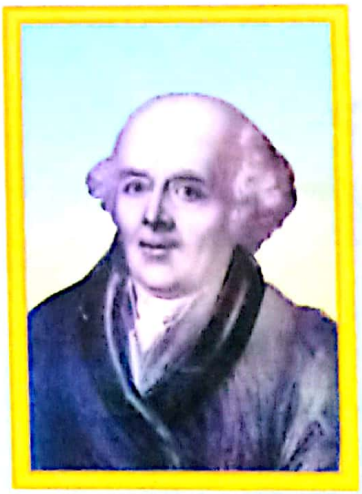
Darpan 98



BHAGWAN DHANWANTRI DAY

CELEBRATION ON 17TH OCT., 1998

Organised by :

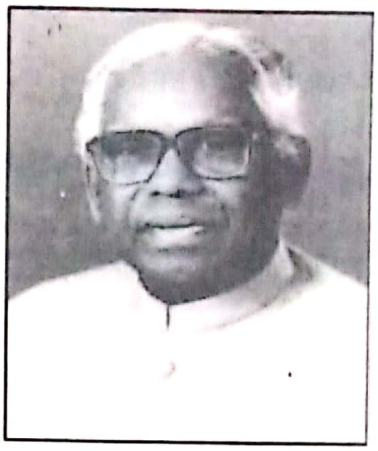
ALL INDIA INDIAN MEDICINE GRADUATES ASSOCIATION

32, Ganesh Nagar, Vistar-II, Shakarpur, Delhi-110092

SOUVENIR

विशेष कार्य अधिकारी
OFFICER ON SPECIAL DUTY
राष्ट्रीय सचिवालय, राष्ट्रपति भवन,
नई दिल्ली-110004,
President's Secretariat, Rashtrapati,
Bhawan, New Delhi-110004

सत्यमेव जयते



No. F.2-M/98

6th October, 1998

Dear Dr. Haseeb,

The President of India, Shri K.R. Narayanan, is happy to know that the All India Indian Medicine Graduates Association, Delhi is celebrating the Birth Day of Lord Dhanvantry, founder of Ayurveda on 17th October, 1998

On this occasion, the President sends his greetings to the Association and wishes the celebrations all success.

With regards,

Yours sincerely,

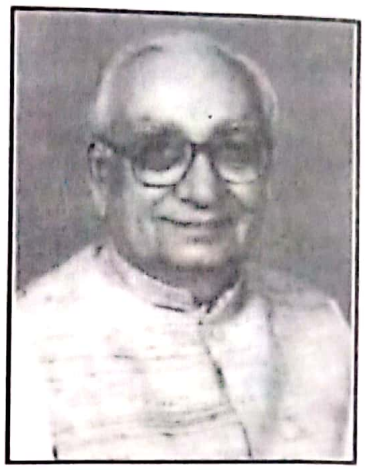
Satya Narayana Sahu

(S.N. Sahu)

Dr. Abdul Haseeb
Editor-in-Chief
All India Indian Medicine
Graduates Association
32, Ganesh Nagar, Vistar II
Shakar Pur, Delhi 110 092

उप-राष्ट्रपति सचिवालय
नई दिल्ली- 110011
Vice-President's Secretariat
New Delhi - 110011

सत्यमेव जयते



No. UPS/M/9811631

13th October, 1998

Message

The Vice-President of India, Shri Krishan Kant, is glad to know that the All India Indian Medcine Graduates Association (Regd.) is celabrating the birthday of Lord Dhanvantry, the founder of Ayurveda on October 17, 1998 at New Delhi.

The Vice-President sends his good wishes for success of the birthday celebrations.

(AJAY MANDLAUS)
INFORMATION OFFICER TO
VICE-PRESIDENT OF INDIA

सत्यमेव जयते

अध्यक्ष लोक सभा

SPEAKER LOK SABHA

12 Oct 1998

Message

I am happy to learn that the birthday of Bhagwan Dhanwantri the founder of Ayurveda, is being celebrated by the All India Indian Medicine Graduates Association on 17th October 1998 at L.T.G. Auditorium Mandi House, New Delhi and to mark the event, a commemorative Souvenir be published.

The Indian system of medicine dates back to thousands of years and are an inseparable part of our culture and tradition. The basic concept underlying the approach adopted by Ayurveda and Unani is to maintain a balance among the various elements of the body so as to make the body system free of disease. The Indian Medicines take into account both the body and the mind while treating any ailment.

I am happy to learn that the All India Indian Medicine Graduates Association is engaged in the propagation of the three Systems of Medicine and safe guard its graduates.

I Wish the All India Indian Medicine Graduates Association all the best the Birth Day Celebrations of Lord Dhanvantry all success.

(G.M.C. Balayogi)

SOMJIBHAI DAMOR
B.Com., LLB (Advocate)
MEMBER OF PARLIAMENT
(LOK SABHA)

PRESIDENT
Akhil Bharatiya Adiwasi Vikas Parishad.
Gujarat Adiwasi Vikas Parishad.
Delhi Adiwasi Vikas Parishad.

सत्यमेव जयते

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Dahod Pin Code 38915 Gujrat
Phone (02673) 20000, 21000, 30100

No. 15, Canning Lane,
New Delhi-110 001
Phone : 3782244

I am glad to know that All India Indian Medicine Graduates Association has proposed to celebrates the birth day of Bhagwan Dhanvantri on 17th Oct. 1998, and going to publish colour ful Souvenir.

I extend my warm greatings to the members of Association and wish the Function all sucess.

Dr. J.S. Panwar
(President)

Sd :-
SOMJIBHAI DAMOR

CONTENTS

From the Desk of

Editor- in-chief

Dr. Abdul Haseeb

The Life is Short
The Art is Long

The father of Medicine Hippocrates says the philosophy of life and healing art in above cited words. Like the last year our esteemed organisation All India Indian Medicine Graduates Association enttrusted me the responsibility of editing this year's annual publication entitled as DARPAN-98. Darpan in Hindi what we call it mirror in english or aiyna in Urdu is appropriate title because it shows what is real or true through a reflection of light. Literly this publication would reflect the activities under taken by AIIMGA During the year passed by. It would show the views of contributors in the form of a number of valuable articals.

It is necessary to bring into knowledge to our colleagues about enciant & latest views symultaniously on the diseases and up date information regarding research which is being in I.S.M.&.H. You will notice changes in the prssentation of this year souvenir. The articals have been selected on important topics viz Dropsy, Seventieth report of parleament on budget on health, research report on air pollution and menopause & HRT by Indian Council of medical research (I.C.M.R.) and other researchers. Drugs de-adiction managment is possible by Unani herbal drugs, Different views of defferent system of Medicines on enxiety which is growing problems of our modern life style. A Clinical study on pelvic tumor and cured through Homoeopathic system of Medicine and also proved by sonography pre and post treatment.

I would like to attract your attention towards a significant development in the form a recent verdict of Hon'ble supreme court of India. A case relating to allow the Doctors of Indian Systems of Medicine to practice in Allopathy system of Medicine came up to Hon'ble Supreme court entitled as Dr. Mukhtar chand and others VS state of Punjab & others civil appeal No 89 of 1987. That time two medical association have filed intervention applications. One of them association is fighting for the supermacy for its system of Medicine and other wants to protect the rights of its members only. There was no such association to represent facts regarding Indian systems of Medicine properly & strongly before Hon'ble supreme court of india.

It was appropriate time, all India Indian Medicine Graduates Association filed an impleadment application in the supreme court of india through Dr. R.S. Chauhan (President) Dr. D.D. Semwal (Gen. Secretary) my self Dr. Abdul Haseeb (Office Seceratary) on 11-10-1992 and after then due to some technical ground, the association filed an applecation through Dr. R. P. Panchal VS. Union of India and others I.A. No-2 of 1996. As you are aware that after a long period of 12 years the much awiated judgment in the case, the Hon'ble supreme court of India has finally pronaunced its judgment on 8th oct. 1998. No Doubt, under the ouspices of A.I.I.M.G.A Dr. R.P. Panchal has persiued the case properly before the supreme court of India but unfortunatly, we could not get success and struggle are remain the same.

6In these circumstances the responsbilities of the association (which represent Ayurveda, Unani & Homoeopathy systems under one banner) have been increased. The comoing days will be more important to decide senseable stratigy to protcet their rights of ISM graduates, and concentration should be focus on upliftment of I.S.M.

I take this apportunity to high light about the following demands for the development of Indian systems of Medicine for which A.I.I.M.G.A. has been fighting since its inception.

1. To declare I.S.M. the Notional system of Medicine.
2. There should be Separate directorate of I.S.M. all state of the countary.
3. To give reimbursement and panel facilitics to I.S.M. physicians as is given to allopathic physicians.
4. There should be separate wing of I.S.M. in every Govt. hospital & dispensaries all over the country.
5. I.S.M. Acadmy should be started in armed forces is along with hospital & dispensaries.
6. Research in I.S.M. particularly aiming at public health hazards, & incurable diseases, Tuberclosis & emergencies.
7. Improvements in educational standard in I.S.M. by way of introducing modern Techniques.
8. Quality control, standardizationn and testing of I.S.M. drugs particularly providing of laboratory facilities through out the country.
9. Development of Medicinal plants and forming of a National policy on growth, along the side National high ways
10. Role of I.S.M. practitioners in primary health care and National programme.
11. Equal powers and rights for the graduates of I.S.M. all over the country.

I tried the best of my capacity and capabilities to maintain standard of the souvenir, but I feel the job of editor-in-chief of Souvenir has become very tidious for the happiness of all the writers and satisfection to the members.

Last but not the least I wish to express my heart felt gratitude to all collegues, Dr. R.S. Chauhan (Petron) Dr. J.S. Panwar (President), Dr. Dinesh Vasishth & Dr. K.S. Kukreja (editor) without their co-operation this publication could not see the lights of the day. I am thankful to the contributors who responded to our request to send their articals and also greatful to I.C.M.R, health-up-date C.C.R.U.M Himalaya Buletin probe & I.J.C.P Group of publication for reproduced article in the Souvenir DARPAN-98.

In the last I have great pleasure to hand over you the Souvenir Darpan-98 as editor-in-chief on the occassion of Dhanvantri Jayanti Samaroh which is being celebrated on oct. 17th 1998.

Dr. Abdul Haseeb *

Editor-in-chief

* Member of Delhi State Haj Committee, Govt. of Delhi, Under the auspices of the Ministry of External Affairs, Govt. of India * Convener 1/c of Medical Committee of State Haj Committee * Ex. Member of Advisory Committee to establishment Directorate of I.S.M. Ministry of Health, Govt. of Delhi * Secretary of All India Unani Tibbi congress * Treasurer of Al-Shifa (Society for welfare to mankind) * Member of All India Conference of Intellectuals * Member of Society for Securing Justice.

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Gen. Secretary's Report

Dr. Dinesh Vasishth

On the eve of Bhagwan Dhanwantri Jayanti I convey my heartiest wishes to respected participants dear readers.

Writing General Secretary's report of any organisation can be anybody's cup of tea but it may not satisfy everybody's liking.

Before bowling the functioning of A.I..I.M.G.A. for the year 1997-98 under the captainship of Dr. J.S. Panwar, President, well kept Dr. N.K. Dhamija, Treasurer & very well fienlded by cabinet members, I would like to draw the attention of the aplauding spectators (honourable member) to the saying of Swami Vivekananda :-

I am to lay my life for the welfare of others & I am ready to go to hell for the sake of others.

The saying of elders & the leardned not only preach but inspire a lot always the world over. It also shows our spirit of doing good & our loyality towards the job (office beareship) assigned to us not bothering about mere appriciation or depriciation out of our performance. These briefs are as follows :

1. Reacting to last years' Dhanwantri Jyanti I would like to extend my congratulations to Dr. Abdul Haseeb & his able editorial board comprised of Dr. Kuldip Singh Kukerja, Dr. K.M. Zakir, Dr. K.S. Vidyarthi, Dr. N.K. Gupta, Dr. Bhushan Chauhan & Dr. Pankaj Bhatnagar for publishing a beautiful coloured Souvenir. The magazine was exceptionally one of the best ever published. The presentation & selection of contents was one of its kind. **The truely professional loking magazine was due to hardworking efforts of Dr. Abdul Haseeb & his team. Chief Editor proved his mettle of discipline and dedication.** Rest of the board member co-operated like anything to make this magazine a praiseworthy achievement of the Dhanwantri Day. I hope this year too same kind of marvellous souvenir will be published to the delight of members & readers. I wish them success.

