulates practice of allopathic medicine, so section 15(2) (b) requires that only those who are registered on State Medical Register alone can practice allopathic medicine and secondly, the prohibition is directed against every person who is not registered on any State Medical Register and all such persons are precluded

from practicing allopathic medicine. The punishment under Section 15(3) is in respect of contravention of any provision of Sub-section (2).

However, the claim of those who have been notified by State Governments under clause (iii) of rule 2(ee) of the Drugs Rules and those who possess degrees in integrated courses to practice allopathic medicine is sought to be supported from the definition of the Indian Medicine in Section 2(e) of 1970 Act, referred to above, meaning the system of Indian Medicine commonly known as Ashtang Ayurvda, Siddha or Unani Tibb whether supplemented or not by such; modern advances as the Central Council may declare by notification from time to time. Lot of emphasis is laid on the words underlined to show that they indicate modern scientific medicine as under integrated systems various branches of modern scientific medicine have been included in the syllabi. A degree

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holder in integrated courses is imparted not only the theoretical knowledge of modern scientific medicine but also training therunder, is the claim. We shall examine the notification issued by the Central Council to ascertain the import of those words. In its resolution dated March 11, 1987, the Central Council elucidated the concept of "modern advances" as follow:

> " This meeting of the Central Council hereby unanimously resolved that in Clause (e) of Sub-section 2(1) of 1970 Act of the IMCC Act,' the modern advances', the drug has advanced made under the various branches of modern scientific system of medicine, clinicl, non-clinical, biosciences, also technological innovations made from time to time and declare that the courses and curriculum conducted and recognized by the CCIM are supplemented by such modern advances."

On October 30, 1996 a clarificatory notification was issued, which reads as under:

> "As per provision under Section 2(1) of the Indian Medicine Central Council Act, 1970, hereby Central Council of Indian Medicine notifies that 'institutionally qualified practitioners of Indian System of Medicine (Ayurved, Siddha and Unani) are eligible to practice Indian System of Medicine and modern medicine including Surgery, Gynecology and Obstetrics based on their training and teaching which are included in the syllabi of courses of ISM prescribed by Central Council of Indian Medicine after approval of the Government of India.

The meaning of the word 'modern medicine' (Advance) means advances made

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> in various branches of Modern scientific medicine, clinical, non-clinical bio-sciences also technological innovations made from time to time and notify that the courses and curriculum conducted and recognized by the Central Council of Indian Medicine are supplemented by such modern advances."

Based on those clarification, the arguments proceed the persons who registered under the 1970 Act and have done integrated coursed, are entitled to practice allopathic medicine. In our view, all that the definition of 'Indian Medicine' and the clarifications issued by the Central Council enable such practitioners of Indian Medicine is to make use of the modern advances in various sciences such as Radiology Report, (X-ray),complete blood picture report, lipids report, ECG, etc. for purposes of practicing in their own system. However, if any state Act

recognizes the qualification of integrated course as sufficient qualification for registration in the State Medical Register of that State, the prohibition of Section 15 (2)(b) will not be attracted.A harmonious reading of Section 15 of 1956 Act and Section 17 of 1970 Act leads to the conclusion that there is no scope for a person enrolled on the State Register of Indian Medicine or Central Register of Indian Medicine to practice modern scientific medicine

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in any its branches unless that person is also enrolled on a State Medical Register within the meaning of 1956 Act.

The right topractice modern scientific medicine or Indian system of medicine cannot be based on the provisions of the Drugs Rules and declaration made thereunder by State Governments. Indeed, Ms. Indira Jaising has also submitted that the right to practice a system of medicine is derived from the Act under which a medical practitioner is registered. But she has strenuously argued that the right which the holders of degree in integrated courses of Indian Medicine are claiming is to have their prescription of allopathic medicine, honoured by a Pharmacist or the chemist under the Pharmacy Act and the Drugs Act. This argument is too technical to be acceded to because prescribing a drug is a concomitant of the right to practice a system of medicine. Therefore, in a broader sense the right to prescribe drugs of a system of medicine. Therefore, in a broader sense the right to prescribe drugs of a system of medicine would be synonymous with the right to practice that system of medicine. In that sense, the right to prescribe allopathic drug cannot be wholly divorced from the claim to practice allopathic medicine.

The upshot of the above discussion is that Rule 2(ee) (iii) as effected from May 14, 1960 is valid and does not suffer from the vice of want of the legislative competence and the notifications issued by the State Government thereunder are not ultra vires the said rule

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and are legal. However, after subsection (2) in Section 15 of the 1956 Act occupied the field vide Central Act 24 of 1964 with effect from June 16, the benefit of the said rule and the notifications issued therunder would by available only in those States where the privilege of such right to practice any system of medicine is conferred by the State Law under which practitioners of Indian Medicine are registered in the State, which is for the time being in force. The position with regard to medical practitioners of Indian Medicine holding degrees in integrated courses is on the same plain in as much as if any State Act recognizes their qualification as sufficient for registration in the State Medical Register, the prohibition contained in Section 15(2)(b0 of the 1956 Act will not apply.

In the result, Civil appeals, special leave petitions and writ petitions are accordingly disposed of. There shall be no order as to costs.

.....Sd/-.....CJI.

.....Sd/-.....J.

(K.T. THOMAS)

.....Sd/- .....J.

(SYED SHAH MOHAMMED QUADRI)

NEW DELHI,OCTOBER 8, 1998.

The Difficult Airway – Causes, Assessment & Management

Dr. R.K.Jaiswal, M.O. Anaesthesia (I.M.),S.S.H., B.H.U., Varanasi.

Definition of the difficult airway is usually related mainly to tracheal intubations or problems with mask ventilation.

Causes of Difficult Airway:

1. **Inability to open mouth:** - There are some conditions in which opening of mouth is difficult e.g
   - Submandibular abscess
   - Ludwig's Angina i.e. cellulitishe mouth & some part of the neck which causes the neck to swell & may obstruct the airway.
   - Tetanus i.e. Lockjaws
   - Temporo-mandibular joint ankylosis
   - Growth in oral cavity
   - Mandibular trauma
2. **Abnormalities of Mandible:** - The following are some conditions in which abnormalities of moldable is found and intubation of these patients is very difficult. e.g.
   - Micrognathia i.e. one jaw is abnormally smaller than other.
   - Pierre Robin syndrome i.e Hypoplastic mandible.
   - Teacher Collin Syndrome i.e. Mandibulofacial dysostosis.
3. **Abnormalities of Tongue: - The** following patients have macroglossia, which is difficult for intubations.e.g.
   - Pierre Robin Syndrome
   - Down Syndrome
4. **Abnormalities of Soft Palate:** - The patients suffering from following syndrome have abnormalities in their soft palate and create difficulty in intubations e.g.
   - Pierre Robin Syndrome – High Arched palate
   - Treacher Collin Syndrome – High Arched palate
   - Marfan Syndrome
5. **Abnormalities of Neck:-** The following abnormalities of the neck make the intubation difficult e.g.
   - Short Neck
   - Restricted Neck movements e.g.
   - Rheumatoid arthritis
   - Spondylitis (osteoatrhritis)
   - Klippel Feil Syndrome (Cervical Vertebrae fusion)
   - Neck Trauma

- Neck Contractor as in – Post burn, Post Radiotherapy
- Neck swelling like large Thyroid gland
- Diabetes mellitus – reduced mobility of atlanto 0occipital joint.

6. **Abnormalities of Larynx: -** The following condition of larynx makes the intubation very difficult e.g.
   - Edema
   - Tumors
   - Steno sis
   - Fixation of larynx to other structure of neck (in malignancy)

Thus the congenital & acquired Cause of the Difficult Airway are as Follows

Congenital Causes

- Pierre Robin Syndrome i.e. Micrognathia, Macroglossia & Cleft palate.
- Treacher Collins Syndrome i.e. Auricular & Ocular defects, molar and mandibular hypoplasia.
- Down's Syndrome i.e. poorly developed or absent bridge of the nose, macroglossia.
- Klippel Feil Syndrome i.e. congenital fusion of a variable number of cervical vertebrae & restriction of neck movement.
- Goitre – Compression of trachea, deviation of Larynx & trachea.

Acquired Causes:-

- Croup- Laryngeal edema
- Ludwig's Angina - Distortion of the airway & trismus.
- Rheumatoid arthritis – T.M.J. ankylosis, deviation of larynx, restricted mobility of cervical spire.
- Obesity – Short thick neck.
- Arcomegaly – Macroglossia, Pragmatism
- Acute burn – edema of airway.

Assessment of Anatomical Factors of the Airway to Predict Difficult Laryngoscopy & Intubations

Different preoperative tests performed are-

1. **Mallampati Test** – Later modified by Sam soon & young, is performed by asking the patient to sit upright, to open his/her mouth widely with head in neutral position & asked to protrude the tongue maximally & no phonation was allowed. According to pharyngeal structures Seen, the airway is classified as follows.

   Class I- Faucial pillars, soft palate & Uvula are visible.

   Class II- Faucial lpillars & soft palate may be seen but Uvula is masked by the base of the tongue.

Class III- Only soft palate is visible.

Class IV- Not even soft palate visible.

2. **Head & Neck Movement:-** It is graded in order of increasing degree of restriction e.g.

Grade I : $> 90^0$

Grade II : $= 90^0$

Grade III : $=$ or $< 90^0$

3. **Receding Mandible:** - Receding mandible is assessed by noting thyromental distance i.e. straight line distance between prominence of thyroid notch & bony point of chin with head fully extended on neck & mouth closed & scored as follows-

> 6.5 cm - Normal

6.5-6.0 cm - Moderate receding mandible

> 6.0 cm - Severe receding mandible

4. **Buck Teeth:** - (A projecting upper front tooth) - It should be assessed whether it is normal moderate or severely projecting.

5. **Other Factors:** - Should be assessed like

- Neck length
- Obesity
- Anterior Mandibular Depth
- Posterior Mandibular Depth
- Neck Contracture
- Neck Tumour

Laryngoscopy grades described by Cormack & Lahore

Grade I – Visualization of Entire laryngeal aperture i.e. glottis

Grade II- Visualization of post. laryngeal aperture.

Grade III – Visualization of only epiglottis.

Grade IV – Not even epiglottis visualized, Visualization of only palate.

Grade grade 1& II given adequate exposure & intubations can be done easily.

Grade III & grade IV gives inadequate exposure and intubations can be difficult.

Difficult Intubation's Score (DIS): - This score is based on that how the intubations performed i.e. easily, slight difficulty or very difficulty or intubations becomes failed.

DIS –1 = easy intubations at 1st attempt. No difficulty.

DIS- 2 = slight difficulty Intubations done after adjusting the blade or Head position without help of S.R.

DIS -3 = Very difficult Intubations done after changing the blade with or without use of stylet or by S.R.

DIS - 4 = Failed Intubations.

Wilson's Rule for Intubation's: - This rule takes into account **five** risk factors, which are likely to constitute a difficulty in laryngoscopy.

Wilson's Score:

Risk Factor	Score	Level
Weight	0	< 90 Kg
	1	90-110 Kg
	2	>110 Kg
Head & Neck Movement	0	Above 90^0
	1	About 90^0 (i.e. $\pm 10^0$)
	2	Below 90^0
Jaw Movement	0	IG > 5 CM
	1	IG = 5 cm (2-5cm)
	2	IG < 2 cm
Receding mandible	0	Normal
	1	Moderate
	2	Severe
Buck Teeth	0	Normal
	1	Moderate
	2	Severe

N.B.- Less the score easy to intubations more scores more difficulty to intubations.