2. In January 1998 the Sports-Meet was organised at D.D.A. sports complex Dilshad Garden under Chairmanship of Dr. Sharat Malhotra. On the concluding day, the Chief Guest Sh. M.L. Gaba Ji, M.L.A. & Sh. Mehender Pal Singh (Mayor) gave/Dr. S.K. Swami, for Table Tennis to Dr. Mukesh Shouri & for Badminton to Dr. Mahesh Gaur. Dr. Gaur has been rendering his lovable services as Chairman Entertainment Committee. The tournament was sponsored by Milap & Sons Drug Pharmaceuticals Pvt. Ltd. (Haridwar) & Co-Sponsored by Gary Pharms. I Sincrely thank the sponsors for their co-operation & congratulate the winners.

3. In our Family Welfare & Immunization programme Secretaries Dr. Sanjeev Shokeen & Dr. S.P. Pandav respectively took pains in conducting training programmes and distribution of vaccines to various Depots. The silent services of Dr. S.P. Pandav has been impressive & unforgettable.

4. For one of the biggest venture, eveready Dr. D.R. Dixit Chairman Bhoodan Samiti is making every effort Lonely in collecting funds to raise "A.I.I.M.G.A. Bhawan" at the earliest. He gets full credit for getting the exemption of donations under 80 G of Income Tax. A detailed report & appeal is also there.

5. As the association is gaining ground & expanding, so the membership and the subsequant resources are on the rise. The brain behind is non other than our old

associate Dr N.K. Dhamija, hardworking, sincere & 'Harfanmolla gentleman. His wife respected Dr. Mrs. Promila Dhamija is also a helping hand to her beloved husband & has been offering her services for the association since a long time.

6. The state unit of Haryana was formed on Ist February 1998. The nominated office bearers are Dr. C.S. Bhardwaj (Faridabad), Dr. Ashwani Sharma (Ambala) and Dr. S.K. Bhargava (Faridabad) as President, Secretary & Treasurer respectivelly:-

a) The first task was overcome by the state unit with the help of central A.I.I.M.G.A. in the case of harresment by Drug Inspectors to our fellow physicians by raiding and checking at their clinics for not allowing them to use Allopathic Medicines. A joind delegation met the authorities. In reference to that Dr. P.L. Jindal. Director General Health Services, Chandigarh issued a against the instuionally qualified gradutes of Ayurveda & Unani e.g. G.A.M.S. & B.A.M.S. for their rights of using Alopathic medicines.

b) A free medical camp was organised by the Doctors of Faridabad at Kheri Chungi Road in February 1998 and distributed free medicines to patients. D.C. Faridabad Sh. B.K. Panigrahi & D. Ayurvedic Officer Dr. R.M. Mohan were present.

c) In Distt. Kaithal, unit of A.I.I.M.G.A. was formed in the presence of Dr. R.S. Chauhan, Dr. T.C. Goyal, Dr. H.S.D. Sharma, Dr. R.P. Panchal, Dr. V.K. Gupta, Dr. C.S. Bhardwaj and Dr. Mukesh Aggarwal were given the charge of president and Secretary respectively. A grand show of enthusiasm was seen at Kiathal

d) A grand fucntion was held in Delite Hotel, Faridabad on 23.03. 1998. A cultural programme of family get together was enjoyed by the respective families for prize distrubution of many programmes followed by music and tasty dinner.

7. A.I.I.M.G.A. is not just growing merely in numbers but on the basis of its authentic working. It has always co-operated with the Doctors of I.S.M. of other states in strengthing their fight in their respective states against state administration's wrong propanganda, whether they are members or nt.

a) For Punjab, the office beaers Dr. A.K. Kapoor accompnised by Dr. Vivek Sood came to Delhi & had a meeting with us and enquired about our working and achievements in cases related to Supreme Court. They were not only impressed but asked us to provide the relevant documents for the same. For which we responded.

b) The people from Andhra Pradesh, Dr. K.S. Chalpathi Rao ans Dr. G.V. Puranchand noted writer came to Delhi as President & Secretary respectively to get acquinted the legal documents. They were convinced and assured us to join our organisation.

c) Doctors of Maharashtra, Karnatka, Orisa & Rajasthan are also in touch with us to broaden our base. Thanks to them for their trust in us .

8. *In our neithbouring state Uttar Pradesh, where A.I.I.M.G.A. is already a sell known name, the doctors of Distt. Muradabad & Jyotibha Phule Nagar approached us to form a unit. A district meet was called in Hotel Swagat at Gajrola On 24.07.1998 InThe Prrsence of Dr. N.K. Dhamija and Dr. R.P. Panchal. Doctors were assured not to worry about the harassing attitude of local health authorities. Press Conference was called and a press release was given in various local news papers the malafied intertions against our collegues. It helped very much to the delight of local practitioners. Doctors members are Dr. M.P. Sharma, Dr. Iqbal Warsi, Dr. Mrs Pareveena Fatima, Dr. B.S. Jindal, Dr Rajesh Saraswat, Dr. Sudhakar Singh from Mandi Dhanora and Dr. R.K. Sharma from Gajrola, Dr. Tyagi from Hassan Pur, Dr. Mewa Singh & Dr Hari Singh Dhillon from Amroha, Dr Javed Chaudhary & Dr. Gupta from Joya besides Dr. Vinod Sharma from Kanth were assigned to job of association. In all apisode Dr. M.P. Sharma took lot of pains in forming A.I.I.M.G.A. unit. He is a man of words and courage. I highly appriciate his painstaking efforts.*

9. Delhi being N.C.T. and attaining the statehood so the state unit of A.I.I.M.G.A. was formed in Delhi too. This was done firstly to involve and cater services to grass root level mambers and secondly to ease our working aiming to expand to other states to give the association on All India status. For this a known figure in A.I.M.G.A. circles Dr. Mohd. Usman and Dr. K.K. Singhal were nominated and declared elected for the posts of Secretary & Treasurer respectively for discharging their duties.

a) Delhi Govt. passed a resolution

in the name of Bhartia Chikitsa Adhinlyam i.e. State Council of C.C.I.N. for I.S.M. practitioners. Suitable suggestions were made & given to Delhi's Health Minister Dr. Harsh Vardhan in the presence of Dr. J.S. Panwar, Dr. R.S. Chauhan, Dr. R.P. Panchal and me.

b) We had a chance to see honourable Prime Minister of India Sh. Atal Bihari Vajpayee and reminded him of his Parliament debate in the year 1959 where he laid stress on the intigrated approach required by Govt. of India involving the practitioners of Indian system of medicines to cater medical services at the the remote and rural areas of India. It was in connection with Supreme Court case.

c) A cultural function was held by Mangol-Puri zine participating the families of the members for music and dinner. The efforts of Dr. Pawan Sharma Dr. Mohd. Uaman (short, sleek and smart secretary of Delhi A.I.I.M.G.A.) and others will remain praiseworthy for the show of family togetherness.

d) A scientific session was held at I.M.A. Hall Inderprastha Estate on Bronchial Asthma dated Learned S.K. Tripathi, Sr. Physician, Moolchand Hospital Dr. V.K. Gupta International Homeopathic consultant. I thank the speakers for sparing their invaluable time to deliver the professionalism. Dr. L.N. Sharma gave special services to make the academic session a real success.

e) Anti quackery bill was tabled in Autumn session of Delhi Vidhan Sabha. The steering committee under Sh. Alok Kumar was given suggestion and necessary amendments for the said bill for the welfare of people of Delhi

10. The latest feather in the cap of A.I.I.M.G.A. is achieving one more post of membership to C.C.I.M. for Dr. Rajinder Chabra on the basis of nomination. I congratulate Dr. Chabra and wish him success for the welfare of practitioners of I.S.M.

11. The last but not least, was the case of supreme court where carear of eight lakhs of prectitioners was at stake. As you know the you belong proudly to an association had been fighting since a long time has finally reached to a decision declared by Hon'ble supreme court of India. The summry of the judgment of the court submitted separetly in the souvenir

Thank God with the blessing of Bhagwan Dhanwantri, w e could save counterparts in dispracing usUnani more heartidly so that the justice could be done by us.

Concluding the report I will extend my wishes & thanks to all the participating people on Dhanwantri Day and wish them Prosperous Dipawli for Health. Happiness and Harmony.

guest speakers shared their clinical expertise with the audiance. They were Dr. Raghu Nandan Sharma, Dr.

DHANVANTRI AWARD 1998

The Association presented Dhanwantri Awards to dignitaries related with Ayurveda, Unanipathy, Homoeopathy Systems of Medicine as a token of gratitude in the appreciation of their services rewarded to the system of medicine.

Personalities selected for Dhanwantri Award for the year 1998 are:

Vaid. Durga Prasad

Prof. Hakeem A.J. Khan
Head of Deptt. Gyn. & Obs.
A. & U. Tibbia College Karol Bagh,
New Delhi

Dr. S.C. Shastri
(Director ISM)

Dr. Deewan Harish Chand
Renowned Physician

SPECIAL AWARD
Dr. R.P. Panchal

AIIMGA AWARD 1998

The Association award is given to a member who excels in the activities of the Association in any capacity bringing a good reputation & impressing upon others to become its member.

Dr. M.P. Sharma
Dr. Mahesh Gaur
Dr. Bhushan Chauhan
Dr. S.S. Nijhawan
Dr. S.K. Panchal

Dr. Bhopal Singh
Dr. S.D. Gaur
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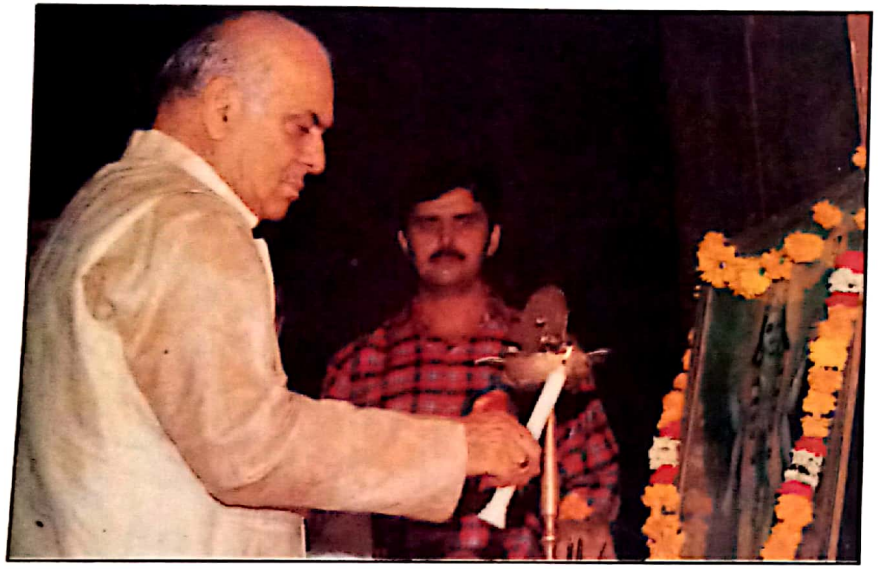
GET TOGETHER OF THE ASSOCIATION

DHANWANTRI CELEBRATION FUNCTION-97



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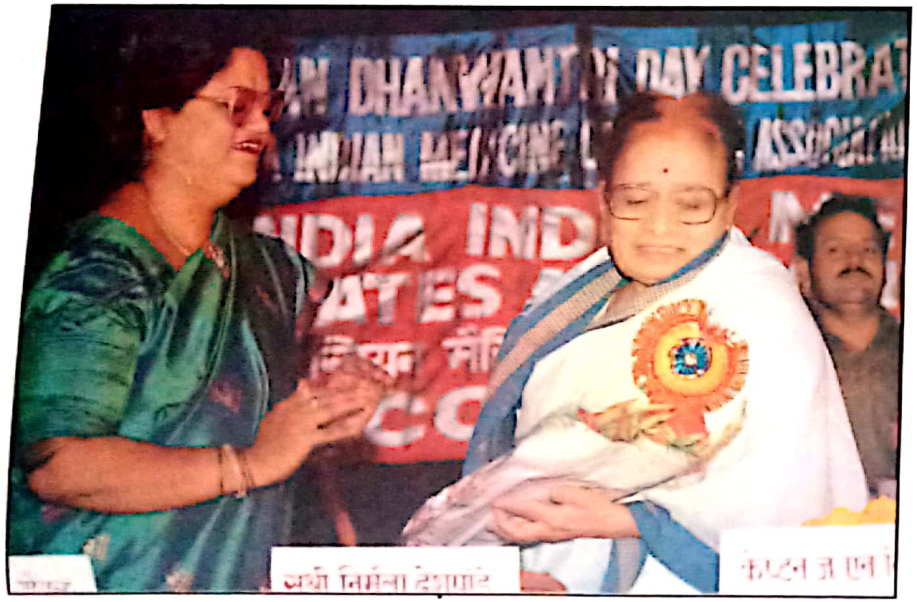

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Dr. J.S. Panwar (President) Dr. Denish Vasisth Dr. N.K. Dhameja With Mrs. Nirmala Deshpandey

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On the Occasion of Scientific Seminar- Dr. R.P. Panchal (President) Delhi State Branch, Dr. Tripathi, Dr. R.S. Chauhan, Dr. V.K. Gupta

At the time of of Annual Function of Rohini Mangol Puri Zone Dr. D.C. Sharma, Dr. R.S. Chauhan, Dr. Nand Kishor, Dy. Director I.S.M.

A View of Audians at the time of Seminar.

Winner Team

RELEASE OF THE SOUVENIR

Dr. ABDUL HASEEB
(Editor-In-Chief) hold a set of souvenir for Release

HON'BLE MINISTER CAPTIN J.N. NISHAT IS RELEASING SOUVENIR-97
DR. ABDUL HASEEB (Editer-in- Chief), DR. K.S. KUKREJA, DR. BHUSHAN CHAUHAN (Editers), DR D.K. VASISHTA (G.Sec.) DR. J.S. PANWAR (President)

Decision of Supreme court of India.

Editor Note :

A case was pending regarding use to allow the allopathic drugs to the Doctors of Indian Systems of Medicine in the Hon'ble supreme Court of India.

Long awaited Judgment has pronaunced on 8th October 1998. The whole Judgment is axtended on 40 Pages. First Portion and last few paragraphs of the Judgment are as under :-

Certified to be true copy
Assistant Registrar (Judl.)
.....199
Supreme Court of India

IN THE SUPREME COURT OF INDIA

CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO. 89 OF 1987

292590

Dr. Mukhtiar Chand & Ors. — Appellants/ Petitioners

The State of Punjab & Ors. — Respondents

WITH

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

J U D G M E N T

QUADRI, J

These cases raise questions of general importance and practical significance - - guestions relating not only to the right to practise medical profession but also to the right to life which includes health and well-being of a person. The controversy in these cases was lriggered off by the issuance of declarations by the State Government under clause (iii) of Rule 2 (ee) of the Drugs and Cosmelics Rules, 1945 (for short the Drug Rules') which defines "Registered Medical practitioner". Under such declaralions, notified Vaids/Hakims claim right to prescribe Allopathic drugs covered by the Indian Drugs and Cosmetics Act, 1940 (for short. 'the Drugs Act'). Furthermore, Vaids/Kakims who have obtained degrees in integrated courses claim right to practise allopathic system of Medicine.

Last Paragraphs

However, the claim of those who have been notified by State Govenment 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 Ayurveda, Ssiddha 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 onthe 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 holder in integrated cousrses is imparted not only the theoretical knowledge of modern scientific Medicine but also traning thereunder, is the claim. We shall examine the notifications 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 follows:

> "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 avanced made under the various branches of modern scientific system of Medicine, clinical, non-clinical, biosciences, also technological innovations made from time to time and declare that the courses and curriculum conducted and recognised by the CCIM are suplemented by such modern advances."

On October 30, 1996 a clarificatory notification was issured, 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 (Ayurveda, Siddha and Unani) are eligible to practise 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 Centrial Council of Indian Medicine after approval of the Government 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 recognised by the Central Council of Indian Medicine are supplemented by such modern advances."

Based on those clarifications, the arguments proceed that persons who registered under the 1970 Act and have done integrated courses, are entitled to practise 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, E.C.G., etc. for purpose of practising 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 practise scientific medicine in any of its branches unless that person is also enrolled on a State Medical Register within the meaning of 1956 Act.

The right to practise modern scientific medicine or Indian system of medicine cannot be based on the provisions of the Drugs Rules and declaration made thereunder by State Govenment. Indeed, Ms. Indira Jaising has also submitted that the right to practise a system of medicine is derived from the Act under which 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 Durgs Act. This argument is too technical to be acceded to because prescribing a drug is a concomitant of the right to practise a system of medicine. Therefore, in a broader sencse the right to prescribe drugs of a system of medicine sould be synonymous with the right to practise 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 are 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 and are legal. However, after sub-section (2) in Section 15 of the 1956 Act occupied the field vide Central Act 24 of 1964 with effect from June 16, 1964, the befefit of the said rule and the notifications issued thereunder would be available only in those States where the privilege of such right to practise 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 inasmuch as if any State Act recognizes their qualification as sufficient for registration in the State medical Register, the prohibition contained in Section 15(2) (b) 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/-
.....C.J.I.

Sd/-
.....J.
(K.T. THOMAS)

Sd/-
.....J.
(SYEED SHAH MOHAMMED QUADRI)

NEW DELHI.

OCTOBER 8, 1998.

बहु प्रतीक्षित सर्वोच्च न्यायालय का निर्णय

डॉ आर० पी० पांचाल चेयरमैन, लीगल कमेटी, एमगा

क्या औषध नियम 2 (ई ई) (iii) विधायी क्षमता की दृष्टि से 'बुरा' है और राज्य सरकारों द्वारा इस नियम के तहत जारी राजाज्ञायें जिनके द्वारा राज्य सरकारों ने आयुनिक चिकित्सा पद्धति के अभ्यासियों की श्रेणियों को ज्ञापित किया, कानून की नजर मे वैध है ?

भारतीय आयुर्विज्ञान परिषद् अधिनियम एवं केन्द्रीय भारतीय चिकित्सा परिषद्, १९७० का औषध नियम २ (ई ई) (iii) तथा उसके तहत राजाज्ञाओं पर क्या असर पड़ता है? और-

क्या आयुर्वेद एवं युनानी के विभिन्न विश्व विद्यालयों से समन्वित पाठ्यक्रमों से उत्तीर्ण चिकित्साभ्यासी ऐलोपेथिक चिकित्सा में अभ्यास करने एवं ऐलोपेथिक दवाओं के नुस्खे देने के अधिकारी हैं?

ये वे तीन प्रश्न थे जो माननीय सर्वोच्च न्यायालय की एक त्रिसदस्यी खण्डपीठ ने अपने सामने रखें। जिसमें मुख्य न्यायमूर्ति श्री एम० एम० पंछी अब सेवा निहित-न्यायमूर्ति श्री एस० एच० एम० कादरी और न्यायमूर्ति श्री के० टी० थामस ने दिनाँक ८ अक्टूबर १९९८ को अपने एक ऐतिहासिक फैसले प्रथम प्रश्न का अत्तर स्पष्ट 'हाँ' में दिया और दूसरे तीसरे प्रश्न को मिला-जुला मानते हुए कहा कि यदि भारतीय चिकित्सा के राज्य अधिनियमों में ऐसा अधिकार दिया गया है तो वह ऐलोपेथिक दवाओं का प्रयोग कर सकते हैं और यह भी कि समन्वित पद्धति में चिकित्सकों की उपाधियों को राज्य सरकारें यदि राज्य की आयुर्विज्ञान परिषदों की अनुसूची में शामिल कर लेती है तो उन पर भारतीय आयुर्विज्ञान परिषद्, १९५६ की धारा १५ (२) (बी) लागू नहीं होगी। केरल राजस्थान उच्च न्यायालय में प्रतिवादी होने के बावजूद १९५६ के नानून की सर्वोच्चयता की दुहाई देते हुये दिल्ली, महाराष्ट्र तथा पंजाब एवं हरियाणा उच्च न्यायालयों मे जनहित याचिकायें दायर कर रखी हैं।

सर्वोच्च न्यायालय के समक्ष यह मामला १९८७ में पंजाब एवं हरियाणा उच्च न्यायालय के एक फैसले स्वर्न सिंह दर्दी बनाम पंजाब सरकार के विरूद्ध नागरिक अपील की याचिका के रूप में आया (धारा १५ (२) (बी) को ऐलोपेथिक दवाओं के प्रयोग में अधिकार के विषय में सर्वोच्च मानते हुये पंजाब सरकार की १९६७ की उस अधिसूचना को रद्द कर दिया जिसके तहत उसने भारतीय चिकित्सा पद्धति के चिकित्साभ्यासियों को औषधि नियम २ (ई० ई०) (iii) के तहत इन दवाओं को गरीबों को देने या नुस्खा लिखने का अधिकार दे दिया अभी जबकि न्यायालय ने इस पर फैसला देना ही था कि वर्ष १९९५ में राजस्थान उच्च-न्यायालय ने आई एम ए की अपील पर फैसला देते हुये सम्बन्धित औषधि नियम बनाने की भारत सरकार की शक्ति को ही मानने से मना कर दिया।

दिनाँक ८ अक्टूबर १९९८ को दिये गये ४० पृष्ठीय निर्णय में सर्वोच्च न्यायालय ने दोनों उच्च न्यायालयों के फैसले को रद्द कर दिया। त्रिसदस्यीय खण्ड पीठ की और से फैसला देते हुए माननीय न्यायमूर्ति श्री कादरी ने स्पष्ट किया कि यह औषधि नियम किसी भी प्रकार की विधायी अक्षमता से पीड़ित नहीं है। और कानूनी तौर पर वैध है।

इस फैसले की दूसरी महत्वपूर्ण प्रस्थापना यह है कि भा० चि० प० में चिकित्साभ्यासी अंग्रेजी दवाओं का प्रयोग कर सकते हैं कि कि उन राज्यों में जिनमें वह रजिस्टर्ड है। उनके सम्बन्धित राज्य भारतीय चिकित्सा अधिनियमों में उन्हें ऐसा करने का अधिकार दिया गया हो।

माननीय न्यायमूर्ति श्री कादरी द्वारा सूनाये गये फैसले की तीसरी महत्वपूर्ण प्रस्थापना यह है कि भा० चि० प० के अन्दर ही ऐसे चिकित्सकों की एक श्रेणी है जिन्होनें अपने पाठ्यक्रमों में आयुर्वेद/युनानी के साथ-साथ आधुनिक चिकित्सा विषयों का अध्ययन-प्रशिक्षण लिया है और जो समन्वित पद्धति के चिकित्सकों के रूप में जाना जाता है। इस फैसले के आधार पर यदि राज्य सरकारें उनकी उपाधियों को मान कर अपने-अपने राज्यों की आयुर्विज्ञान परिषदों की अनुसूची में शामिल कर देती है। तो वह १९५६ के केन्द्रीय कानून की धारा १५ (२) (बी) के बाध्यकारी प्रभाव से मुक्त हो जायेंगे।

इसके अलावा इस फैसले में १९९२ में सर्वोच्च न्यायालय की एक खण्डपीठ न्यायमूर्ति फातिमा बीवी एवं न्यायमूर्ति श्री एच० सी० अग्रवाल के इस फैसले पर नकार दिया है कि इन प्रावधानों (धारा १५ (२) (बी)) के मुताबिक "कोई व्यक्ति ऐलोपेथिक का किसी राज्यादेश में तभी अधिकारी बन सकता है एवं इसके पास मान्य चिकित्सा उपाधि हो। एलोपेथी की मान्य उपाधि रहित व्यक्ति को उसमें अभ्यास के अधिकार की अनुमति केन्द्रीय कानूनों के प्रवधानो के विरूद्ध होगी''

इसी प्रकार १९९६ में पूनम वर्मा बनाम डॉ अश्विनी पटेल एवं अन्य के मामले मे दिये बहुचर्चित फैसले का भाग वहा तक ही माना है जहाँ तक नीम-हकीम की व्याख्या का प्रश्न है। उल्लेखनीय है कि आई एम ए ने इसी फैसले की आढ़ में दिल्ली, पंजाब व बम्बई उच्च न्यायालयों में नीम-हकीमी रोकने हेतु जनहित याचिकाये दायर की हैं और इसी फैसले के आधार पर कई राज्य सरकारों ने समन्वित चिकित्सकों समेत भा० चि० प० के सभी चिकित्सकों के विरूद्ध प्रशासनिक-कानूनी कार्यवाही शुरू कर दी। वर्ष १९५९ में लोकसभा में फार्मेसी अधिनियम मे संशोधन हेतु लाये गये विधेयक पर बोलते हुये उन्होंने काशी एवं अहमदनगर के (ऐसे) चिकित्सकों को अंग्रेजी दवाओं के प्रयोग के अधिकार की जोरदार वकालत ही थी। सारे देश से सैकडों तार भेजकर उनसे औषध नियम २ (ई ई) (iii) को बनये रखने की पुरजोर अपील की गई। परन्तु सर्वोच्च न्यायालय में सुनवाई के दौरान भारत सरकार के वकील ने बेहद ढूलमुल रवैया अपनाया। **इस पर अपने विचार व्यक्त करते हुए न्यायमूर्ति श्री कादरी ने 'अचम्भित' होने का उल्लेख करते हुए लिखा है 'नियम बनाने वाले' प्राधिकार को अपने ही बनाये नियम की वैध्यता एवं मान्यता को समर्थन देने में रूची नहीं है, न कि वह इस नियम को पूरी तरह से खत्म ही करना चाहती है''**