Management of the Difficult Airway: - It is divided in to following two headings-

II- Anticipated Difficult Intubation.

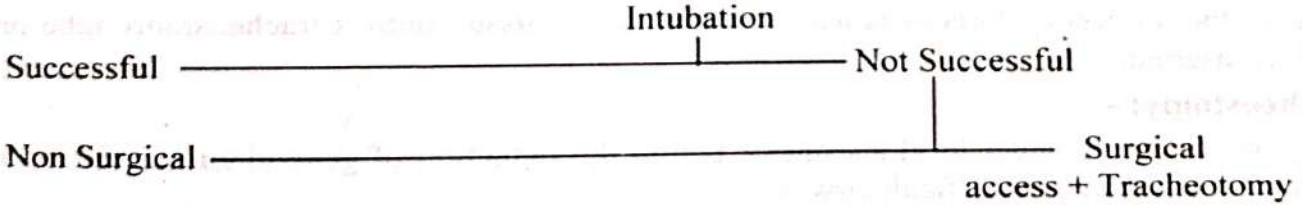
III- Non-Anticipated Difficult intubation.

I- Anticipated Difficult Intubation:-

II- Intubation with the help of volatile Anesthetic gases.

III- Awake Intubation – By blocking glossopharyngeal nerve & Superior laryngeal Nerve by xylocain Spray.

If intabation is done by above method than it is O.K. otherwise following method are used.



Surgery with bag & mask, Blind nasal Intubation, Change of laryngoscope blade, Intubation Stylet

Retrograde intubation:- In this technique catheter is passed through cricothyroid membrane and pulled out from mouth, tube is threaded over it.

Fibre optic Laryngoscope.

II- Non-Anticipated Difficult intubation:- (Patient under Anesthesia)

1. Ventilation C bag & mask possible (Non-emergency)
2. Ventilation with bag & mask not possible (emergency) than –

Immediate Call for Help

Non-Surgical	Surgical
The Laryngeal Mask Airway (LMA)	- Cricothyroidotomy
Combi tube	- Transtracheal Jet Ventilation
	- Emergency Tracheostomy

The Laryngeal mask Airway (LMA):-

LMA comes in the following sizes:

Size 1 – For children weighing less than 6.5. Kg., Size 2 – For Children Weighing between 6.5. to 25 Kg., Size 3 – For small adults, Size 4 – For large adults.

LMA is inserted orally until it is seated behind the larynx & cuff is inflated. Positive pressure ventilation indications proper positioning. The LMA can establish an airway when the trachea cannot be visualized & it may also be used as a guide for placement of an endo tracheal tube (E.T.T.) (A 6 mm diameter E.TT.will pass through LMA nos. 3 & 4). The LMA does not protect against regurgitation or pulmonary aspiration & require topical, regional or general anesthesia for placement.

The Light Wand: -

The light wand consists of a malleable lighted stylet over which an oral E.T.T. can be passed blindly in to the trachea. The operating room lights are dimmed & the light wand & E.T.T. are advanced following the curve of the tongue. A glow noted in the lateral area of the neck indicates that the tip of the of the E.T.T. lies in the priforma fossa. If the tip enters the esophagus, there is a marked diminution in the light's brightness. When the tip is correctly positioned in the trachea, a marked glow is noted in the anterior portion of the neck, At this point, the E.T.T. is lid off.

Cricothyroidotomy:-

It is a rapid, effective method for relieving severe upper airway obstruction. With the neck extended, a small incision is made in the cricothyroid membrane in the mid line. The handle of the scalpel or Kelley forceps is used to separate the tissue until a tracheostomy tube or E.T.T. is inserted.

Tracheostomy: -

It may be performed under local anesthesia before the induction of general anesthesia for a patient with a particularly difficult airway.

Technique: -

After careful dissection of vessels, nerves, & the thyroid is thymus, an incision is made usually in the 3rd or 4th cartilaginous ring of the trachea.

Complication:-

Include haemorvhage false passage & pneumothorax.

संज्ञाहरण दिवस दिनांक ६ फरवरी २००६

आज दिनांक ६ फरवरी २००६ को सुश्रुत व्याख्यान कक्ष में प्रातः ६ बजे संज्ञाहरण दिवस का आयोजन भारतीय संज्ञाहरण एसोशिएसन व संज्ञाहरण प्रभाग, शल्य शालाक्य विभाग, चि०वि० संस्थान, का०हि०वि०वि० के संयुक्त तत्वाधान में हुआ।

संज्ञाहरण दिवस का उद्घाटन मुख्य अतिथि प्रो० गजेन्द्र सिंह, निदेशक चि०वि० संस्थान, का०हि०वि०वि० द्वारा किया गया। मंच पर संकाय प्रमुख प्रो० मंजरी द्विवेदी, चिकित्सालय अधिक्षिका प्रो० एस० चूड़ामणि गोपाल, डा० एस० बी० पाण्डे, संरक्षक, डा० डी० एन० पाण्डे, विभागाध्यक्ष शल्य शालाक्य विभाग व अध्यक्ष भारतीय संज्ञाहण एसोशिएशन, डा० के०के० पाण्डेय आयोजन सचिव, डा० पी० के० शर्मा, अध्यक्ष भा० सं० ए० उ० प्र० शाखा तथा सचिव डा० हरिओम सिंह उपस्थित थे। डा० के० के० पाण्डेय ने अतिथियों का स्वागत किया एवं संज्ञाहरण के ऐतिहासिक तथ्यो का उल्लेख किया। प्रो० एम० साहू० ने सभा को सम्बोधित किया। इस अवसर पर संज्ञाहरण की उपयोगिता तथा आयुर्वेद के विकास हेतु उसकी शिक्षा की अनिवार्यता पर चर्चा हुई। डा० एस० बी० पाण्डे ने ऐसोसिएशन व संकाय के लोगो के सहयोग की सराहना की। प्रो० मंजरी द्विवेदी संकाय प्रमुख ने कहा कि आज आयुर्वेद संकाय में संज्ञाहण अनुभाग सही दिशा में और समन्वित चिकित्सा पद्धति मानको के अनुरूप कार्य कर रहा है और संकाय के अन्य विभागों को सतत् सहयोग कर रहा है। इसके विकास के लिए हर संभव प्रयास किये जायेगें।

चिकित्सालय अधिक्षिका प्रो० चूड़ामणि गोपाल ने अपने भाषण में कहा कि भारत में बी० एच० यू० प्राचीन काल से शल्य चिकित्सा का केन्द्र रहा है और निश्चित ही संज्ञाहरण सुश्रुत काल से ही रहा है। उसके वैज्ञानिक सन्दर्भो का आधुनिक परिप्रेक्ष्य में विकास होना चाहिए। उद्घाटन के पश्चात् जलपान का आयोजन किया गया तत्पश्चात् भा० सं० ए० के कानूनी सलाहकार श्री जीवन प्रकाश शर्मा द्वारा इन्टिग्रेटेड प्रैक्टिशनर्स के संरक्षण कानूनो पर विस्तार से प्रकाश डाला।

भोजन के पश्चात् समारोह का समापन हुआ।

IX[th] NATIONAL CONFERENCE PROCEEDINGS

IX[th] National Conference of AAIM was held on 25-26[th] Dec. 2005 at KATS Ayurveda College Ankushpur, Berhampur (Orissa). The venue was on the sea beach of Gopalpur beautiful placing in Orissa. The inaugural function with other scientific programmes was organized in as decent manner as below: -

25.12.2005

8.0 AM- 10.00 AM	Registration
10.00 AM – 11.00 AM.	Late Prof. P.J. Deshpande oration
	Lecture on Pain Clinic
	Orator Prof. Pramod Kumar, Prof & Head, Deptt. of Anesthesia, M.P.S. Medical College Jamnagar.
	Chairperson: Dr. S.B. Pande
	Co- Chairperson: Dr. N.P. Das
11.0 – 1.0 PM	Inaugural Function
1.0 – 2.0 PM	Lunch
2.0 – 3.30 PM	Scientific Session I
	Late R.A. Pande Memorial Best Paper Session
	Chairperson: Dr. N. P. Das
	Co-chairperson: Dr. D.N. Pande.

Papers Presented

1. Effects of *Dosaghna Lepa* in the management of Superficial vein thrombosis - Dr. Guraj Tantri, S.D.M. Ay. College, Udupi.
2. The role of *Bala Taila Matrabasti* in Post-operative pain management *wsr* to inguinal hernia. Dr. Shri Niwas Reddy, SDM Ay. College, Udupi.
3. Post-spinal headache causes, its prevention and treatment – Binod Bihari Dora, K.A.T.S. Ay. College, Berhampur.
4. Physiology of Hypertension and it is control before anaesthesia – Jabi George, KATS, Berhampur.
5. Management of hypertension during anesthesia – Nirupama Jena, KATS, Berhampur.
6. Anesthesia in Ancient Time vis a vis to recent time – Sashi Kant Majhi KATS, Berhampur.
7. Physiology of Pain pathway – its knowledge required for anesthesia – G.S. Panda, Government Ay. College, Bolangir.
8. Pain and it is modalities – An Ayurvedic View – Jagdish Sing, IMS, BHU.

   4.0 – 4.30 - Tea Break, 4.0 – 5.30

   Scientific Session II- Best Paper Session- Late R. A. Pande Memorial.

   Chairperson: Dr. Shyndye V.N.

   Co-chairperson: Dr. Sanjeev Sharma.
9. Resuscitation in Meconium Stained Baby – Dr. Bimal Panda KATS, Berhampur.
10. Dental Extraction by Jalandhar Bandha – Dr. B.C. Serapati – Government Ay. College, Bolangir.

11. Vat Shamak are Vedanasthapana – Gyan Ranjan Mishra, KATS, Berhampur
12. Comparative study of midazolam and pentazocine v/s. Diazepam and Pentazocine in caesarean section.
13. Anesthetic effect of *Sarpgandha* and *Bhanga* - Trilochen Bind, KATS, Berhampur.

26/12/2005

8 - 9 AM	Breakfast
9 - 10.45 AM	Late Dr. Bhaskar Gobind Ghanekar memorial oration **Integrated Health Education in India** **Neonatal Resuscitation Demonstration** **Orator**: Dr. D.N. Pande, IMS BHU Varasnasi **Chairperson:** Prof D.P. Purnik, Tilak Ay. College, Pune. **Co-Chairperson:** Dr. R.K. Gupta, Sawantwadi
19.45 – 11.0 AM	Tea Break
11.00AM - 1.20 PM	Scientific paper Session III[rd] (Best Paper).

14. Therapeutic standardization of Ras-Sindura wsr to its Rasayan Effect – Dr. Pankaj Rai, BHU.
15. Hypnotic effect of Swarna Makshika and its use in premedication - an experimental study - Dr. Sudhal Dev Mahapatra, BHU.
16. Role of some indigenous drug in depressive illness – Dr. Praveen Kumar Rai, BHU.
17. Ahiphen – its Pharmacological properties and use in anesthesia – Dr. S.K. Mishra, KATS, Berhampur.
18. New Advances in preparation of Mensta – Dr. Saurabh Nayak, Dabur India.

Guest Lecture Session:

1. **Dr. V.N. Shyndye** – Blind Nasal intubation- its technique and use in anaesthesia.
2. **Dr. Borse N.V.** - Kshar Surtra application in hemorrhoid and Fistural in ano.
3. **Dr. D.N. Pande / Dr. Awaneesh** –Shock and its management.

The conference ended with a great success with the assurance of Dr. Chandrashekhar Sahu – M.P., Berhanpur district to promote integration in Orissa and to extend his help at all levels to promote Ayurveda. The chief guest of valedictory function, Dr. Trinath Behara M.L.A. Gopalpur assured to extend all his help to promote Ayurveda in Orissa. He also declares to demand more posts for Ayurvedic doctors in the state hospitals. The Director Imdian Medicine and Homeopathy also expressed his constructive views to promote Ayurveda. Sri Santanu Ratha, Astt. Director, A.I.R., Berhampur assured to propogate the activities and achievements of Ayurvedic doctors via electronic media. The best paper award in the memory of late Pt. Ram Autar Pande was presented by the Honorable Chief Guest – Dr. Trirath Behera M.L.A. Gopalpur to Dr. Gura Raj Tantri Udupi (IST Prize), Dr. Awanesh Kumar (B.H.U.) (IInd Prize) and Dr. Sudhal Dev Mahapatra (B.H.U.) (III Prize). A Memento with certificate and cash of Rs. 501, 301 and 201 respectively was presented to the winners. Prof. D.P. Purnik, Former President of AAIM expressed his thanks to the organizers. Dr. S. Sharma, Secretary AAIM also expressed his compliments to the organizers and the college administration for their dedicated hard work for success of the conference Dr. D.N. Pande, President AAIM expressed his appreciation for hospitality and other management. Prof. B K Jaisingh, Principal KATS, Ay. College proposed the vote of thanks to all the participants, guests, orators, members of associations, organizing committee members, local administration and press & media for their support to this memorable event at sea beach of Gopalpur.

Sangyaharan Shodh – Feb. 2007, Vol. 10, No. 1

Ashwinau Award – 2005

Awarded to Dr. Rajesh Kumar Gupta

BIO DATA

Name	: **Dr. Rajesh Kumar Gupta.**
Age & Date of Birth	: 46 yrs. 17.09.1958
Resident Address	: Deep darshan, khaskilwada, Sawantwadi - 416510
Office Address	: B.S. Ay. Mahavidyalaya, R.J.V.S. Hospital Sawantwadi
Qualifications	: B.A.M.S, P.G.-A.V.P. (Shalya-Shalakya)
Experience	: Registrar cum tutor in surgery & Anaesthetist 3 year 1983 to 1986 (M.A. Podar Hospital Worli) : R.M.O. at R.J.M.H. Sawantwadi, 1986 to 1988, 2 year. : Lecturer in Shalya & Shalakya, 1988 B.S. Ayurved Mahavidyalaya Sawantwadi : Reader in Shalya, Dec. 2001 : I/c Principal, 1999 to 2002, 3 years
Present Position	: H.O.D. Shalya Shalakya, B.S. Ayurved Mahavidyalaya
Examiner in U.G.	: *Subject-Shalya-Shalakya* -Bombay, Amaravati, Pune, M.U.H.S. Nashik University : Sampoor Nand Sanskrit University, Varanasi
P.G. Examiner	: Shalya-Shalakya and Sharir Rachana: Pune and Amaravati University for last 10 yrs
Examiner in PHD (Shalya)	: Banaras Hindu University, Varanasi
Life member	: 1. National Integrated Medical Association 2. Deccan Surgical Society 3. National Association for Blind, Maharashtra 4. Indian Red Cross Society- Sindhudurg 5. Association of Anaesthetist of Indian Medicine India
Founder president	: NAB- Sindhudurga
President	: Doctors Fatemity Club, 2004-2005, Sindhudurga. : Sindhudurga Judo Karate-Akido Association
Member	: Board of studies, Goa University, Ayurveda faculty : B.O.S. Banaras Hindu University, Member : District Tuberculosis Control Programme. Sindhudurga.

Member Board of Directors : 1. Jana Shikshan Sanastha-Shramik, Vidyapeeth-Sindhudurga
2. Association of Anaesthetist of Indian Medicine. India
3. Usha Ispat Ltd. Reddi.

Vice-President : AAIM – Maharashtra

Executive member : Red Swastik Society, Sindhudurga.

Awards : "Sushruta Ratna 2002 for Best Young Surgeon By National Sushruta Association of India Dhanvantari 2003 for outstanding Medical services to Humanity in Sindhudurga by Shivbhumi Bhikshan Santha, Kolhapur.

: Masters Training Certificate in AIDS by Arcon & Director of Ayu., Govt.of Maharashtra.

Project Co-ordinator & Executive member : Red Swastik Society, Maharashtra State.

Guest lecturer : 6th- 7th AAIM conference at Varanasi. Delievered lecture at Teachers Orientation programme for Teachers in Shalya, R.A. Podar Medical College 2003 2004, 2004-2005
Acharya Shushrut at A.I.R. Ratnagiri

Guest Speaker : All India Ano Rectal-Disease-up date at Nasik in Jan. 2005

Participated as Operative Surgeon Live demonstration workshop at Proctology Update 2005 YMT Medical College Khar, Navi Mumbai.

Participated as a Operative Surgeon & Anaesthetist at All India Shushrut Conference at Pune 2002
Written articles in Madhujeevan a Reputed magzine From Bombay. JNIMA

Work experience

Surgery : Operated more than 10,000 pt. in last 15 years.

Major Surgery : Hernia, Appendix, Hysterectomy, LSCS, Laparotomy, Int. Obstruction, Septic wound, Thryoridectomy, CA Breast, CA Penis, Prostate, Piles, Fusula, Fissure, CA Rectum.

Anesthetist : Administered Anaesthesia to more than 15,000 patients in

Organized Conferences and Seminar

1. V National Conference Association of Anasthetists of Indian Medicine at Sawantwadi, Jan. 2002.
2. FPAI Action now in Familly Planing 1988.
3. Medico Legal Problems 1992.
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RECENT RESEARCH UPDATES ON GUDUCI

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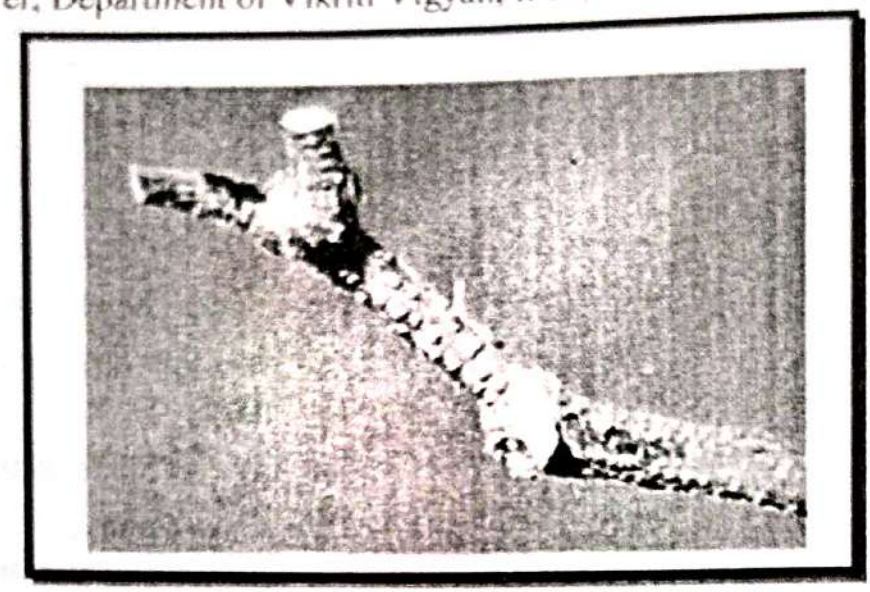

Groups (gana) : Vayahsthapana, Dahaprasamana, Trsnanigrahana, Stanyasodhana, Trptighna (Caraka.), Guducyadi, Patoladi, Argvadhadi, Kakolyadi, Vallipancamula (Susruta.).

Botanical Name: Tinospora cordifolia (Wild) Miers. Ex Hook. F. and Thoms

Family: Menispermaceae

Classical Name: Guduci

Sanskrit Names: Guduci, Chinnaruha, Kundalini, Madhuparni, Vatsadani, Cakralaksanika, Amrita, Tantrika, Cakrangi

Regional Names:

English - Heart-leaved, Moonseed, Gulanch tinospora, Hindi - Giloya, Giloya Guruch, Galoya, Gulanca Amrita, Kannad - Amrtaballi, Yaganiballi, Madhuparni, Bengali - Gulanch, Marathi - Gulvel, Gujarati - Galo, Telugu-Tippatiga, Amrita, Arabi - Gulanch, Maliyalam - Cittamrtu, Amrtu, Tamil-Amurutavalli, Cintilikkoti

Description:

A large decidous climber with succulent, corky, grooved stems; branches sending down slender pendulous fleshy roots, terete, striate, with tuberced, pale, sometimes shining or glaucous bark.

Leaves membranous, 7-9-nerved, 5-10 cm. or rarely 12 by 10 cm. roundish subdeltoid cordate with a broad sinus and large basal lobes, obtuse or more or less cuspidate, reticulately veined with microscopic glistening glands, beneath; petiole 2.5-6cm. long.

Racemes rather lax, 5cm. long, elongating and finally often longer than the leaves, axillary, terminal or form the old wood.

Male flowers:

Clustered in the axils of small subulate bracts. Sepals the 3 outer very small, ovate-oblong, acute, the inner larger, membranous broadly elliptical concave, 3-4 mm. yellow.

Petals 6, equal, about 2 mm. long, broadly spathulate, each loosely embracing a stamen when young, claw cuneate, lamina triquetrous or subrilobed, reflexed at apex. Pistillode O.

Female flowers:

Usually solitary, similar to male, but sepals green, margins not reflected, staminodes, short, linear.

Carpels 1-3 widely separated on the short fleshy gynophore, dorsally convex, ventrally flat or nearly so, scarlet, size of a larger pea; style scar subterminal.

Stone broadly ellipsoid, with a slender dorsal ridge and a ventral depression, slightly muricate.

Stem :

The fresh stem has green succulent bark; covered by a thin brown epidermis, which peels of in flakes; it is studded with warty prominences here and there, gives of roots and branches bearing smooth, heart-shaped leaves and bunches of red berries; when dry it shrinks very much and the bark separates from the wood and becomes of a dull brown colour; the latter consists of a number of wedge shaped bundles, the taste is very bitter; the odour not on any way peculiar.

The pieces of stem in dried state form raw material of market drugs.

Flowering and Fruiting Time: Summer to winter season

Distribution:

It is found throughout tropical India. Large climbers on trees, shrubs and hedges occurring mostly in tropical regions.

Chemical Composition:

An unidentified compound mp, 114°, an amorphous compound, mp.90°, a physiologically active unidentified compound, mp, 115°, a sterol mp. 134°, and a fatty acid. mp.84°, isolated from plant (J. Proc. Inst. Chemists, Calcutta, 1959, 31, 12; Chem. Abstr. 1960, 54, 4637); a diterpenoid of columbin type tinosporin (0.02%), mp. 184° isolated from plant (Sci. Cutt. 1960, 26, 140, Sci. Res. 1964, 1, 177; Chem. Abstr. 1964, 61, 12331b); tinosporide, mp. 236° and cordifolide, mp. 176°, isolated (Sci. Res. 1964, 1, 1977. Chem. Abstr. 1964, 61, 12331b).