सर्वोच्च न्यायालय के इस फैसले के बाद आशा की जानी चाहिये कि भा० चि० प० के चिकित्साभ्यासियों में अंग्रेजी दवाईयों की भा० चि० प० के चिकित्साभ्यासियों के अंग्रेजी दवाईयों (अनूसूचि एच० एवं एल०) के प्रयोग के अधिकार पर गैरजरूरी एवं विनाशकारी बहस बंद हो जायेगी। "औषध नियम २ (ई ई) (iii) मे न तो कोई बदलाव किया जायेगा तथा न ही उसे हटाया जायेगा और कोई नया कानून बना कर उन्हें प्रताड़ित नहीं किया जायेगा।

SUPREME COURT VERDICT ENDS CONTROVERSY OVER ALLOPATHIC DRUGS

BY DR. BHARAT BHUSHAN

The Supreme Court of India, in a Landmark judgement, on 8th October' 98 has ruled that the Drug Rule 2 (ee) (iii) is valid (ii) practitioners of Indian medicine are covered by this rule (iii) they can use allopathic drugs if State Act (s) under which they are registed permits them to do so and (iv) integrated medical practitioners (for short integrates) can get registration with state medical counils, if the state governments wants so.

The 40-page judgement was delivered by Mr. Justice S.H.M. Quadri on behalf of a three-judge bench headed by the Chief Justice, M.M. Punchhi (now retired), and comprising Mr. Justice K.T. Thomas and Mr. Justice Quandri himself, in a case-Dr. Muktiar. Chand and others Vs State of Punjab and others in civil appeal No. 89 of 1987 with other civil appeals and special leave petitions.

It happened so that in 1986 a two-judge banch of Punjab and Haryana High Court comprising Mr. Justice Tewata and Mr. Justice D.D. Sehgal in Dr. Swarn Singh Dardi vs State of Punjab case struck down a Gazette notification issued by the Government of Punjab in 1967 under powers vested vide D.R. (2)(ee)(ii) as it clashed (in the view of the High Court) with section 15(2)(b) of the Indian Medical Council Act, 1976. The H.C. also rejected, thereafter, a review petition forcing petitioners/ intervenors to move to the Supreme Court in 1978. Following a disagreement in the two-judge bench C.J.I., Mr. Justice Pathak, which committed the case to a larger bench of three juges.

While the Punjab and Haryana High Court did not question the legislative competence of the Government of India to make such rules, the High Court of Rajasthan did the same, while striking down the state notification of 1982. As such a S.L.P. was filed against this judgement too before the Supreme Court.

Meanwhile, two judgements of the Supreme Court complicated the matter a little more. In 1992, a two-judge bench comprising Mrs Justice Fatima Beevi and Mr. Justice S.C. Aggarwal in Dr. A.K. Sabhapati vs State of Kerala ruled that section 15(2)(b)of 1956 ACT debars non-allopaths from using the allopathic (schedule H&L drugs) drugs and, in 1996 another bench comprising Mr. Justice Kuldeep Singh and Mr. Justics Sagir Ahmed in Ms Poonam verma vs Dr. Ashwani Patel reiterated the supremacy of the IMC Act, 1956, while declaring Dr. Patel a 'quack'.

The three-judge bench, as Mr. Justice Quadri notes in the judgement, considered three questions for determination.

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 invalid in law?
2. what is the impact of Indian Medical Council Act, 1956 and Indian Medical Central Council Act, 1970 on rule 2 (ee) (iii) of the Drugs Rules and the notifications issued thereunder?
3. whether the persons who have qualified the integrated courses in Ayurveda and Unani from various universities are entitled to practise in and prescribe allopathic medicines.

Here it is noteworthy that Mr. Justice Quadri on 29th July, '98 issued an order on behalf of the three-judge bench, which was a sort of curtain-raiser for the judgement of 8th October '98. The order said:

" For the last few days have heard a batch of civil matters in which sub-clause (iii), clause (ee) of rule 2 of the Drugs and Cosmetic Rules, 1945 has been the subject matter of debate in its widest spectrum. Prime facie conclusions drawn therefrom make us feel that judgement of the High Court cannot be faulted with. The respondent does come within the definition of a registered medical practitioner entitled to keep allopathic medicines by virtue of his degree and registration in the State of Bihar. we thus find nothing to interfere in this appeal. The appeal is therefore dismissed."

Therefore, it was quite natural for their lordships to declare, that Rule (2)(ee)(iii) as effected from 1960 is valid and does not suffer for want of legislative competence and notifications issued by state governments thereunder are not ultra vires of the said rule and are legal.

So far questions No. 02 and 03 are concerned, considering them

a little overlapping opines Mr Justice Quadri" as a result of the insertion of sub-section 2(b) to section '15' of the IMC Act, 1956 in 1964, the privilege of the right to use allopathic drugs would be 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".

It is noteworthy that under sub-section 3(b) of section '17' of the IMC Act, 1970, a practitioners enjoys Nationally only those rights that are given to him/her in the state act for Indian Medicine, because that is the spirit of this provision. In other words, if in a State Act of Indian Medicine, its practitioners is given the right to use allopathic drugs only then the spirit of D.R. (2)(ee)(iii) will become effective.

In the judgement of 8th Octoer, '98 the three-judge bench disagreed with the judgement given in the Sabhapati case, but accepted the definition of a quack as laid down in the Poonam Verma case. In other words, if a practitioner of Indian Medicine has studied subjects of modern Medicine, then he/she can't be considered a quack.

The most significant of the October 8 judgement is recognition of the fact that there exists a class of practitioners of integrated Medicine (of course within the broader spectrum of Indian medicine) that needs a separate, special and different treatment. As such, the jugement declares regarding them that " their position is on the same plain in as much as if any State Act recognises their qualifications as sufficient for registration in the State medical register, the prohibition contained in section 15(2)(b) of the 1956 act will not apply". In other words, an integrated practitioners can get himself registered with a state medical council provieded the Government of the said State recognises their qualification. This comes as a sort unsolicited windfall for integrates.

In the whole case, the role of the Government of India and Governments of States of Rajasthan, Punjab as well as Haryana became exposed so much so that the Oct 8 judgement states, "Here we are constrained to observe that the stand taken by the Central Government shows utter bewilderment inasmuch as the authority and the validity of the rule nor does it want to do away with the rule whole heartedly" And Dubbed plea of Govt that the Rule it self was invalid as "Strange"

The judgement of Oct 8 and order of 29th July, exposes the nexus between the Health authorities of the Centre and the States.

It is true that the Congress failed to honour its solemn pledge made in 1920 with regard to I S M etc. but it was only in the BJP ruleds States that vaids/hakims were dubbed as quacks paraded handcuffed on the roads, slapped with saction 420 of IPC and, above all, killed in police custody.

The Supreme Court judgement of Oct 8 must now lay to rest the ghost of Quackery as resurrected by the IMA with the active connivance of the health authorities. The Goverment of India has promised to abide by the judgement of the Supreme Court.

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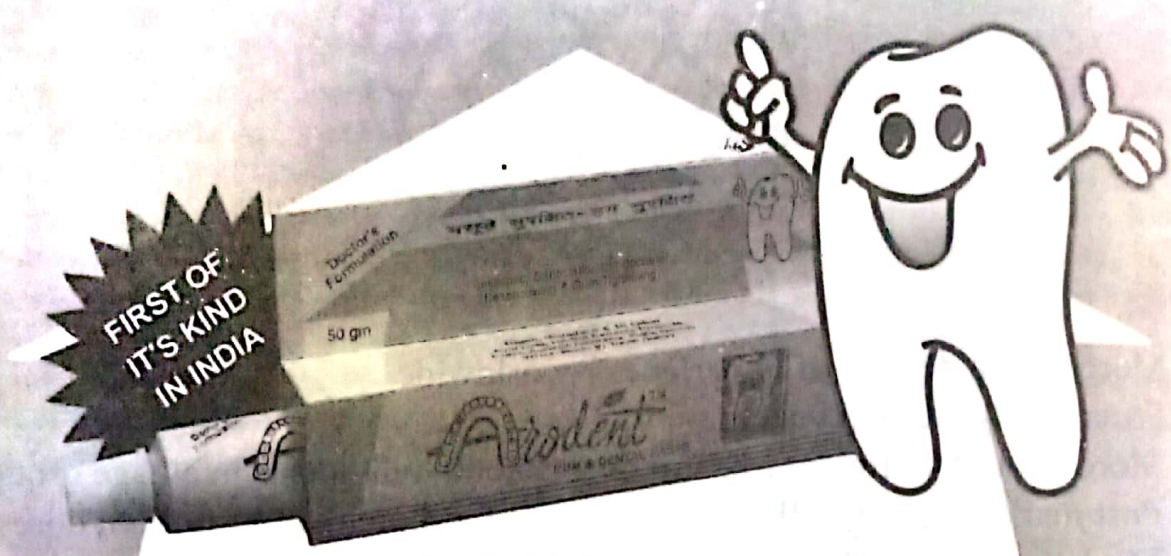

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शिवानन्द

सुप्रसिद्ध हिमालयी आयुर्वेदिक उत्पाद

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पृथ्वी पर ईश्वर की सबसे अनूठी रचना है आपका शरीर। इसके पालन पोषण के लिए उसने दुर्लभ आयुर्वेदिक जड़ी–बूटियॉ भी उपलब्ध कराई है। इन्ही जड़ी–बूटियों की दिलचस्प दुनिया ने एक समय के एलोपैथी के डाक्टर रहे स्वामी शिवानन्द को ज्ञान की प्राचीन विद्या–आयुर्वेद की ओर खींच लिया। आयुर्वेद संस्कृत के दो शब्दों आयु या जीवन और वेद या विज्ञान से उपजे इस जीवन विज्ञान में ऐसी जड़ी–बूटियों का उल्लेख है जो शरीर के पोषण करने और इसे नई ऊर्जा देने के लिए जानी जाती है।

नव बाल च्यवन प्रभा:

यह बालकों के बढ़ते शरीर व दिमाग के लिए अति उत्तम टॉनिक है। इसमें ब्राह्मी बूटी व शखपुष्पी का विशेष योग ही जिससे बालको की स्मरण शक्ति का सतुलन बना रहता है। पैकिंग २५० ग्राम, ५०० ग्राम, १००० ग्राम।

नवच्यवनप्रभा (केशर व अष्टर्गयुक्त):

मानसिक दुर्बलता, रक्ताल्पता, निर्बलता, युक्त, व्याधि, श्वास–कास, सर्दी दमा तथा हृदय की दुर्बलता मे लाभप्रद उपचार। यह मानव शरीर के नाड़ी सस्थान, रक्त सस्थान आदि को औजशक्ति प्रदान कर शरीर के विकास मे नियमित लाभ पहुँचाता है। प्रत्येक ऋतु मे सेवनीय आदर्श टॉनिक।

पैकिंग : २५०, ५०० तथा १००० ग्राम।

नव अमृत च्यवन प्रभा:

नव अमृत च्यवन प्रभा विशेष कर उनके लिए है जो ४० साल की आयु पार कर चुके है। यह बहुत सी हिमालियन जड़ी बूटियो के मिश्रण तथा विभिन्न भस्मो के द्वारा निर्मित किया गया है। यह मानव शरीर के लिए शक्ति वर्धक टॉनिक है और मास पेशियो को मजबूत बना कर वातावरण प्रदूषण के खिलाफ रोधक शक्ति बनाने मे मददगार है। पैकिंग २५० ग्राम, ५०० ग्राम, १००० ग्राम।

डायबोसिड टैबलट :

यह मधुमेह की एक उत्तम औषधि है। पैकिंग : ६० टैबलट।

ब्राह्मी ऑवला केश तेल :

रूसी मुक्त व चमकदार बालो के लिए सोते समय इस तैल की सिर पर मालश सुखद नीद सुनिश्चित करती है।

शिवानन्द दन्तरक्षक :

यह सुप्रसिद्ध दन्तमजन दातो के विविध रोगो मे हितप्रद, दात दर्द व उनका हिलना, मसूड़ो मे सूजन, खून या मवाद आना आदि कष्टो मे आदि कष्टो मे अद्वितीय, दातो को स्वच्छ, चमकीला एव मसूडो को मजबूत बनाता है। पैकिंग ३०, ५० तथा १५० ग्राम!