Tinosporidine and β-sitosterol isolated from stems; cordifol, Hepatocosanol and octa cosanol from leaves (Sci. Res. 1970, 7, 61; Chem. Abstr. 1972, 77, 137-377n; Indian J. Applied Chemistry. 1971, 34, 46; Chem.

Abstr. 1974, 80, 24816y); a new furanoid diterpene-tinosporide isolated from stems and its structure determined (Indian J. Chem. 1978, 16B, 317).

Revised structure of tinosporide (J. Bangladesh Acad. Sci. 1978, 2, 25; Chem. Abstr. 1980, 93, 72009C); magnoflorine (0.07%). isolated from Stem (Arch. Pharm. 1981, 319, 251; Chem. Abstr. 1981, 95, 3352P).

From Tinsopora Cordifolia root, isocolumbin, (yield 0.0032%), Tetrahydropalmatine (0.0018), magnoflorine (0.005) and Palmatine (0.002) were isolated and identified. (Fitoterapia, V. 69 (6): P. 541-542, 1998).

In Tinsopora cordifolia (S) – norcoclaurine was exclusively O-and-N-methylated and not its (R)-enantiomer. The methylating enzyme activity was purified and shown to catalyse

stereoselectively only the methyl transfer from SAM to (S)-configured norcoclaurine and coclaurine (Phytochemistry, V. 38 (6): P 1387-1395, 1995).

Furanoid diterpine glucosides palmatosides C and F have been isolated tetra acetates from the n-BuOH fraction of T. cordifolia stems. Their structures have been elucidated by extensive ID and 2D NMR studies (Indian Journal of Chemistry V, 35 B (6): P 630-634, 1996). Stem wood of T. cordifolia has yielded a novel 18-norclerodane diterpine O-glucoside that has been assigned the trivial name tinosporaside. On the basis of extensive NMR studies this has been assigned the structure (relative stereo chemistry) 1, 17-dioxo-8 beta, 10 alpha, 12 alpha, 19 alpha, 20 beta-18-norclerod-2, 13, (16), 14 trien-4-alpha-beta-D-glucopyranoside-12, 17; 15, 16-dioxide. (Phyto Chemistry, V. 28 (1) : P. 273-275, 1989).

Five novel diterpene furan glycosides, viz. cordifolisides A-E and two phenyl propane glycosides have isolated from the polar fractions of the aqueous extracts of T. cordifolia and their structures elucidated with the help of high resolution 1D and 2D NMR Spectroscopy (Second International Symp. On Innovations in Pharmaceutical Sci. and Technol. Ahmedabad, P. 70, 25-27th Feb. 1994).

Several glycosides were isolated as polyacetates from the n-BuOH fraction of the T. cordifolia stems. The structures of three new norditerpene furan glycosides cordifoliside A, B and C have been established by 1D and 2D NMR spectroscopy (Phytochemistry, V. 37 (3). P. 781-786, 1994).

Mineral elements Na, Mg, K, Ca, Cr, Mn, Fe, Co, Zn were found to be present in Tinospora cordifolia (Hamdard Medicu. V. 37 (4): P. 18-22, 1994).

Cordioside, A clerodane furano diterpene glucoside has been isolated from the stem of T. cordifolia and characterized on the basis of NMR spectroscopy. Four known compounds: tinsoporaside, syringin, columbin and a cordioside derivative have also been isolated and identified (Phytochemsitry, V. 38 (2) : P. 447-449, 1995).

The chromatographic fractionation resulted in the isolation of compounds A and B from Tinospora cordifolia. On the basis of IH-NMR and FAB-MS, compounds A and B were identified as syringine and syringine apiosylglycoside. (Planta Medica, V. 60 (5): P-596-597, 1994).

By using 1D and 2D NMR spectra, including 1H-1H and 1H- 13C long-and one bond shift correlation, and NOE difference spectra and structure of a steroid, isolated from the ethyl acetate extract of the aerial parts of T. cordifolia has been established as 2 beta, 3 beta, 14 alpha, 20 beta, 22 alpha-25- hexahydroxy-5-beta cholest-7-en-6-one (20 beta hydroxyecdysone) A11 1H and 13C resonance's have been unequivocally assigned (Indian Journal of Chemistry, V. 34 B (7): P. 674-676, 1995).

Tinosponone (C 19 H 22O5, MP 172°) and tinocordioside (C 25 H 3409) have been isolated from the stem of T. cordifolia. (Phytochemsitry, V. 38 (3) : P. 659-661, 1995).

Pharmacodynamics: Rasa : Tikta, Kasaya, Guna : Guru, Snigdha, Virya : Usna, Vipaka : Madhura, Dosakarma : Tridosasamaka.

Action and properties :

***Karma* :**

Rasayana; Vayahsthapana; Dhatukrit; Katupoustika; Jvaraghna; Dahaprasamana; Kusthaghna; Vedanasthapana; Kaphaghna; Vrsya; Caksusya; Medhya; Balya; Kesya;

Kesaropana; Bhramahara; Hrdya; Raktasodhaka; Raktavardhaka; Amasayasthamlata nirodhaka; Trsnanigrahana; Chardinigrahana; Pathya; Bhutaghna; Dipana; Pacana; Sangrahi; Anulomana; Pittasaraka; Krmighna; Mutrajanana; Mutravirajaniya; Visaghna.

***Roga* :**

Jvara; Jirnajvara; Visamajvara; Daha; Trsa; Chardi; Srama Ksaya; Dourbalya; Dhatuksaya; Vatarakta; Amavata; Raktavikara-dosa; Mutrakrcchra; Mutradaha; Puyamehaprameha; Sukradourbalya; Kasa; Svasa; Kustha; Visarpa; Kandu; Carmaroga; Phiranga; Hrddourbalya; Pandu; Kamala; Halimaka; Agnimandya; Chardi; Sula; Arsa; Amlapitta; Pravahika; Grahani; Krmiroga; Visa; Bhrama; Netraroga; Timira; Plihodara; Pradara; Stanyasuddhi; Kesaroga; Vali; Palita; Jara vyadhi; Bhuta; Graha badha.

Therapeutic Uses :

Guduci is alterative, anthelmintic, antiarthritic, anti-periodic, anti-pyretic, aphrodisiac, bitter tonic, blood purifier, and general tonic, nutritive and stomachic. It is useful in biblious fever, chronic diseases or diarrhea and dysentery, fever, rheumatism and gout, skin at diseases, general debility, malarial fever, seminal weakness, spleenic effect and urinary diseases.

The fresh stem is more efficacious than the dry one. It is recommended that the stem of this plant drug may preferably be used always in green and fresh state; and if storage is desired, the stems should be properly collected during the rainy season and then stored (packing in suitable container) after drying in shade. This kind of raw drug material (dried stems) may be used in medicine till the dried of herbal drug remains medicinally potent since old raw material becomes inert.

The drug is commonly used in rheumatism, urinary diseases, dyspepsia, general debility, syphilis, fever, skin disease, biliousness, haemorrhoids, bronchitis, spermatorrhoea, impotency, jaundice and morbidity of liver.

An infusion of the plant is given in (one to three ounces twice or thrice a day) in fever, blood impurities, malarial and periodic fevers and various other ailments which are to be treated with this drug.

The expressed juice of the fresh plant is given (in doses of two or four drachmes) with long pepper and honey, in gonorrhoea, cough and chronic fever. The fresh juice of the green plant is administered with milk as a general tonic.

The roots are used in medicine in the same way as the stem. Leaves of the plant are also medicinally useful as they are useful in various diseases and especially their vegetable (guduci patrasaka) is therapeutically recommended.

The watery extract (also known as Indian quinine) is very efficacious in common fever due to cold or indigestion. The facula prepared from the roots and stems, generally from the stems, is commonly known as Gilo sat or sat giloy (guduci satva), it is highly valued drug for intermittent fevers, chronic diarrhoea, chronic dysentery, burning sensation, secondary syphilis, chronic gonorrhoea, leucorrhoea, jaundice, rheumatism, urinary disorders and some other ailments.

A medicated garland of small pieces of the stem is usually worn in certain parts of country with the claim to effect against jaundice. In rural and tribal regions, the stems are used popularly as a folk medicine.

This herbal drug is one of the highly valuable and most common drugs in Indian System of Medicine which incorporates it is potent classical drug; it is employed as an important ingredient in a number of formulations (yoga) under pharmaceutics and herbal drug industry, being and efficacious medicinal plant, with abundant and easy availability and recognition during source plants collection for genuine raw drug with good demand.

The drug possessing restorative and alterative properties is a significant rejuvenation (rasayana) drug, which is recommended in certain disease under the group, as a preventive as well as curative herbal remedy.

The oil prepared with stem (guduci siddhataila) is externally applied to leprosy, skin diseases and particularly gout. If the decoction and other forms of preparations of the drug are specifically prescribed in the diseases of gout and rheumatism and allied ailments. The stems decoction, infusion and powder are used frequently in the spleen and liver disorder, anaemia, jaundice, biliary troubles, hyperacidity, colic, worms, pthisis, senile diseases, measles, poisoning, heart troubles, filariasis and various other disease.

Aqueous extract of stem showed anti inflammatory, analgesic and anti pyretic actions in rats and immuno suppressive effect in rabbits; 50 mg/100g, orally and i.p., significantly inhibited acute inflammatory response evoked by carrageenin. It significantly inhibited antibody formation by typhoid "H" antigen. It also potentiated morphine analgesia (Indian J. Pharmacol. 1977, 9, 221).

Immunopotentiating compounds from Tinospora cordifolia. Syringin and cordiol inhibited the in vitro immunohaemolysis of antibody coated sheep erythrocytes by guinea pig serum. (Journal of Ethnopharmacology, V. 58 (2) : P. 89-95, 1997).

Antimicrobial activity of Tinospora cordifolia was discussed (Journal of Non Timber forest products, V. 5 (1 and 2): P. 79-81, 1998).

Chemical constituents and anti stress anti diabetic, hepato protective anti inflammatory and immunomodulatory activities of T. cordifolia have been discussed (Indian Drugs, V. 30 (11) : P 549-54, 1993).

Hepatoprotective action of T. cordifolia was established (Indian Journal of Veterinary Medicine, V. 9 (2) : P. 1989).

Antipyretic activity of T. cordifolia was confirmed (Journal of Ethnopharmacology, V. 33 (1-2) : P. 193-196, 1991).

Anti hepatotoxic activity of Tinospora cordifolia was studied. (Indian Drugs, V. 30 (7) : P. 338-341, 1993).

Immunomodulatory activity of imunocin (a herbal formulation containing Tinospora cordifolia etc) was confirmed. (Indian Journal of Pharmaceutical Sciences, V. 62 (4) : P. 257-260, 2000. Structure elucidation of columbin ($C_{20}H_{22}O_6$, mp, 192-95°) isolated from T.cordifolia stem has been reported (ASO MPS, VIII, Malaysia, 1994).

Parts Used: Stem

Dose : Decoction 50-100 gms., Powder 1-3 gms, Fecula (Satva) 10-30 grains.

Formulations (yoga) : Guducyadi curna, Guducyadi Kvatha, Guducilouha, Guduci taila, Guduci satva, Amrtarista etc.

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EFFECT OF KSHEERA BALA TAILA IN THE MANAGEMENT OF SCIATICA

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Key word: Ksheerbala, Rasayana, Brimhana, Sahasra yoga, Kalka.