शिवानन्द प्लस उपसूल :

यह कैपसूल वात–पित कफ को सतुलित करके शरीर मे शक्ति पैदा करता है तथा खून साफ करता है, मधुमेह, किडनी हृदय की दुर्बलता मे भी सहायक है। यह कैपसूल शक्ति वर्धक टॉनिक है।पैकिंग ३०, कैपसूल।

आरथिरिड आयल :

यह तेल विभिन्न प्रकार के वात–विकार मे उपयोग किया जाता है। जैसे का दर्द, कमर दर्द और नाड़ियो की दुर्बलताओ के लिए विशेष महत्वपूर्ण है। (मालिश के लिए) पैकिंग ५०, मि० ली०।

ब्राह्मी ऑवला औषधीय तैल :

हिमालिय जड़ी–बूटियो से निर्मित यह औषधिय तैल का झडना, रूखापन आदि दूर कर केश रोगो को रोक कर बालो की जड़ो को शक्तिशाली बनाता है। मस्तिष्क एव नेत्रो को शीतलता प्रदान कर विकसित नेत्र–ज्योति तथा स्मरण–शक्ति को विकसित करता है। पैकिंग १०० तथा २०० मि. लि.।

हीलैक्स मलहस :

यह मलहस सूखी त्वचा, फटी ऐडियो और फोडे–फुसी, छाला आदि मे सर्वोत्तम है। पैकिंग : ३० ग्राम की टियूब।

इच्छुक सेल्स प्रतिविधि एवं स्टॉकिस्ट कृप्या लिखे

पता: मुख्य ऑफिस, १२ यमुना मार्ग, सिविल लाईन्स दिल्ली - ११००५४ फोन : २६४४६६१

निर्माण :- बी-३० झिलमिल इण्डसट्रियल एरिया, शाहदरा दिल्ली फोन :- २२८३२६७, २२८३०३७

Seventieth Report
on
Demand for grants 1998-99 (Demand No.41) of the Department of Indian System of Medicine and Homoeopathy (Ministry of health and Family Welfare)

EDITOR NOTE :-

Shri S.B. Chavan, Chairman of Department Related Parliamentary Standing Committee on Human Resources Development - The Committee base on 13 Member of Rajya Sabha and 43 members of Lok Sabha.

The Committee considered the various documents and relivant papers received from the department of Indian system of Medicine and Homoeopathy, Ministry of Health and Family Welfare.

The report was presented to the Rajya Sabha and Lok Sabha on 6th July 1998.

REPORT

INTRODUCTION

1.1 The National Health Policy of 1983 emphasised to initiate organised measures to enable each of the systems of Indian Medicine to develop in accordance with its genius and find an appropriate role and place for these different systems in the overall health care delivery system for the benefit of the people. India has a large resource of ISM&H practitioners whose services need to be fully utilised in the national health care delivery system. For this purpose, a new Department of Indian systems of Medicine and Homoeopathy (ISM&H) has been set up to promote and develop the Indian systems of Medicine (Ayurveda, Siddha, Unani, Homoeopathy and drugless Therapies like Yoga and Naturopathy).

1.2 The Indian Systems of Medicine and Homoeopathy have practically grown and developed in the Indian society on the basis of learning through family traditions of Guru Shishya Parampara, although a few colleges had come up in the late 19th century and the earlier part of the 20th century. There was practically no Governmental support to this systems. There were no regulations either, regarding the practice and educational standard. Patients used to approach these indigenous physicians on the basis of faith in their skill, knowledge and integrity.

1.3 However, after Independence, institutions like Central Council of Indian Medicines and Central Council for Homoeopathy were established to register practitioners in these Systems and to lay down minimum standards for education. The Central Council of Research in Ayurveda and Siddha, the Central Council of Unani Medicine, the Central Council of Research in Homoeopathy, the National Institute of Ayurveda at Jaipur and the National Institute of Homoeopathy at Calcutta have been set up as apex bodies for research and teaching. In order to formulate standards for Drugs, Pharmacopoeia Committees for each of these Systems were set up and supported by the Pharmacopoeia Laboratory for Indian Medicine (PLIM) and the Homeopathic Pharmacopoeia Laboratory (HPL) both located at Ghaziabad, U.P. The Central Council of Indian Medicine (CCIM) and the Central Council of Homoeopathy (CCH) are responsible for laying down and maintaining uniform standards of education and regulate the professional practices of the practitioners in the field of Indian Systems of Medicines and Homoeopathy, respectively.

II. EIGHTH FIVE YEAR PLAN

The Eighth Plan outlay for ISM&H was Rs. 88 crores. However, the annual allocations made

during the plan period come to Rs. 104.44 crores. The actual expenditure made by the Department is only 92.07 crores. The Plan allocations made could not be utilised fully during the 8th Plan period except in the first year i.e. 1992-93.

III. BUDGETARY ALLOCATIONS

3.1 The total allocation, both plan and Non-Plan taken together, provided to the Department for the year 1997-98 was Rs. 58.80 crores in BE which was enhanced to 66.45 crores at RE stage. The allocation made for the year 1998-99 is Rs. 85.60 crores (Plan Rs. 49.00 and Non-Plan Rs. 36.60 crores). The Committee finds that the Plan allocation has been increased only by Rs. 5.20 crores. The Committee is of the firm belief that ISM&H facilities need to be developed at a faster pace. It, therefore, recommends that Plan allocation should be increased at RE stage.

3.2. The Committee is happy to note that the Department has initiated some sort of monitoring system and activities undertaken by Research Organisations, National Institutes, achievement of targets. The problems are being examined every month and corrective measures are being taken. The flow of Budget under various schemes is also being reviewed quarterly. The Committee appreciates this and hope that effective monitoring will continue in the coming years.

IV. NINTH FIVE YEAR PLAN

4.1 A Working Group was set up by the Planning Commission for the development of Indian Systems of Medicine and Homoeopathy during the Ninth Plan Period. The Working Group after detailed study and deliberations formulated proposals for Ninth Five Year Plan suggesting and outlay of Rs. 1840.00 crores. Based on that, the Department formulated its proposals for Ninth Five Year Plan for the Rs. 1997.87 crores with programme - wise and scheme-wise break up and submitted the same to the Planning Commission for consideration. However, the Department was asked by the Planning Commission to slide down the proposed outlay due to resource constraint. After re-prioritising its schemes and programmes, the Department, accordingly, submitted the revised propsal for Rs. 1436.00 crores to the planning commission. On yet another request made by the planning commission to reduce the proposed outlay the Department again re-considerd its requirement and worked out the minimum required domestic budgetary support for the with in five year plan as Rs. 754.00 crores by phasing and deferring some of the schemes and sudbmitted the same to planning commission. However, even this minimmum requirement has not been agreed to by the planning commission an outlay of only Rs. 280.37 crores has been provided to the department. The secretary clarified that as ths outlay is woefully inadequate there is a genuine need for significant increase in plan allocation for the ISM&H sector as it has accumulated large deficiencies in almost all the vital areas.

4.2 The Committee is in agreement with the contention of the Department with regard to inadequacy of allocation. The Committee strongly feels that this meagre allocation will defeat the very purpose of setting up a separate Department of ISM&H. Though there might be some exaggeration in the proposal of Rs. 1998 crores for the Ninth Five year plan. The Committee fails to understand on what basis Rs. 280 crores was allocated to the Department, out of projections of Rs. 1997.87 crores which is just about 15% of its demand. The Committee feels that since the existance of this Department is vital to the health care of Indian masses it is imperative that adequate funds will have to be made available and if necessary, a re-appraisal of projections for the Ninth plan in respect of ISM&H may be considered.

V. AYURVEDA

5.1 The alloction made for Ayurveda was Rs. 20.25 crores in BE last year which was raised to Rs. 34.59 crores in 1998-99 (plan 10.54 corres and Non-plan24.05 crores). Explaining the reason for the increase it is mainly due to the allocation for Ayurveda, the Department submitted that it is mainly due to the enhances allocations for Central Councll for Research in Ayurveda & siddha (CCRAS). Besides meeting the expenditure on implementation of 5th pay Commission

Recommendations and continuing research activities, the enhanced allocation will be utilised for construction of building for various field units which could not be taken up earlier

5.2 The Committee has observed that plan allocation to CCRAS has been increased from Rs 495 lakhs to Rs 744 lakhs in the Annual plans of 1997-98 and 1998-99 respectively. The committee hopes that the increased allocation will be fully utilised in the developmental activities of Ayurveda

VI. UNANI

6.1 Under the allocation for the Unani system, plan provision was enhanced from Rs. 5.05 crores in BE 1997-98 to Rs. 5.40 crores in the RE and further a quantum jump to the leval of Rs. 8.55 crores has been effected in BE 1998-99. The Department informed that in 1998-99, besides the research activities the additional funds will be utilised for strengthening central Research Institute of Unani Medicine, Hyderabad, construction of building for RRIUM, Srinagar and Karimganj for which the land has already been provided by the State Govts. and acquisition of land and construction of building for RRIUM, Delhi.

The Committee hopes that all activities as envisaged will be undertaken during the current year.

6.2 The Committee is perturbbed to note that the construction work of the main building of the National Institute of Unani Medicine Bangalore has been delayed due to the decisions of the Governing body to start only PG courses instead of UG and both. The Committee recommends that this building plan be finalised expeditiously keeping in mind the future development of Unani system of medicine.

VII. HOMOEOPATHY

7.1 For Homoeopathy, the BE 1997-98 on the plan side was Rs. 5.11 crores which was increased to Rs. 6.94 crores at RE stage. In BE of 1998-99 it has been reduced to the level of Rs. 6.77 crores. When the Department was asked to explain the reasons for these variations, it was informed that in the RE 1997-98, a provision of Rs. 6.94 crores was made primarily to meet the arrears and enhanced pay and allowances on account of 5th Central pay Commission recommendations in NIT and CCRH where there are a number of plan posts. The liability of arrears to be paid to the employees during 1998-99 has become less and hence provision has been reduced.

7.2 The Committee notes with serious concern that expansion of NIH Calcutta proposed to be made during 1997-98 from 50 beds to 100 beds could not be taken up. The Committee is dismayed to note that the expansion of bed capacity does not find a place in the Annual Action plan for this year too. The Committee is not aware, except one time payment of Rs. 88 lakhs made to west Bengal Govt., on what other activities the amount of Rs. 253 lakhs released to NIH, Calcutta was utilitised. The Committee would also like to suggest that research on detoxication of arsenic poisoning being conducted by NIH, Calcutta should be intensified as this problem has severely affected west Bengal.

VIII. YOGA AND NATUROPATHY

8.1 For yoga and Naturopathy, the BE for 1997-98 on the plan side was Rs. 1.70 crores, which was reduced in the RE 1997-98. However, it has been increased to Rs. 3.95 crores in the BE 1998-99. When asked how it proposed to utilise the additional sum, the Department explained that due to non-finalisation of project report for Morarji Desai National Institute of Yoga (MDNIY) the founds provided for acquisition of land and construction of building could not be utilised. Now an amount of Rs. 170 lakhs has been provided in BE 1998-99 for MDNIY. During the current year, provision for MDNIY. During the current year, provision for MDNIY has been considerably increased on the decisions of the Department to set up re-acticite MDNIY. Besides this, allocation for CCRYN has also been increaesd from Rs. 75 lakhs in BE 1997-98 to Rs. 130 lakh in be 1998-99 to meet the committed liabilities.

8.2 The Committee feels that yoga be taught in the schools right from the primary Level. The Committee therefore, recommends

that the Department may take up this issue with the Departmant of Education.

8.3. Regarding Notional existence of National Institute of Naturopathy (NIN), pune, the Department submitted that compehensive project Report for establishment has been finalised and it will be shortly placed before the EFC. The Department futher submitted that a provision of Rs. 7 lakhs has been kept for the purpose and if required, it would seek additional alloction at RE stage. The committee would like to recommend that every effort should be made for early implementation of the project.