Abstract: In the present study modern Bhatti is used to prepare the drug on a large scale. The observation of Pharmaceutical study suggests that one should be very careful regarding identification of the particular stage of Paka, because the time between the different stages of Pakas is quite short, especially when the amount of preparation is small.

It is clear that Gridhrasi is occurred more in males. Probably it is occurred due to their excess physical labour and constant sitting position. It is clear that Gridharasi is occurred more in 41 to 70 years Groups. Mainly this condition is occurred due to aggravation of Vata.It is clear that occurrence of Gridhrasi is occurred more in Vatic Prakriti. It is confessed that Gridhrasi is a Vatik disease and also Gridhrasi is occurred due to aggravation of Vata. It is clear that gridhrasi is occurred more in Lower Class, malnutrition is found their and due to this malnutrition gridhrasi is occurred for aggravation of Vata due to Dhatu Kshaya.Gridhrasi is occurred more in labour, domestic work and agriculture occupation groups. In all these groups are physical labour found more than other occupations.

Introduction:

In Ayurveda Ksheerabala Taila is one of the most popular oil preparations; it is recognized as one of a very effective remedy for vatic (neurological) disorders like sciatica. The use of internal or external or local application of the oil by massaging is recommended and for obtaining Rasayana. Brimhana and fertility it is prescribed internally. Ksheerabla taila is first described in Sahasra Yoga and this is selected for present study. An attempt has been made in this present study to evaluate "Effect of Ksheerabala Taila in vata roga".

Preparation of trial drug:

Equipment: A wide mouthed vessel, strong spatulae, laddle, clean clothes, grinder, thermometer, bhatti.

Drugs for Paste: Root of Bala (Sida cardifolia)

Oil and other liquid: Tila Taila, Ksheera (cow's milk)

Preparation of Kalka: 1.25 kg. Of fresh root of Bala were taken and prepared into a paste (kalka) form with the help of grinder.

Preparation of Ksheera bala Taila:

5 Liters 600 ml. of the Tila Taila was put in container and kept on the mild fire, heated properly to evaporate the moisture present in the oil. This stage was confirmed by dipping a wet mango leaf that converts into a brittle one. Then allow it to cool and missed the paste slowly and gently. Twenty liters of milk was added to the mixture and kept it on fire, and subjected for slow heat till the water content evaporated. During the process different stages were recognized (by the indications and test) and temperatures of the stage were recorded.

Mridu Paka	-	96 ° C	-	98 °C
Madhyam Paka	-	98 ° C	-	100 °C
Khara Paka	-	105°C	-	107 °C

Three samples of Ksheerabala taila were prepared in this study

Sample I Sneha paka done once

Sample II Sneha paka repeated three times

Sample III Sneha paka repeated seven times

Observations: At Mridu Paka stage- the Kalka was soft and containing water. Kalka produced sound when kept on fire. At Madhyama Paka –the Kalka was soft and free from water. At Khara Paka stage the Kalka was turned to snuft colour, having hard and sandy consistency.

Clinical study:

AIM – To evaluate the effect of Ksheerabala taila in patients of sciatica.

Material & Methods: In present study 30 patients of sciatica were taken and divided into 3 groups consisting of 10 patients in each group.

Group A - Treated with sample I Ksheerabala taila

Group B - Treated with sample II Ksheerabala taila

Group C - Treated with sample III Ksheerabala taila

After the treatment of patient, for the result mainly intensity of features in the patient and its recovery after treatment are considered as standard. Intensity of the features has been measure as follows. The basis of feature present in the patient before treatment:

Most serve	-	++++
Serve	-	+++
Medium	-	++
Mild	-	+

Observation & Results:

Demographic Profile: Most of the cases belongs 41 to 70 years age group. 80% cases belong to vata prakriti. Most of the cases(36.66%) were related to middle class status.80% cases belong to Hindu religion. 80% cases were belong to vegetarian diet. 46.66% cases had the addiction of tea. 86.66% cases were married. Most of the cases related to domestic work.73.33% cases belong to Sadharana Desa. Most of the patient was having the history of 1-3 month's duration.

70 % cases belong to Krura Koshtha.In most of the patients site of the disease is lower limb. 60% cases had mandagni. 56.66% cases had madhayam satva.36.66% cases were illiterate.

Table : Showing the Relief Percentage in Symptoms:

S.No.	Symptoms	Relief % Group A	Relief % Group B	Relief % Group C
1.	Vedana	66.66	64	78.57
2.	Nigraha	36.36	61.11	70
3.	Stambha	54.54	70	62.5
4.	Toda	81.48	62.5	71.42
5.	Spandan	54.16	37.5	55.55
6.	Sphurana	36.36	72.72	63.63
7.	Sangyaheenata	61.53	40	57.14
8.	Disturbance in Gati	65.51	50	55

Discussion:

In the present study modern Bhatti is used to prepare the drug on a large scale. The observation of Pharmaceutical study suggests that one should be very careful regarding identification of the particular stage of Paka, because the time between the different stages of Pakas is quite short, especially when the amount of preparation is small.

For the clinical study the cases are selected from the Rasa Shastra & B.K., O.P.D./I.P.D. of National Institute of Ayurveda, came for the treatment. It is clear that Gridhrasi is occurred more in males. Probably it is occurred due to their excess physical labour and constant sitting position. It is clear that Gridharasi is occurred more in 41 to 70 years Groups. Mainly this condition is occurred due to aggravation of Vata.It is clear that occurrence of Gridhrasi is occurred more in Vatic Prakriti. It is confessed that Gridhrasi is a Vatik disease and also Gridhrasi is occurred due to aggravation of Vata. It is clear that gridhrasi is occurred more in Lower Class, malnutrition is found their and due to this malnutrition gridhrasi is occurred for aggravation of Vata due to Dhatu Kshaya.Gridhrasi is occurred more in labour, domestic work and agriculture occupation groups. In all these groups are physical labour found more than other occupations.

Gridhrasi is occurred more in Vegetarian Groups and is due to in take of ruksa, seeta ahara and deficiency of Vitamins and Proteins Gridhrasi is occurred more in Kroor Kostha Groups due to constipation, sacral region is pressurized by stool and Vata is aggravated. Gridhrasi is occurred more in Mandagni groups due to constipation and anorexia.

Conclusion:

Though the satisfactory results are obtained in the present study, further study on the large number of patients is necessary to arrive at some definite conclusion.

RADIOLOGICAL EMERGENCIES-MANAGMENT AND PREVENTION

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Key words : Contrast agent, hemorrhage, shock, fracture, and loss of consciousness, radiological procedures, and emergency conditions.

Abstract : Radiology is known mostly for its radiation hazards as its untoward effects but so many other dangerous conditions may occur in the radiology department. These other condition is not being taken into account while prescribing radiological procedures. Present article is an effort to through some light on other conditions, which may create danger to the life of patient.

The term radiological emergency has come to be associated in particular with a dangerous condition arising in a patient as the result of the use of radiological contrast agent. However, an emergency may be precipitated, not necessarily of this but by some other cause, for example the administration of a local anesthetic, pre-existent cardiovascular disease or even an accident such as electric shock. Dependly in the causes, details of the treatment naturally will vary. The following emergencies may arise in radiology room.

(1) Cardiac and respiratory arrest, (2) Shock, (3) Hemorrhage, (4) Burns, (5) Loss of consciousness, (6) Electric shock, (7) Fractures/Dislocations

Cardiac and Respiratory Arrest :

A patient whose brain is deprived of oxygenated blood for longer than 3-4 minutes is likely to suffer irreversible cerebral damage. It is consequently of subsequence importance that the diagnosis of cardiac arrest be made quickly and treatment be begun quickly. Cardiac arrest cannot be treated on its own, since it will be accompanied by respiratory failure. Restored cerebral circulation is of no use to the patient if the blood is inadequately oxygenated.

In a patient who appears to be collapsed the signs of cardiac arrest are -

1. Absence of palpable arterial pulse.
2. Dilatation of pupils (a late sign, not seen within one minute).
3. Pallor or cyanosis.
4. Failure to bleed (may be confirmed by making scratchy incision).
5. Convulsions (these occurs sometimes as a secondary manifestation of diminished cardiac output).

The above observations should be made within 20-30 seconds of the onset of disaster. Absence of arterial pulse is of decisive significance in case of cardiac arrest.

If the cardiac arrest is thought to have occurred or even is suspected cardiac stimulation and pulmonary ventilation is required.

Cardiac Stimulation :

May be achieved by following procedures

1. Patient is kept supine with head low.
2. Thump the lower part of the sternum sharply with the ulnar border of the hand (Precordial percussion). Percussion may be made and continued at the rate of 60 strokes per minutes.
3. Raise the legs and if possible the upper limbs as well. Another useful maneuver is forcible flexion of the hips and knees to bring the thighs sharply against the lower trunk; it may produce a rush of blood into right atrium, which is sufficient to initiate a cardiac impulse.
4. External cardiac massage (1) manual - external cardiac massage is performed by means of rhythmic manual compression of the sternum (2) external cardiac massage may also be done by defibrillators.Drugs may be used to stimulate the heart.

Pulmonary ventilation :

Pulmonary ventilation is process of re-oxygenation of lungs of a patient who is in respiratory failure. This can be achieved by (1) Artificial respiration (2) the supplementary administration of oxygen.

A number of means of performing artificial respiration are known and have been used to good effect. However, at present the method most widely advocated is the one which is known properly as expired are resuscitation and popularly in magazines and newspapers as the "Kiss of Life".

Shock:

It occurs when there is loss of blood or plasma. Blood loss may be external or internal. Usually traumatic injuries are more common which may give rise to condition of shock patient shows variation in degree of shock due to difference in age, general physical constitution and temperament and stage of shock. In shock patient has lowered blood pressure, rapid pulse, pale and cold appearance, sweating and restlessness. Patient is treated on emergency basis by administration of drugs, oxygen, intravenous fluids etc.

Hemorrhage : Hemorrhage may be arterial, venous or capillary. Nature stops the bleeding first of all by contraction of severed vessel wall, secondly by clotting of the blood and thirdly by lowering of the pressure of the blood within the vessel walls. Hemorrhage may occur due to injuries pre-existing disease etc. Hemorrhage is treated by applying pressure over injured area, and if patient goes into shock. The drugs and intravenous blood or fluid is administrated as required.

Burns : Burn is produced by dry heat whereas scalds are produce by moist heat. Although possibilities of burns is less in radiological unit, even then proper facility of primary treatment of this condition must be available in the department. Especially fire control system control system must be there.

Loss of consciousness : Loss of consciousness may be partial (stupor) or complete (coma), condition is recognised on the basis mode of onset, condition of skin moist or dry, condition of face- paled or cyanosed, condition of body and limbs-rigid or slack or in spasmodic muscular contraction and incontinence of urine or faeces. Treatment is done on the basis of condition of the patient. Causes may be elliptic fits, cerebral hemorrhage etc.

Electric shock : An electric shock is the result of the current passing through the body, there is tendency for electric passing through the body. There is tendency for electricity to escape to earth and where there is failure to safety devices, the path of least resistance may be through body of someone landing the equipment. So an electric current passes through the person and degree the electric shock received depends on the strength of the current. If the body offers a high resistance to the passage of electricity, then the current will be low and shock will be light in the radiology department, electric switches in dark room are dangerous and liable to cause shock. Therefore, especial wiring system, wearing of rubber gloves and rubber soled controlled shoes, is necessary, possibilities of electric shock may also be minimized by remote controlled light system, standing on dry floor, on insulating surfaces like cork or rubber mats. Patient should be pulled a way by the clothing and the rescuer's hands should be protected by insulating material e.g. rubber or cloth. An articles used for the purpose of insulation must be dry. Lead rubber aprons and gloves may be readily available. Lead rubber will be adequate for voltage upto 400 volts. Once the patients has been rescued from the source of the current the treatment required will depend upon the injury sustained. The conditions which may be present are - (1) Cardiac arrest (2) respiratory arrest (3) burns (4) fractures (5) shock.

The rule in all first aid procedures is to treat the most serious condition first.

Fractures and dislocation : Fractures means breakage in bones. Dislocation means movement of articulating ends of bones from its normal place. If this condition occurs in radiology department, patient should be supported by proper splint, wheel chair or stretcher and should be sent for proper treatment to the respective department.

Conclusion :

Radiology department is mainly diagnostic department but emergency conditions may arise because of use of contrast agents, electric shock, trauma to the patients etc. Sometimes patients with pre-existing diseases will have to undergo different procedures they may have acute attack of diseases. Therefore, proper knowledge of emergency conditions and their primary treatment is necessary for staff of radiology department. They should be fully equipped with the medicines which are used in emergency like steroid, anti-allergic, vasoconstrictors, bronchodilators, cardiac stimulants and respiratory stimulants etc. along with material for bandaging, splint, intravenous fluids. Certain equipment like oxygen cylinders with masks, cardiac defibrillator, should be available to combat the situation. Infact Radiology department should work in close contact with all the other departments' especially emergency department staff.

Radiology department should be trained for emergency procedure from time to time. Patients with pre-existing diseases like cardiac diseases; especialist physician must supervise epilepsy, neurological disorders, hypertension, diabetes etc. during performing radiological procedures. While performing radiological procedure if there is any pre-existing disease that should be well controlled by medications.

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POORVA KARMA IN VIKIRAN AVUM CHHAYA VIGYAN (RADIOLOGY & IMAGING)

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Key Words: Vikiran, Poorva Karma, Virechan & Vatanuloman, Tarpan

Abstract: All the mental and physical managements of the patients, which are done before the main procedures, are consideved as poorva Karma in Chhaya Avum Vikiran Vigyan. The ultimate aim of the Poorva Karma or previous preparation is to minimize the hindrance and to get a better picture with maximum information for better diagnosis.

Depending on needs, assurance, Aptarpan, Tarpan, Virechan, Basti and Virechan & Vatanuloman etc. Twelve Karma must be consideved as poorva Karma in Chhaya Avum Vikiran Vigyan.

INTRODUCTION:

The managements of the patients, which are done before the main procedures, are considered as Poorva Karma. It is considered in the same way for Vikiran Avum Chhaya (R & I). It contains both mental and physical managements of the patients.

Aim of Poorva Karma in Vikiran Avum Chhaya Vigyan

- ***To avoid blurring***- If the movements of the patients are restricted, blurring will be negligible.
- ***Arte facts*** can be avoided in the films by removal of interfering materials.
- ***To avoid the reactions and save the patient's life*** – It is important to know about the disease and allergic history of the patient sensitive to contrast media used in R&I. The contrast media reaction may be avoided by premedication of the patient and life too can be saved.
- ***To avoid the over and repeated exposures***- Always select the appropriate procedure for maximum information and correct diagnosis. It will save the patient from over and repeated unwanted harmful exposures.
- ***To avoid the conceal of the information*** - This aim may be obtained by removing the gas and solid waste from bowel, arte factual and interfering material from the body.
- ***To get a better picture***- several previous preparations of the patient will certainly help to get a better picture.
- ***To get maximum information***-A good picture always have maximum information about the patient's that particular part or structure.
- ***For better diagnosis***- A better diagnosis will be made on the basis of correct information obtained from the good quality of radiological and imaging picture.

The following managements should be considered as Poorva Karma in Vikiran Avum Chhaya Vigyan . The management of the patients are based on the daily experiences about problems and their solution in the radiodiagnosis department of an educational hospital. These points should be followed consciously.

- **Enquiy-** Enquiry should be done regarding the causes of advise of radiography and imaging. Check the advise of consultant and if necessary select and advise the correct procedures. Always ask about any previous radiography which will help in the selection of appropriate procedure. Ask to patient for last menstrual period and last radiography, so that the date of H.S.G. and next radiography may be fixed. Check the biochemical investigations of blood e.g. blood urea and creatinine before fixing the date of I.V.P.

  Try to take a short history of the patient about occupation, trauma, tubectomy and other diseases for better diagnosis. Dehydration should not be advised to the patient having the history of Diabetes Mellitus and renal failure. Patient of P.U. Should not be kept on empty stomach for a long time. Patient of asthma and allergy may react with contrast media used in HSG, I.V.P and Angiography etc., MRI Should never be done in patient having pacemaker and proper care should be taken in patient having prothesis and denetures.

- **Assurance-** It is very important for sensitive persons, children, pregnant woman and elders. Assure to the patient regarding machine and whole procedure of radiography and imaging. Clarify all queries of the patients and total duration of the procedures. Mind of the patients specially children, should be diverted to get better co-operation.

- **Instructions-** Fix the appropriate date for R&I procedures e.g. date of H.S.G. fix in between bleeding and ovulation period. Appropriate time also should be fixed for R. &I. Procedures e.g. patients of D.M., PU, and hypertension should be done in early working hours to avoid nil orally for long time. Instruct the patients that they should come in cotton cloths without ornaments or other interfering materials at that particular part. Advise them to bring the necessary contrast media and other accessories and come, if necessary with attendent and doctor.

  Give instructions regarding Aptarpan, Tarpan, Virechan, Vatanuloman, Basti and premedication what ever is needed: Clearly indicate the procedures fee and hospitalization also.

- **Aptarpan-** Food should be restricted for six to ten hours in x-rays e.g. barium investigation,L.S.Spines, plain abdomen &KUB, Abdominal USG and abdominal CAT. Light meal may be taken in fistulogram. Fatty diet should be avoided in prior night in gall bladder R&I. Food may not be restrict in children, PU and emergencies, Food and fluid should be restricted for ten hours in I.V.P. and ERCP except in renal failure and Diabetes Mellitus.

- **Tarpan-** Drinking of cold or lukewarm (according to season) water or fruit juice should be given in USG for acaustic window, and carbonated drink in case of IVP if necessary.

- **Virechan-** Virechan or purgatives should be advised in prior night to remove solid waste from bowel. It may be avoided in emergencies. It is advised in IVP, L.S. spines, barium enema, fistulogram and plain abdomen KUB x-rays, abdominal USG and abdominal CAT.

- **Virechan and Vatanuloman-** Kupilu Hingwadi Bati 2 Tale BDPC and KsharRaj 1gram & Shatsakar churna 3 gram at bed, may be advised for two days to remove solid

wastes and air from the bowel in case of IVP. L.S. spines abdomen KUB x-rays, abdominal USG and abdominal CAT.

- **Basti-** Objective of Basti or enema is to clean the large bowel. High enema is used in Barium enema investigation but avoided in septic ulcerative colitis. Low enema should be advised in abdominal USG and x-rays e.g. fistulogram, Urography and L.S. spines.
- **Part preparation and sterilization-** Part preparation and sterlization are indicated in Angiography and HSG etc. Only sterilization is sufficient in IVP, RG cystogram,RG cystourethrogram and RGU.
- **Urinary bladder condition-** Urinary bladder should be emptied in IVP, HSG and Barium enema. But fall urinary bladder is usefull in USG of pelvic organs and x-rays e.g. RG cystourthogram and RG cystogram.
- **Premedication-** Inj. Deximethason I.M. should be injected 18 hours prior to IVP to avoid allergic reaction in patients with history of allergic reactions. Syrup Paraldehyde or phenergon should be used in children as sedatives to avoid the movements. Sarpgandha churn or ghansatwa is useful in adult psychic patients. Smooth muscles relaxant should be used in double contrast barium meal stomach & Duodenum, Barium enema and HSG x-rays. Sadatives and tranquilisers may be used in aggressive patients. Occasionally analgesic may be used for better cooperation of the patients.
- **Removal of interfering materials-** Cloths of silk or with metal embroidery, hooks, metallic zips should be removed from that part before x-rays and USG. All the metallic, ornaments and non metallic stones necklace etc should be removed from that part in x-rays, USG&CT Ferromagnetic ornaments, hooks, zips, hairpins, key, Jantars, lockets, coin, watch, belt and dentures should be removed from the room before MRI.But removed only from parts of interest in x-rays. Mobile, magnetic strip ATM, cradit or identity card etc should be removed from the room to avoid the erasing of informations. Bra hook should be released in case of female chest x-rays to better visulisation of lower lateral part of the chest, other materials e.g. onion from upper pocket also removed because it may cast shadow similar to coin lesion. Always remove the purse from chest area specially in female chest x-rays.
- **Safety of gonads and pregnant uterus-** Safety of gonad from radiation is important in child bearing female and fertile male. Radiation should be avoided on pregnant uterus specially in first trimester to avoided mutation and malformations.
- **Education-** Just before the main procedure, it is very important to educate the patients regarding respiration, movements and instruments insertion. Clearly educate the patient about holding of the respiration in inspiration or expiration conditions specially in x-rays and USG procedure. Patient has to educate about all the movements restriction specially in MRI, CAT and x-rays procedures. It is very important to get the patient' s co-operation that Radiologist asks to patients about the instruments and its insertion inside the body..

If a radio diagnostic center follows these Poorva Karma, certainly a good picture with maximum information will be obtained which will help in correct diagnosis without any hazards to the patients.

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HIMRATAN OIL (हिम रत्न)

Indication : For local application in Shirahshool (Headachey)/muscular spasm/low backache and Arthritis.

Method : Take 2-5 ml or Himratan oil and massage gently on the effected part.

हिम रत्न (आयुर्वेदिक शीतल तैल – हिमालय की जड़ी–बूटियों से निर्मित)

आयुर्वेदिक दवाओं के शास्त्रीय सिद्धान्तों का अनुसरण करते हुए, हिमालय के वनों से प्राप्त प्राकृतिक जड़ी–बूटियों का प्रयोग कर, आधुनिक वैज्ञानिक अन्वेषणों और प्रयोगों के अनुसार निर्माण कर हिमालय तेल को अनसाधारण तक पहुँचाना ही हमारा उद्देश्य है।

हिम रत्न शीतल तेल – इसका प्रयोग सिर दर्द दूर करता है। यह सिर को ठंडा और दिमाग को तरोजाता रखने में विशेष उपयोगी है।

इसका मधुर गंध चित्त को प्रसन्न करता है तथा साधारण तेलों की तरह इसमें कोई रासायनिक तत्व नहीं है। इस तेल को आयुर्वेदिक चिकित्सकों के परीक्षण और उपयोगी करने वालों के प्रामाणिकतानुसार बालों की विभिन्न समस्यओं में अत्यन्त उपयोगी पाया गया है। हिमरत्न शीतल तेल चिपचिपाहट रहित, भीनी–भीनी सुगन्ध वाला बालों का पोषक है। इसके नियमित इस्तेमाल से बालों का प्राकृतिक सौन्दर्य सदैव कायम रहता है। बालों की लम्बाई बढ़ती है, बाल और सिर की त्वचा स्वस्थ रहती है। रुसी और जू दूर होता है। यह बालों की जड़ो तक पहुँचकर उन्हें पुष्ट करता है जिससे बालों का झड़ना रुक जाता है। आलोपेशिया (गंजापन) दूर होता है। असमय बाल पकना रूकता है। मामूली जलने–कटने में भी यह तेल जल्द असर करता है।

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ANUSHASTRA KARMA- PARASURGICAL THERAPY

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Raktamokshana is a term employed to denote a parasurgical procedure to expel out the vitiated blood from selected areas of the body by specific method.