IX. MEDICAL EDUCATION

9.1. The Committee was informed that the standards of education in the ISM&H Institution are far from satisfactory. The facillities available are inadequate. They are no where near the norms fixed by the Statutory bodies. There is a mushroom growth of sub standard colleges. Though the norms for running the colleges and hospitals of ISM&H have been laid down but these are not fulfilled even by the state Government colleges in all respects. The shortcomings are mostly in non filling up of the posts of teachers, lack of adequate space, college builidings, hospitals, hostel facilities, equipped laboratories, library, medicinal plant gardens etc. The Secretary informed that as a policy, Government does not encourage setting up of new substandard colleges. Various conferences have passed resolutions that no new colleges be permitted during the 9th Five year plan period. This decision has been communicated to all State Governments so that attention is focussed on strengthening the already existing colleges.

9.2 The Committee was given to understand that Govt. Would notify the guidelines to establish a new college and also to prescribe the minimum standard for the existing colleges within 2 months after receiving the same from CCIM and CCH. Although the Department has received the recommendations of CCIM about the norms for phased manner development of new Ayurvedic colleges, the comment of the State Govts in this regard, are yet to be received. The Department futher informed that it is studying amendments made in the Indian Medical Council Act about the sub standard education and the mushrooming growth of sub standard medical colleges and the same would be taken into account before finalising the amendments. The Committee feels that speedy action is called for checking the growth of sub standard colleges and also having minimum standard of education in the existing infastructure.

9.3. Another aspect on which the Committee is worried is that there are ISM&H colleges where not even 20% of the students have passed. The results of such colleges range between zero to five percent and zero to ten percent consecutively and they have not shown any improvement whatsoever. The Committee feels that urgent steps needs to be taken to arrest this trend. The Committee would like to have a detailed State-wise information of such colleges.

9.4 As part of the continuing education and reorientation, training programmes for teachers, physicians and para medics have been undertaken. The State Governments have also been asked to take more interest in sponsoring teachers and physicians to these courses. However, the benefit is yet to fully reach the physicians and para medics.

9.5. The Committee was also informed that the Department is yet to tackle the need for para medic aducation in pharmacy and Nursing. Though some isolated courses are being conducted in pharmacy and nursing, they do not have Government recognition. There are no separate Statutory Councils for laying down the standards and norms for pharmacy and nursing colleges of ISM&H, the Secretary admitted. Project Reports have been prepared for pharmacy colleges of Ayurveda, unani and Homoeopathy. The Department is examining the feasibility of setting up separate Councils for pharmacy education in ISM&H. Another area of teaching is in the field of yoga and Naturopathy. There is no regulatory body for regulating the education in yoga and Naturopathy. Temporarily the Department has thought of entrusting the work to the Central Council for Research in yoga and Naturopathy.

9.6 The Committee recommennds that action should be intiated shortcoming by January, 1998. The Committee would like to know the latest position in this regard.

9.7 The Secratary informed the Committee that in order to check huge amounts of donation/ capitation fee being taken by some colleges as per guidelines of Supreme Court orders is being finalised actively. The Committee recommends that the Department should intensify its efforts in this direction.

X. POOR QUALITY OF DRUGS

10.1 The Secretary informed the Committee that the pharmacopoeial committees have been reconstituted recently and a thrust is being given to a time bound programme to complete the work of laying of standard for ISM&H by 9th plan period. At present two drug testing laboatories are providing the technical back up to these pharmacopoeia committees. There is also a need for setting up of Regional Drug Testing Laboratories. In order to accelerate the work of evolving of standards, 30 Research institutions' laboratories have been provided financial assistance for working on the standard for 10 drugs per year.

10.2 Although the pharmacopoeia Committees have been in operation for a long period, fool proof method of testing the quality of drugs has not been evolved so far. This is one of the weak areas which needs specific attention. The Committee feels that it is necessary to prescribe standards for ensuring efficacy of ISM&H drugs, in view of the fact that manufacturers of such drugs do not have sophisticated and latest technology for ensuring meticulous standards required for preparation of these drugs.

XI. NON-AVAILABILITY OF HERBS AND MEDICINAL PLANTS

11.1 The Department informed the Committee that it has initiated various steps to enhance the supplies of medicinal plants. These are conservation and preservation of medical plants. These are conservation and preservation of medicinal plants through in situ and ex-situ cultivation, developing tissue culture, storage in gene banks, developing large scale gardens of medicinal plants in co-ordination with concerned Ministries/Departments. A special scheme to proivide assistance to research organisations for development of agro techniques has also been introduced. 26 such organisations are participating in the scheme and 97 species of plants have been allotted to them. A component of R&D has also been included under the scheme to achieve better results. The Committee appreciates the steps taken by the Department and hopes that desired results would be achieved in this regard.

11.2 The committee feels that the Department may approach the States for exploring the possibility of earmarking some portion of forest lands for Ayurvedic and Unani colleges for development of medicinal plants.

XII. PATENT CELL

12.1 The Department informed the Committee that a major area of concern is the keen interest taken by foreign countries in the development of herbal products and intellectual property rights. Some of the well known medicinal plants of India have been patented abroad. In order to put a stop to these attempts, a Patent Cell has been formed in the Department.

12.3 The Committee is, however, constrained to note that the Patent Cell is functioning with inadequate manpower and various posts are lying vacant. The Committee, therefore strongly recommends that vacant posts should be filled up at the earliest. The Committee feels that this is a genuine case for substatial enhanced allocation.

XIII. RESEARCH AND DEVELOPMENT

13.1 There are 4 apex research councils which are carrying out research activities like clinical research, drug research, laboratory research, family welfare research, etc. The Central Council of Reaearch in ayurveda and Siddha (CCRAS) is the largest council with over 86 units spread all over the country. The Council has patented 18 ayurvedic and siddha drugs. The Central Council for Research in Unani Medicine (CCRUM) is another major research organisation having a network of 32 Institutions/units functioning in different parts of the country. This counil has also

developed some products and is in the process of patenting them. The Central Council for Research in Homoeopathy (CCRH) has a network of 50 institutions/ units located all over the country. However the Central Council for Research in Yoga and Naturopathy (CCRYN) has a very limited activity. It is providing grant to voluntary yoga and nature-cure institutions for running training programme. The Department also informed that the research Councils have been advised to have time bound research projects and to focus attention on National Health Programmes such as AIDS and Family Welfare etc. A new orientation is being given to the research activities.

13.2 The Committee was given to understand that it is not possible for the Research Councils to take up all the research work by itself. A Scheme of Extra Mural Research has been introduced under which financial assistance is provided for special research projects (slide) to accredited research organisations.

13.3 The Committee in its 61st Report has inter-alia observed that no research activity worth the name is carried out by the Research Councils. The Committee still has the impression that research activities have not picked up in these Councils in the desired measure inspite of increased allocation in the first two years of Ninth Plan. The Committee recommends that effective, monitoring of the research undertaken by these councils be made regularly and it must be ensured that the Councils do real work. The Committee desires that the Department should make afforts to publish the research activities that has been carried out so far by these Councils.

XIV. PUBLICITY

14.1 The Committee was informed that a number of measures have been taken by the Department for giving wide publicity to merits of ISM&H Systems. NGOs have also been involved in spreading the message. The Committee, however, feels that adequate attention has not been paid to this aspect and their is a greater need to focus on the utility of ISMH particularly in chronic diseases and even in those areas where allopathy has not succeeded sofar. There is thus an equal need for enhancing the allocation proporti- onately.

14.2 The Committee expressed its serious concern over the fact that a lot of misleading advertisements appear in the newspapers and on radio and television on magic remedy drugs. The Drug Controllers of the States have been advised to take stringent action against such misleading advertisments, the Department informed.

XV. COMMITTED LIABILITY

The Committee in its 56th Report had recommended that the Department should make a through review of the schemes and identify the committed liability. In this matter, the Committee considered the Report of the Tenth Finance Commission. The Tenth Finance Commission have observed as under :

"Although the Tenth Finance Commission have gone by their terms of reference in deciding the cut off date for transfer of committed liability on account of plan scheme, the incremental liability on account of plan scheme, the incremental liabilities that would arise in 1997-98 on account of 8th Plan scheme completed in the next two financial years would have to be provided for. The Commission are, therefore, of the view that the Planning Commission may consider providing for the maintenance of such schemes till 1999-2000 in the Plan itself as was done for the schemes of the two Annual Plans of 1990-91 and 1991-90."

The Committee in this connection heard the views of the Secretary, Department of Expenditure last year to clarify the position. He informed the Committee that even though communications were sent to various Ministries the Ministries could not identify the committed expenditure on time. Accordingly a lumpsum amount has been provided under Demand No.31. The Secretary also assured that if required more funds for this purpose will be provided at the RE stage. He also stated that the Departments may approach the Department of Expenditure for their share.

The Committee notes that the Department has informed that

the Budget proposals for Revised Estimates 1996-97 and BEs 1997-98 both Plan & Non-Plan were framed in accordance with the guidelines of the Planning Commission. The Budget proposals for 1997-98 (being first year of the 9th Five Year Plan period) inter-alia included the committed liability of the order of Rs. 11.90 crore as a result of completion of some schemes/creation of some posts during 8th Five Year Plan period. As the amount was not agreed to be allocated in 1997-98, the matter was taken up demi-officially at secretary and Minister level with Ministry of Finance who somehow did not agree there-to.

The Committee views with concern that the Finance Ministry has not honoured such clear cut commitment made before the Parliamentry Committee. The Committee, therefore, recommends that the Department of Education should get the assurance immplemented without any delay.

RECENT ADVANCES IN RESEARCH IN AYURVEDA

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The Process of development of Ayurveda, since the ancient times, is very well reflected in the literature of Ayurveda. Newer theories, approaches of treatment and introduction of newer drugs have been a continuous process. Most of important developments, in post independence era. The important developments in the field of policy planning, infrastructure and facilities along with newer therapies/drugs putforth in last 50 years will be discussed in this article.

On the eve of Independence the Conference of Health Minister of States in 1946 resolved for the applications of scientific methods of investigations for the developments of Ayurveda with reference to maintenance of Health and prevention of diseases. The Chopra Committee(1948) identified the objective and areas of research in Ayurveda. These recommendations were largely designed to isolate active ingredients from medicinal plants though research on fundamentals and literary aspects were also recommended. Research projects in eminent Ayurvedic Colleges were Launched as a follow up measure. A Central Research Institute for Ayurveda was established in Jamnagar in 1953. Later a post - Graduate teaching programme was also established in 1956 at Jamnagar.

The research objectives were more precisely defined by Udupa Committee in 1958. The importance of Diagnosis as per Ayurvedic methods was also emphasised A post Graduate Institute of Indian Medicine was established in 1963 in BHU, Varanasi. Much more emphasis was laid on research programmes. The research scholars and teachers were well acquainted with modern methods of investigation. Some clinical and experimental studies were taken up in this Institute.

Composite Drug Research Scheme was started in 1964 under I.C.M.R. with the sole objective to isolate and develop phyto-chemical plant products as drugs. This multidisciplinary research programme could not contribute any such product despite tremendous effort.

Vyas Committee (1966) Stressed on the role of Ayurvedic physician in research in Ayurveda. The Ayurvedic physician was required to be well acquaint himself with research methods.

The Govt. of India finally established a Central Council for Research in Indian Medicine (CCRIMH) in 1969. Simultaneously Post Graduate Courses were also started in selected subjects in selected colleges. The CCRIMH took up research programmes in its own Institutions of Ayurveda, Unani, Homeopathy, Siddha. The Central Council for Research in Ayurveda and Siddha (CCRAS) came in existence in 1978 as a result of reorganisation of CCRIMH.

The Clinical studies persued through CCRIMH/CCRAS putforth many effective drugs and procedures for management of many important diseases. Some important achievements are discussed herewith

SOME LANDMARKS IN AYURVEDIC RESEARCH

1946 Application of Scientific methods for Ayurveda for its application in maintenance of Health and Cure of diseases-**Health Ministers Conference.**

1953 Central Research Institute for Ayurveda at Jamnagar, **Pandit Committee.**

1956 I.G.P.T.R. at Jamnagar

1958 Categorised research as Clinical Literary, Botanical, Chemical, Pharmcological and Basic Principal of Ayurveda-**Udupa Committee.**

1960 Central Council for Ayurvedic Research.

1963 Post Graduate Institute of Indian Medicine, BHU, Varanasi.

1966 Emphasis on Orientation of Ayurvedic Physicians in modern methods for research in Ayurveda-**Vyas Committee**

1969 First Research Organisation for Ayurveda, Siddha, Unani & Homeopathy and Yoga-**Central Council for Research in Indian Medicine and Homeopathy.**

1975 First National Institute for Ayurveda at Jaipur

1978 Central Council for Research in Ayurveda and Siddha.

C.C.R.A.S.