Sushruta Samhita, the oldest available scientific book on Surgery devoted an entire chapter for the description of Jalaukas and Jalauka Vacharan for the purpose of blood letting.

Jalaukavacharan is claimed to be the supreme therapy because of safety and higher efficiency in blood disorders (Rakta Janya Roga). It is indicated for King, rich, old aged, fearful, weak, women and even is sofisticated peoples.

Jalauka → Jala + Ayu means the animal who`s life is depend on water.

Shabda Kalpa druma mentioned Jalauka as feminine gender and considered as a aquatic creature employed to bringout the vitiated blood.

Synonym :

Jalayuka, Jaluka, Jalita, Jaloka, Jalatani, Jalasuchi, Jalasarpini, Raktapayani.

Types :

1. Savisha (Venomous) – 6 in no.
2. Nirrisha (Non-Venomous) – 6 in no.

1. **Savisha Jalauka** – Originates in decomposed urine and fecal matter of toads and poisonous fishes in ponds of stagnant and turbid water.

Character – Thick, slow locomotion, fatigue, midpart elongated, delay in sucking non-commondable, suck little blood.

These are six in number having following features :

1. Krishna – तासु अन्जनचूर्णवर्णा पृथुशिराः – कृष्णा।

   Krishna is thick and of black colour.

2. Karbura – वर्मिमत्स्यवदायता छिन्नोन्नतकुक्षिः – कर्बुरा।

   Karbura is as like Verminfish which ventral surface is convex.

3. Alagrda – रोमशा महापार्श्वा कृणमुखी – अलगर्दा।

   Alagrda is thick, Hairy, round at sides, black at the mouth.

4. Indrayudha – इन्द्रायुधवदूर्ध्वराजिभिश्चित्रिता – इन्द्रायुधा।

   Indrayudha is of rainbow like colour, lining on whole body.

5. Samudrika – इषदसितपीतिका विचित्र पुष्पकीतचित्रा – सामुद्रिका।

   Samudrika is of blackish yellow with dotted skin.

6. Gochandana – गोवषणवदधोभागे दिधाभूताकतिरणमूखी गोचन्दनेति।

Gochandana is of narrow mouth, marked by bifurcating lines, end part like scrotum of a bull.

Savisha Jalauka – Symptoms

If accidentally Savisha Jalauka is applied, symptoms of Burning, itching, swelling, Drowsiness, fever, delirium, unconsciousness etc arise.

Nirvisha Jalauka : Originates in decomposed vegetable matter as– Padma, utpala, Nalini, Kumud, Pundarika which are found in clean water.

अथनिर्विषा कपिला पिङगला शन्कुमुखी मूषिका पुण्डरिकमुखी सावरिका चेति।

Geographical Distribution

Sushruta mentioned that leaches are found in Yavana Pradesh.

Habitat

They swim in sweet scented water, live on nonpoisonous weeds, lie on leaves of flowering water plants and suck blood from affected part of a human being without any harm or discomfort.

Gneral Character

Strong large bodied, ready suckers, greedy.

Individual Character

1. Kapila – तत्र, मन:शिलारञ्जिताभ्यामिव पार्श्वाभ्यापृष्ठे स्विग्धमुद्गवर्णा कपिला।

   - Colour like manahshila at the sides, dorsal surface are slimy and coloured like Mudga.

2. Pingala – किन्चिद्रक्ता वृत्तकाया पिङ्गाडशुगा च पिङगला।

   These are reddish in colour, round in shape and speedy in locomotion.

3. Shankumukhi - यकृद्वर्णा शीघ्रपायिनीदीर्धतीक्ष्णमुखी शन्कुमुखी।

   These are blackish red as like liver in colour and fast sucking in nature.

4. Mushika – मुषिकाकृतिवर्णा निष्टगधा मूषिका।

   These are of faecal smell

5. Pundarikamukhi – मुद्गवर्णा पुण्डरीक तुल्यवक्त्रा पुण्डरीकमुखी।

   These are of Mudga like colour, like full blown lolus lillies.

6. Savarika – स्निग्धा पद्मपत्रवर्णाष्टादशान्ङगुलप्रमाणासावरिका साचपश्वर्थे।

   These are marked with impression like lotus leaves, 18 fingers in length, to be applied only in animals.

Collection and Presentation

The leeches can be collected from a pond by use of a wet leather keeping in the stream or by fresh meat of dead animal.

Time – best time is Sharad Ritu (Atumn).

Preservation – they should be kept in a wide spacious pot. The pot should be filled with pure water of pond with lotus. It's normal feeding is with shaival, meat of animals, powder of small plants, grass and leavesr of small plants .On every third day water should be changed and feeding should be kept into the pot. Ater 7 days pot should be changed.

Indication of Leech Application

Gulma, Arsha, Vidradhi, Kustha, Vat Rakta, Galaroga, Netraroga, Visha Dvashta and Visarpa. – Vagbhat

Poorvakarma

Examination of the patient undergoing Jalaukavacharan.

- Shodhana of Leech – The leech should be kept in Haridra powder mixed in water for one minute and then washed in clean water.
- Preparation of the patient : Affected part should be cleaned and swedan karma is done. The affected part should be rubbed (Vigharshan) by the rough powder of cow dung or clay. It is contraindicated if part is ulcerated.

Pradhan Karma –Jalaukavacharan :

After preparation of patient the leech will be too much unctuous, Pichchila and soft that it slips from the hand. It should be caught with gauze or with hands covered with gloves. Then leeches should be taken out from their receptles and sprinkled over the cater. Leeches attach to the skin by two muscular suckers before biting with three teeth inside their anterior suckers. Blood is sucked in to the stomach by peristalsis. Each leech will ingest blood nearly ten times of its body weight before falling off. The middle part of the leech will be swollen ,as soon as it starts sucking the blood. It suck only impure blood first. If patient notice pain during sucking it should be think that pure blood is now sucked by leech. Then the leech should be removed instantaneously by pouring Saindhava lavana at its mouth. It they refuse to stick over the desired spot, the affected part should be painted with milk or blood. Other fresh leech may be applied.

Inference of Sucking

During sucking from affected part the leeches assume the shape of horse shoe and raise their neck when they attach to the seat of the disease. During sucking cold water should be sprayed over the leeches.

Symptoms of fresh blood sucking

- Sensation itching at site of application.
- Drawing pain at the site.

It these symptoms occure, leeches should be removed.

Removal of the leech

The powder of Saindhava is sprinkled. They will give up sucking.

Paschat Karma

Management of leeches – The leeches should be kept on rice powder, their mouth should be lubricated with composition of oil, common salt. Then they should be caught with tail with help of thumb and forefinger of the left hand. Their back should be fastly rubbed

with the same fingers of right hand from tail to the mouth in upward direction so that they may eject the whole blood which they sucked. This should be repeated until emptying of their stomach. Now the leech should be kept in fresh water in a separate pot with label.

Symptom of complete emission

If the leeches are dull and upset, the ejection is not adequate, if the leeches are moving here and there in quest of food in water, the emission is adequate. If emission is inadequate Indramada may occure which is incurable. After a week leech can be reapplied.

Special after care

After complete emission leeches should be put in a new pot and be treated as earlier mentioned. As per Vagbhat used leech should be kept in a dilute solution of water and turmeric powder for some time. Then it should be shifted into fresh water. The 7days rest is advocated for them.

Patient care

Due to hirudin the blood of the affected part will not coagulate. The Shatadhaut Ghrit is applied on the wound or a pichu dipped in shatdhaut ghrit is kept on the wound. If the blood letting is unsatisfactory or improper, the wound must be rubbed with honey and cold water or it must be bandaged with cold paste.

Number of leeches applied

It is decided to apply leeches as – one leech per two years of age upto adult age of the patient for a complete course schedule. A leech should not be used for several patients but for each patient separate leech should be applied.

As average size leech will cause bleeding of ½ to 2 ounce of blood.

Each leech will feed for 30 minutes to 1 hour, remove around 20 ml of blood before falling off. Though bleeding from the wound can resulted the blood loss upto ten times of this amount.

The leeches are now applied worldwise in the cases of skin grafts to encounter blood congestion, in haematomas, purpura fulminans, paronychia, vascular congestion of Penis, Tumors, Skin diseases, Venous illness, acute phlebitis, Varicose Veins, acute gout, infections, facial boils and insect bite, high blood pressure, haemorrhoids, delayed wound healing.

The active leech substances totally block the enzymatic processes activated and often exceeding within inflammation and trauma. The salivary glands of leeches also produce a cornucopia of other pharmacologically active substances including an antihistaminic proteases and possibly an anaesthetic & an antibiotic.

The therapeutic effect is not only from the loss of blood but due to secretion which the leech expel into the wound.

Complication :

- Allergic reaction due to histamin release.
- Soreness after the bite rarely appears.
- Small scar at the site of bite may remains for weeks.

LEECH APPLICATION IN THROMBOSED PILE MASS

Materials :

Leeches, bowls – 3-4, Gauze pieces, Haridra powder, warm and Cold water, Gloves, Cotton pad, Bandages.

Poorvakarma :

Leeches are put into the bowl containing solution of Haridra and water for 15-20 minutes. Then leeches are washed in pure water for 10-15 minutes.

Then patient is kept in lithotomy position. The posterior sucker of leech is kept in one hand and the anterior sucker is placed at the site of application. Then the posterior sucker is released and attached to the surrounding of perianal region. In cases of strangulated piles it is applied over the tip of Strangulated mass. In cases of thrombosed external piles it is applied over the most prominent part of the swelling. Then leeches are covered with a gauze piece to keep it moist with water drop pouring intermittently. The leeches are removed when the adequate sucking is over. In these emergency conditions only one course of application give relief to the patient immediately. The patients get relief from pain and swelling immediate after the therapy.

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ROLE OF POORVA KARMA IN URINARY DISORDERS

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Ayurvedic approach of treatment is divided into 3 broad sections Poorva Karma, Pradhan Karma and Paschat Karma. Majority of the population have been using the drugs of Indian System of Medicine in different forms since creation of life. No doubt is indeed a great tribute to the richness of the Ayurvedic system that even after lapse of centuries. It is highly appreciable for its scientific and therapeutic values. This Ancient system has the concept of maintaining a balance in the body between different elements or humours of which it is constituted. Any imbalance in this cause disease and system. Works to restore the balance through intake of medicine as local or systemic administration in the terms of herbs, minerals or animal origin drugs.

Scope and Importance of Poorva Karma

1. **As Curative**
2. **As Preventive**
3. **Rejuvenation**
4. **Preparatory for Surgery**

Trividha Karma

Sushruta has given concept of Trividha Karma

त्रिविधं कर्म – पूर्वकर्म, प्रधानकर्म, पश्चातकर्मेति, तद्भयाधि प्रति प्रत्युपदेक्ष्माम्।। Su. Sa. Su. 5/3

Importance of Trividha Karma

Trividha Karma has its individual importance and these all three - Karma's ultimately affects the outcome of treatment that is why it is clearly mentioned as individual entity.