1994 Deptt. of ISM & H, Ministry of Health & F.W.

RESEARCH PROGRAMME BROAD OUTLINE

RESEEARCH ACTIVITIES

The research activities in Ayurveda have been broadly categorised as under:

1. CLINICAL RESEARCH

a) Clinical therapeutic trial. Evaluation of selected Single drugs, simple herbals, and herbo-mineral combinations.
b) Diet
c) Prakriti and Agni etc.
d) Drugs preparation/Pharmacy.
e) Health Care Research Services including Research Oriented Survey and Surveillance. Community/Tribal Health Care Research Programme.

2) DRUG RESEARCH

a) Medico-botanical Survey, Identification/Location, Cultivation, Herbarium and Museum.
b) Drug Standerdisation and Rasa Sastra.
c) Scientific investigations-Pharmacognostical, Chemical and Toxicological Studies.
d) Musk deer breeding.

3) LITERARY RESEARCH

a) History of medicine.
b) Documentation/Publication
c) Revival of Oriental Literature.

4) FAMILY WELFARE RESEARCH PROGRAMME

a) Clinical Evaluation.
b) Pharmacological and Toxicity Studies.

A brief review of the activities and achievements under these research programme is provided here under :

Clinical Research Programme

Clinical Research in Ayurveda and Siddha include fundamental studies, therapeutic studies and health care research studies. Sofar fundamental studies on the concept of Agni as related to the treatment of Grahaniroge (Sprue/malabsorption Syndrome), study of Prakriti both in health and disease situations and study of the effect of selected dietary articles pescribed in Ayurveda have been carried out. The clinical therapeutic studies to assess the efficacy of single drugs, compound formulations and herbo-mineral preparations in the management of about 50 clinical conditions have been carried out. Studies carried out so far have resulted in evolution of durgs like AYUSH-64 for "Malaria". AYUSH-56 for "Epilepsy" and "Solamarine" an Anti cancerous drug which have been patented. Coded drugs like AYUSH-82 for Madhumeha (Diabetes mellitis), AYUSH-55 for Medoroga (Obesity) and AYUSH-57 for Switra (Vitiligo) have demonstrated their efficacy. Efficacy of a number of other drugs like Guggulu and its preparations in the treatment of Medoroga-Medodosha (Obesity lipid disorders), mandukaparni in mental retardation, Katuki in liver disorders and 777 oil in psoriasis have been established besides standardisation of " Ksharsutra techniques" in the treatment of Bhagandra/Arsha and "Amashya sodhan chikitsa" in the treatment of parinamasula (Acidpeptic diseases). During the execution of these programme incidental medical aid have been extended to 46.25 lakh patients at OPD level and more than 35,400 patients at IPD level. Efforts have also been made to consolidate the work carried out so far and publish the same in the form of monographs Ten monographs based on these studies have been published.

HEALTH CARE RESEARCH STUDIES

Health Care Research studies being carried out by the council include Service Oriented Survey and Survreillance Research Programme, Community Health Care Research Programme and Tribal Health Care Research Programme. Priorities of research should have a wider utilitarian base and should flow to the nook and corner of the country. These Programme envisage collection of data pertaining to the nature and frequency of prevalent diseases, food habits with regard to different seasons, socio-economic factors, natural resources, the standard and type of treatment available to rural/tribal folk besides collection of folk medical claims. Under these programme the villages/tribal pockets and provides incidental medical aid besides collecting requisite the ways and means of healthful living and about the therapeutic usefulness of the herbs locally available in combating minor ailments. About 600 villages/tribal pockets consisting of total population of more than 8.25 lakhs have been covered so far. Incidental medical aid patients from neighboring villages/ tribal pockets. A monograph entitled " Study of Health Statistics under moblie clinical Research Programme (Ayurveda)" resisting out of these studies have been published. keeping in view the emphasis being laid down by the Government more efforts are

made to see that the benefits of research reaches to the common man specially weaker section of the society.

Drug Research Programme

The Programme connected with various aspects of drug research have been taken up through medico botanical survey, cultivation of medicinal plants, multi-disciplinary research programme which envisages pharmacognostical chemical, pharmacological/ toxicological studies and drug standardisation studies.

Medico Botanical Survey

Medico botanical survey mainly include identification, collection and supply of medicinal plants besides actually locating zone of the distribution of particular drugs. So far 350 forest areas have been explored and more than one lakh plant specimens respresenting a large number of different families, genera and species have been collected. About 1600 drug samples of plant origin, mineral and animal origin have been collected and added to the Museum of Institutes/Centers. During survey of medicinal plants information on 3800 folk lores have also been collected and a monograph covering about 2900 folk lores have been compiled. The Council has also taken steps to establish a Central Medicinal Plants Herbarium and Museum in the New Building Complex at Janakpuri. Consolidation of work carried out so for has resulted in to publication of four monographs on Medico-botanical Survey.

Cultivation of Medicinal Plants

The Council has initiated steps for developing medicinal plants gardens/farms at Jhansi (U.P.), Mangliawas (Rajasthan), Pune (Maharashtra) and Ranikhet (U.P.), for experimental as well as small scale cultivation of medicinal. These farms have taken up experimental small scale cultivation of about 500 medicinal plants species including saffron and guggulu. Efforts are being made to strengthen the Medicinal Plants Garden at Jhansi, Poona, Itanagar besides undertaking a new project at Mettur (Tamil Nadu) for medicinal plants used in Siddha system of medicine. During the VIIIth Plan period emphasis will be laid on expansion programme for Musk Deer Breading Project and cultivation of herbs at Dhramgarh (Tarikhet) and new areas will be explored.

Pharmacognostical Research Studies

The Pharmacognostical Research studies cover elaboration of details in respect of their origin, botanical identification and correct determination, Ayurvedic nomenclature including synonyms together with properties, botanical descriptions and key characters besides detailed structural examination of the plant together with changes in the content of the active principle depending on ecological variations besides the analysis of powdered drugs which helps in checking adulterations to a significant level. Pharmcognostical investigations on about 170 important Ayurvedic medicinal plants/drugs mentioned in Ayurvedic formulary Part-I have been completed so far. Pharmacognostical studies of 25 drugs used in Siddha and identification of 33 plant drug ingredients of the formulations of National Siddha Fromulary Part-I have also been carried out.

Chemical Research Studies

Since most of the drugs used in Ayurveda come from herbal source, it becomes imperative to isolate and know the active ingredients which claim to possess the therapeutic potentiality. Phytochemical research studies hold key in this field and it provides clue or a finger print for drug action. On many occasions, one finds presence of two antagonistic factors in the crude drugs one that is active and the other which has lowering or nullifying effect of the other and it has advantages since it checks any untoward or adverse effect that the highly active constituent can cause. It is perhaps the reason why Ayurveda largely advocated use of crude drugs and not isolates. The chemical research studies are carried out using a wide range of organic solvents and current phytochemical teachniques. So Siddha System of Medicine have been Carried out. A monopgraph entitled "Phytochemical investigation of medicinal plants used in Ayurveda" covering 205 drugs has been published.

Pharmacological and Toxicological Research Studies

The active principles/fractions isolated during Chemical Research studies have been taken up for systematic pharmacological screening to evaluate their general pharmacological profile and specific potential claimed in experimental models alongwith toxicological studies. The toxicity studies are invariable components in the programme since the drugs are ultimately to be used clinically. So far more than 370 drugs used in

Ayurveda and Siddha including single drugs, compound formulations and coded drugs have been investigated in vivo and vitro experimental models for routine pharmacological screening as well as for specific effects e.g. analgesic, anti-pyretic, anti inflammatory, anti histaminic, CNS depressant, hypolipidaemic, cardio-vascular, antiulcer and adoptogenic effects etc. besides acute and sub acute toxicity studies. A monograph entitled "Pharmacological Investigations of certain Ayuvedic and Siddha Plants" covering 246 drugs have been published.

Drug Standardisation Research Studies

The Standardisation studies include stnderdisation of single drugs, processes of manufacture of formulations and finished preparations/formulations such as Rasa, Taila etc. besides other ancillary studies like shelf life, role preservations etc. So far physico-chemical values/ data for about 500 single drugs, detailed standardisation values for 50 formulations and rapid analytical values for about 675 formulations of the I and II volume of Ayurvedic Formulary of Government of India, Rural Health Scheme kit medicine and the medicine included into WHO medicare programme have been laid down desides studies relating to the standardisation of method of preparations/formulations such as Asava, Arishta, Bhasmas, Tailas, Churnas etc. The Council has brought out almost a new edition of Pharmacopoeial Standards for Ayurvedic Formulation. As a second phase of studay, a scheme has been drafted to eveluate detailed anaytical studies of the formulations to find out the composition and percentage of the important ingredients used and to prepare the formulations in various different proportionate combinations other than the standard formulary (Ayurvedic Formulary of India) and to study whether there is variation in the composition and percentage of the constituents in formulation and to derive a characteristic isolate from the standard formulation and their identification on about 60 simple formulations. Standardisation studies on 80 single drugs and 50 finished products used in Siddha have also been carried out. During VIIIth plan period more emphasis will be put on quality control, Standardisation, Shelf Life studies of the Ayurvedic and Siddha drugs.

Musk Deer breeding Programme

The Council has been maintaining a Musk Deer Breeding farm at Maharuri (Dhramgarh 1200 m.a.s.l.) where breeding of musk deer in captivity is in progress. At present there are 19 animals.

Literary Research Programme

In this field, efforts have been made to translate/scrutinize, edit, publish and microfilm the old and rare literature. Collection of references on drugs and diseases by preparing bibliographical documents from information available in the biomedical journals is made so that the research workers engaged in different programme can have easy access. The Council has published critical editions of bhela Samhita,Bhaisajyakalpa, uttarakhand of Astanga-Sangraha and Sabdachandrika. The work on Sahasra Yoga from original Malayalam to Sanskrit and Hindi has been completed and got printed. The work om Abhinav Chintamani has been completed and efforts are in process to get the same printed. The medico historical studies related to ancient authors of Ayurvedic texts collection of Medical and allied sanskrit literature and non medical resources have resulted into drafting of catalogues and other material useful for reference and guidance. Information on about 350 drugs and 10 diseases have also been compiled.

Literary Research in Siddha include publication of 10 books, collection of 318 cudjan leave and 23 old books.

The Council has published about 80 books/monographs and Proceedings. The council is also publishing quarterly "Journal of Research in Ayurveda and Siddha" and a "Bulletin of Ethno-medico botanical Research" besides half yearly "Bulletin of Indian Institute of History of Medicine".The Council is also publishing a monthly/bi-monthly news letters to appries the scientific community with on going activities of the Council.

The Council has brought out a booklet depicting the activities and achievments of the Council. A video film " Resurgence" on different research activities of the Council was telecasted by Doordarshan Kendra New Delhi on 20th July 88. Few functioning under the Council have also been produced. It has also been organising Training programme for its research workers.

Family Welfare Research Programme

Clinical screening and

Pharmacological studies of the oral contraceptive agents are being carried out under this programme. The Clinical research studies are carried out for evaluation of the recipes as oral contraceptive agents to establish their known antifertility activities whereas pharmacological research studies on experimental animal models are carried out to establish mainly their anti implantation, anti ovulatory as well as effects on oestrous cycle besides toxicity studies of certain drugs. So far 12 recipes at clinical level and about 25 drugs through pharmacological studies have been attempted. The Council has taken up a folk lore drug Vandhyavri (vicoa indica) used by Adivasis of Sakhodeora and other neighboring villages in Bihar State as an anti fertility agent for an in depth interdisciplinary investigation of the claim. The work carried out sofer under this programme has been compiled and analysed and efforts are in process to prepare a monograph based on this information.

A STUDY OF THE EFFECTIVENESS OF A PACKAGE OF AYURVEDIC SERVICES IN THE MANAGEMENT OF PUERPERIUM.

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Editor Note :
Puerperium is known as first Six weeks period after child-birth. Maternal health seruices are based on Ante-Natal Care, delivery care and Prost-Partum Care. In the developing countries, the risk of death from pregnancy to puerperium period is 1 in 48 women while it is very negligible (1 in 1800 women) in developed countries. This rate may become remarkably low if proper medical care is provided during pregnancy. Most maternal deaths occur either during pregnancy or in puerperium period, As a result 0.5% to 1% serviveing children die in their infantile life and the surviveing lack proper medical, heath & mother care.
The ISM's natural & holistic approach can contribute considerably to bring down these alarmingly high death rates of mother & child both.
Recently, a workshop sponsored by W.H.O. was held on 15-5-97 on this study.