Diseases of Urinary System

The disease of urinary system as described in Ayurvedic classics includes a wide range of pathologies covering all kinds of Urinary infection, obstructive uropathy and renal failure, as known today in the form of 13 types of Mutraghata, 8 types of Mutrakrichha and 4 types of Ashmari.

Symptomatology of Mutraghata According to Charaka

	Obstruction	Drubbing	Pain	Burning	Haematuria
Retention of Urine					
Vatakundalika	+		+		
Ashthila	+		+		
Vatavasti	+		+		

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Mutrateet	+				
Mutrajathar	+		+		
Mutrotasang	+		+		
Mutragranthi	+		+		
Mutrakriccha					
Ushnavata			+	+	
Vidavighata	+				
Vastikundal	+	+	+	+	
Suppression of urine					
Mutrasaad				+	+
Mutrashaya					

Symptomatology of Mutraghata According to Sushruta

	Obstruction	**Pain**	**Burning**	**Haematuria**	**↑ Frequency**
Retention of Urine					
Vatakundalika	+	+			+
Ashthila	+	+			
Vatavasti	+	+			
Mutrateet	+	+			+
Mutrajathar	+	+			
Mutrotasang		+		+	
Mutragranthi	+	+			
Ushnavata		+	+	+	
Mutrasukra					
Pittajamutrotasaad		+	+		
Kaphajamutrotasaad					
Mutrashaya		+	+		

Symptomatology of Mutrakriccha according to Charaka.

	Pain	**Burning**	**Frequency**	**Heaviness**
Vataja Mutrakriccha	+		↑	
Pittaja Mutrakriccha	+	+	↑	+
Kaphaja Mutrakriccha				
Sannipataka Mutrakriccha				
Abhighataja Mutrakriccha	+			
Sakritjanya Mutrakriccha	+			
Sukraja Mutrakriccha	+			
Asmarij Mutrakriccha	++			

Poorva Karma

Whenever a medical or surgical procedure was thought obligatory the patients was usually subjected to an initial preparatory regimen. This was called the POORVA KARMA therapy for subsequent interferences. This was followed by the necessary medical treatment Samsodhan Therapy and surgical treatment e.g. excision of the growth, opening of big abscesses, exploration of the diseased organs removal of the diseased tissue, plastic procedure and the like. This latter maneuver were called the medical/surgical measures proper are the PRADHAN KARMA. Following this the patient was transferred to the ward where he/she was look after by an attendant for a period till he recovered and rehabilitated by bringing up his physiological functions and nutrition to normal. The management of the patient during this period was called the PASCHAT KARMA, which was directed to achieve a quick and uncomplicated convalescence and to ameliorate the sequeliae of the main disease

DALHANA, an eminent commentator of Sushruta has stressed that Poorva-karma is not only the preparation of the patient undergoing an elective surgical procedure but also is a standard procedure to prepare a patient before he undergoes the therapies of RASAYANA KARMAS and SHODHAN KARMAS which form an important part of internal medicine (*Kayachikitsa*).

In old age, the geriatric disabilities were being treated by subjecting the individuals to rigorous physiotherapeutic and medical management for *Rasayana* (Rejuvenation). In these cases, before administration of the *Rasayana* proper, which form the principal measure, the individual is prepared to receive the *Rasayana*. He is given such measures initially to cleanse his *Koshtha* (Chest and Abdomen). This preparation enabling the administration of *Sansodhan* including *Sansarjan* for building up of the physique forms the Poorva Karma in *Rasayana*.

Sometimes the disease process is treated with specific medication according to the stages. A disease is initiated becomes apparent, runs its course and terminates. Till it becomes apparent or it is manifested with symptoms, the disease is said to be in Poorva Rupa (Prodromal stage). Starting from *Chaya* of doshas leading to *Prakopa*, *Prasara* and *Sthanasansraya*. The symptoms of disease to not attain enough significance for recognition of the nature of the disease and consequently the disease is said to be in Poorva Rupawastha (Prodromal Stage). All such measures indicated for suppression of disease during Poorva Rupawastha are classified as Poorva Karma.

Poorva Karma has variability according to different diseases which have been clearly understood as per commentary of Acharya Dalhana like

लङ्घनादि विरेकान्तं पूर्वकर्म व्रणस्य च।

अन्मे तु संशोध्यस्य पाचन स्नेहन स्वेदनानि पूर्वकर्म।। DALHANA

According to Ayurveda concept diseases is a result of vitiated doshas and it can be diagnosed on the basis of symptomatology. The physiology or urination and daefecation is under the control of Apan-vayu, the seat of Apanvayu is Pakvasaya.

If Apanvayu gets vitiated it can cause a number of urinary disorder – Ayurvedic text have a vivid description of the condition resembling Prostatic hypertrophy as Vatasthila a

type of Mutraghata. According to the clinical feature of UTT can best be correlated with mutrakriccha.

As vitiated Apanvayu is presumable responsible for the all urinary problems it is supposed to normalize the vitiated vayu by Vasti Chikitsa. (C.Si. 20.15, Ch. Sidh. 1/32)

Without Vata there should not be pain as mentioned in Sushruta Samhita.

वातादृते नास्तिरूजा: न...पाक: पित्तादृते नास्ति कफाच्च पूय: (Su.Su. 17/12)

Snehana :

स्नेहनं स्नेह विअ्यन्दं मार्दव क्लेद कारकम्। (C.Su. 22/10)

The efficiency of any mechanical appliance depends upon proper lubrication of its various parts. Much in the same the living body needs external and internal application of greasy material, so that it may be function well. All the greasy materials have been broadly classified:

A. Either belonging to vegetable kingdom

B. Or belonging to animal kingdom

स्नेह्णभ्यक्ते यथाअक्षे चक्रं साधु प्रर्वत्तते (Su. Sharira 4/15)

Snehana means oleation therapy as a matter of fact Sneh is a property of Jala Mahabhuta body becomes oily and smooth due to Snehana which is supposed to remove the roughness and the dryness of the body. The principle features are Sharira Vayu. In this context Snehana could be the specific therapeutic measure of the Vatic disorder and allied conditions.

स्नेहोऽनिलं हन्ति मृदुकरोति देहं मलानां विनिहन्ति सङ्गम्। (Ch.Sidd.)

Importance of Sneh

a. Improvement of the power of digestion
b. Maintenance of a healthy gastro-intestinal tract
c. Production of new tissues
d. Improvement of the strength and lustre of the body
e. Early correction of wear and tear of the body.

Benefits of Snehana prior to Swedana

स्निग्धधस्य सूक्ष्मेअ्वमनेषु लीनं स्वेदस्तु दोषं नमति द्रवत्वम्। (Ch.Sidd. 1/8)

Swedana

Swedana consists of foementation including Swed or sweating. Swed is an internal mala in the body. Induction of sweating prior to main therapy is known as Swedana therapy.

Swedana is a process by which the temperature of local or systemic is elevated whereby sweating is induced.

It helps in two ways:

1. It increases the blood supply and this helps in the supply of more oxygen and nutrient material and elimination of noxious metabolites.

2. It also stimulates the sweat glands, which by drawing fluid and salts from blood throws them out as sweat. It dehydrates the area and eliminates some metabolites. *Sushruta has classified Swedana* in four types according to the different characteristics of their use and benefit in different diseases.

Evidence of Poorva Karma in Shalya Tantra

In elective surgery patients is first prepared for the nutritional status. He is give a good nourishing diet which helps him to stand the operative procedure. He should also be given a beverage which will alley his pain but in such cases as impacted labour, abdominal swelling, hemorrhoids, calculi of the urinary tract (Ashmari), diseases of mouth the patients is usually fasted just before operation as the presence of food may complicate the operative procedure.

Poorva Karma in Ashmari

Before operation, the patient is given snehan and swedana and again Vaman and Virechan remove his accumulated doshas. He is a little emaciated by Karhsan therapy to make him easily operable. But care should betaken that his general vitality should not be affected (DALHANA). He is also fasted or light diet may be given to built his deficiency, then only he should be taken for the operation.

Poorva Karma in Mutraghata

क्षारमद्यासवस्वेदान वस्तीश्चोतर सज्ञितान् (Su. Uttar. 58/27)

Poorva Karma in Mutrakriccha

यथोदोषं प्रमुन्जजी स्नेहादिमपि च क्रमम्। (Su.U. 59/16)

Thus, we see that the preparation of the patient for elective surgical procedures have been laid in ancient text in their own way. It is obvious from their description that Poorvakarma serves two important purposes, which are essential for the patients undergoing a surgical procedure.

1. Lesion is made easily operable by the removal of doshas from the body and by softening of the lesion itself.
2. It enable the patient to withstand surgical risk, improving the nutritional status of the patient and sharpening his metabolic reaction to the trauma achieve this.

REFERENCE: 1. Charaka Samhita 2. Sushruta Samhita 3. Dalhana Commentary on Sushruta Samhita.

ABBREVIATION : Su.Sa.Su. – Sushruta Samhita Sushtra Sthana, Su.U. – Susruta Samhita Uttar Tantra,C.Si. - Charaka Samhita Siddhisthana.,C.Su. – Ch.Samhita Sutrasthana

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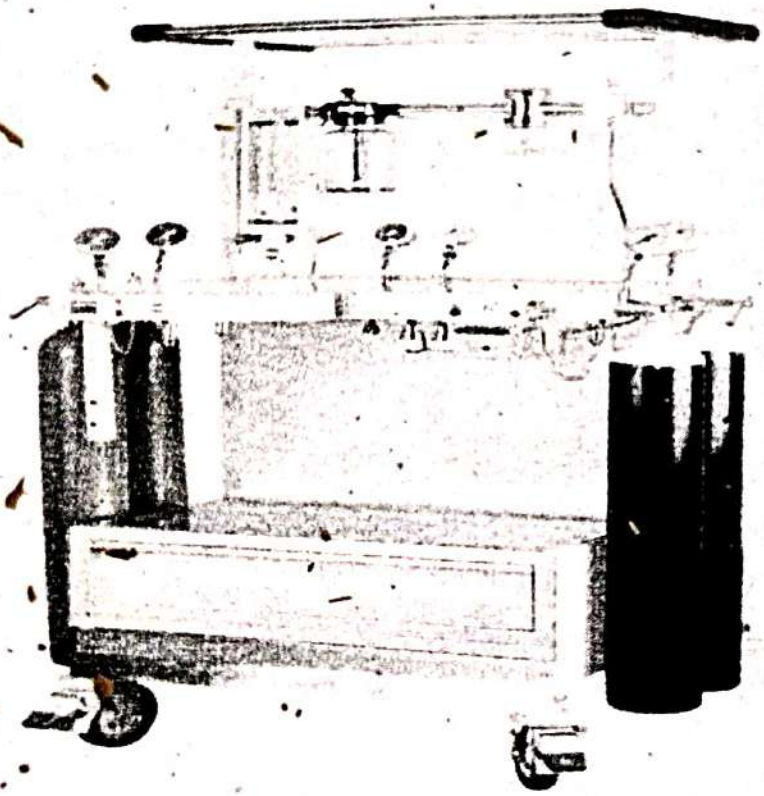

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7th – 11th Feb. 2007	Kochi INDIA	13th Annual Conf. of Indian Society of Critical Care Medicine 2007	Website: www.criticare 2007.com mail@criticare2007.com
9th – 11th Feb. 2007	New Delhi INDIA	8th Annual Conf. Indian Society of Neuro-Anaesthesiology and Critical Care	Email: pkbithal@hotmail.com isanacc2007@rediffmail.com
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