Introduction

The period following childbirth is termed as puerperium and the duration of puerperium is about six weeks. This period is extremely dangerous and can be classified into High-Risk period. i.e. first seven days, and Remote period, remaining thirty five days. Most maternal mortality and morbidity take place during the first six weeks after the childbirth. Certain psycho-somatic changes such as, loss of weight, loss of strength, loss of blood, loss of body fluids and mental stress, etc. take place during the puerperium. Most of the changes lead to different types of maternal health problems. According to Ayurveda, most of these chagnes lead to ATI-APATARPANA (poor-nutritional status) of the mother during puerperium. This status cause VATA-VRIDDHI, (accelerated Vata Dosh), which is responsible for different types of health problems. Such as puerperal-sepsis (Sutika Jwar). anaemia (Pandu). Prolapse of uterus, etc. The following diagram shows the interrelation as stated above.

The surveys of the National Nutrition Monitoring Bureau (NNMB) indicate that a large proportion of women are undernourished. The general resistance or immunity of the mother is also reduced due to childbirth process. The uterus provides an ideal environment for the growth of organisms. Thus, puerperal-sepsis (SUTIKA JWAR) is most common ailment in this stage.

The management of puerperium is necessary (a) to avoid casualty, occurance of infection. Severe anaemia, etc. and (b) to promote the rapid and early recovery of the maternal health so that the mother may be able to resume her normal activities as early as possible Accordingly, the concept of puerperium management in term of appropriate care can be made applicable as well as feasible.

A substantial number of deaths and status of maternal morbidity after delivery can be reduced by developing an appropriate package of Ayurvedic services. Puerperium management has been defined in this study as a process of (i) providing adequate care of mother in terms of diet, exercise, rest and commonly used harmless herbs as well as of (ii) testing the efficiency of such a package of services. Therefore, the management of puerperium is one of the most significant and challenging concept. The present study was an attempt to examine the effectiveness of this package of Ayurvedic Services in the management of puerperium.

OBJECTIVES OF THE STUDY

(A) GENERAL : The overall objective of the study is to promote maternal health and to achieve the goal of "HEALTHY MOTHER" through a package of Ayurvedic Services.

(B) SPECIFIC : (i) To assess the effectiveness of a package of Ayurvedic services in the management of puerperium.
(ii) To recommend to the Health-

authorities for implementing appropriate additional strategies on the basis of, and subject to, relative effectiveness of the above package.

(B) VARIABLES

The study had the following independent, dependent and treatment variables. While the independent variable were kept as far as possible constant or controlled (as causal variables), the dependent variables were examined to gauge the effects of independent variables. in fact, when the independent variables have been kept constant, the impact of the third variable, i.e. treatment/ experimental/intervention variable was more perceptible or measurable through the changes in the dependent variable.

1. INDEPENDENT VARIABLES : There were the following independent variables in the present study

(i) Gravida/Para : Numbers of deliveries in each of primary-para, secondary-para and tertiary-para. The present study was restricted upto third deliver of, i.e. tertiary-para

(ii) Age : Keeping in view the general trend of pregnancy at different ages in Indian women, the age group ranging from 19 years to 35 years of mothers was taken for the entire sample.

(iii) Occupation : (employed/self-employed and housewife)

(iv) Social-economic status : This variable has been classified again into following groups (a) Social status i.e., (i) S.C./S.T., (ii) O.B.C. and (iii) General (other) caste, (b) Economic status, e.e., (i) L.I.G. (monthly income upto Rs. 2000/-), (ii) M.I.G. (monthly income from Rs. 2000 to Rs. 3500) and (iii) H.I.G. (monthly income beyond Rs. 3500), (c) Level of education, i.e. (i) Illiterate (uneducated), (ii) Matriculate and below, and (iii) Above matric standard, and (d) Diet habits, i.e. (i) Vegetarian and (ii) Non-vegetarian

2. DEPENDENT VARIABLES : The following were the dependent variables or indicators to carry out the present study :

(i) Body-weight : Body weight of the mother was recorded firstly within 24 hours of the delivery (child-birth) then the weight was taken every week in the morning before break-fast. The unit of weight was in kg.

(ii) Haemoglobin : Haemoglobin (Hb) level was estimated in grams/100 c.c. of blood, as well as in percentage with the help of Sahlis haem-oglobinometer, firstly, within 24 hours of delivery. Then measurement of haemoglobin was recorded every fortnightly.

(iii) Body Strength : The perceived subjective body-strength was tested by an instrument, namely, wrist-grip fixed with 5 point rating-scale, resumption of her normal activities, hunger and bowel habits.

(iv) Cheerfulness : The cheerfulness was observed and confirmed by interview on the basis of the gender of the newborn baby, previous record of her daughter/son and physical-mental status of the mother.

(v) Puerperal Sepsis : Occurance of infection, specially puerperal sepsis, was observed. The temprature and pulse rate were recorded every day, preferable twice a day during the first week of puerperium. Besides, mother's subjective report was collected every week regarding temperature and pulse rate including the lochia/vaginal discharge, if any

3. EXPERIMENTAL OR TREATMENT VARIABLES : Since the main experimental variables have been treated in terms of an intervention or a package of Ayurvedic services, whose influence has to be examined upon the dependent variables

Intervention Through A Package of Ayurvedic Services : According to Ayurvedic principles, the recovery process could be accelerated and period of recovery could possible be reduced, if the package of Ayurvedic Services during puerperium is applied. It is quite possibly that the mother could regain her weight, original strenght, potency and cheerfulness in a shorter period , if the following package of Ayurvedic services, is adminstered :

(i) Edible Ayurvedic Herbs
(ii) Abdominal Belt
(iii) Massage
(iv) Exercise

The above package of services was administered in the present study along with monitoring and evaluation of mother's health status concurrently right after the delivery of baby.

DEVELOPEMENT OF TOOLS FOR DATA COLLECTION

(i) History Sheet & Progress report : In order to collect relvant information and specific data for the study, initially a comprehensive chart was developed with the help of Deputy Medical Supdt/Subject Expert of the Faculty and the same was

finalized with some modifications by Project Advisory Committee (P.A.C.) before the Pilot Study.

(2) Temprature Chart : A separate chart to record the temperature, pulse rate, blood pressure and excreta was introduced. These examinations were carried out by qualified physicians and record was maintained by nursing personnel, like other hospitals during hospitalization of the mother.

(3) Laboratory investigation Reports : Routine examination of blood for D.L.C., T.L.C., Hb% and total R.B.C. count was done in the attached laboratory. Urine, stool and other examinations were also done on the request of the Physician.

(4) Wrist-grip with scale : An instrument called wrist-grip, commonly used for the exercise of wrist, was modified by adding a 4 point rating scale on one of its leg. This measuring scale was divided into four divisions by putting different colors, i.e., the red color showed the poor status of the subjective strength, while the blue color was for fairness, black showed good result and yellow was for very good result. On applying the wrist pressure, if the pointer touches the end point of yellow color, it would show the excellent result of the subjective strength.

(5) Questionnaire : To record the status of subjective cheerfulness, a detailed questionnaire was also prepared in advance before starting the Pilot Study. This was filled up by the Project Officer/Asstt. Project Officer during the weekly visits of the mother.

PILOT STUDY

First of all, the pregnant women, attending the hospital for ante-natal care (A.N.C.), were registered for Pilot Study. Twelve such cases, which made the 25% or 1/4th of the total number of the proposed sample of E.G., were included in the Pilot Study. These women of E.G. were exposed to the package of Ayurvedic services fo six weeks. The clinical examinations including laboratory investigation were carried out apart from routine tests, i.e., temperature, pulse, blood pressure, weight, etc. by the qualified personnel as suggested in the proposal.

The body weight, level of haemoglobin, perceived body strength and cheerfulness of the respondents were all imporved remarkably after a month. During this period, no case of puerperal sepsis was reported. The mothers regained their strength and weight in a shorter period, i.e. by the end of 4th week of the puerperium is spite of the fact that the level of Hb, showed only moderate result. Moreover there was no adverse affect of Ayurvedic medicines on the mothers of E.G. during the intervention of this package.

DATA PROCESSING AND ANALYSIS

Since the present study involved a quasi-experimental design, it was necessary to compare the repondents of E.G. with C.G., i.e. between those who were exposed to intervention of a package of Ayurvedic Services and those who were not. First of all, the total count and percentages were worked out on the basis of the independent variables, i.e., parity/ gravida, age, occupation and socio-economic status (S.E.S.) of the mothers with the help of computer. The S.E.S. was determined by a composite ten point score.

So far as the analysis of the data on dependable variable was concerned, the raw-data were obtained in the form of raw score first, and then the Mean/Average, Standard Deviation (S.D.) percentages, etc. as the case may be, were worked out for both the groups were statistically worked out by means of the I-test or critical ratio.

FINDINGS AND ACHIEVEMENTS

First of all, the findings on the various characteristics of the sample in terms of independent variales, i.e. parity, age, occupation and socio-economic status (S.E.S.), for both the groups were presented with a view to observe the extent to which both the groups were comparable. The purpose of this exercise was to control the extraneous variables or errors, so that the true effects of intervention in term of a package of Ayurvedic services upon the dependent variables, i.e., weight, haemoglobin, body strength, cheerfulness and absence of puerperal sepsis, may be isolated.

Demographic and Socio-economic profile of the sample

1. Parity/gravida : It may be recalled that there were 53 mothers in the E.G. and 51 in the C.G. out of the total of 104 mothers in the final sample. Considering the size of both the groups they were comparable indeed. Not only this, further breakup (subgroup) of each independent variable in terms of gravida, namely, primary, secondary, and tertiary the numbers in each of the subgroup of both E.G. and C.G. were also

comparable.

2. Age : The average age of the mothers in the E.G. was 2.43 years which was quite comparable to the average age of the mothers in C.G. which was 2.42 years. The mean age of both the groups was also representative considering the smaller magnitude of standard deviation (S.D.) of 2.97 for E.G. and 2.72 for C.G. Here therefore both the groups had a good matching on age.

3. Occupation : An overwhelming majority (97.12 percent) of mothers in the total sample were House wife. Only a fraction of them (2.88 percent) were employed or self-employed. Thus, both the groups were perfectly matched.

4. Socio-economic status : In fact 44.23 per cent and 55.77 per cent mothers were from the middle and the upper S.E.S., respectively. Similarly, out of the total obtainable score of ten, the Mean S.E.S. score of the total sample was 6.72 indicating that relatively higher percentage of respondents were on the upper class of S.E.S. and their distribution was more reliable and consistent inview of lower S.D. of 1.42. As regards the S.E.S. difference between the E.G. and C.G., the same was almost negligible when compared to Mean S.E.S. score of 3.92 with 6.53. Therefore the main respondents of this study were confined to middle and upper S.E.S. who were evenly distributed among Experimental and Control Groups.

The overall Effect of Intervention upon Dependent Variables :

During the period of puerperium, the package of services was administered to the mothers of E.G. at specified intervals and accordingly, at the end of each week, the changes in all five dependent variables were also recorded while the package was administered to E.G. the changes were recorded from both E.G. and C.G. The main changes in terms of loss or gain as well as the weekly Net-gains in the E.G. were recorded. The S.D. and the *I*-ratios were also worked out in order to indicate the statistical significance of difference between the Means of E.G. and C.G.

WEIGHT : There has been considerable loss in weight in the C.G. during the 1st 2nd and 3rd weeks successively and only from 4th week the mothers started gaining some weight progressively while in the E.G., the partial loss was confined only to first week, there was a progressive gain in weight every week, from 2nd week onwards upto 6th week, attaining a gain of 1.67 kg. at the end of 6th week (as compared to 0.74 kg. in the C.G.). Thus, what the C.G. gained after six weeks, the E.G. gained the same in the 4th weeks itself. Thus, the intervention was very successful in terms of rapid and substantial recovery of weight among the puerpera.

HAEMOGLOBIN : The gains in the haemoglobin was worked out throught two indicators, the first was change in Hb, and the second was the total Hb, level in percentage. The total Hb level had a base in terms of percentage points immediately within 24 hours of the delivery. The subsequent increase in the Hb, level was calculated at the end of 2nd , 4th and 6th week. The change in Hb, had been worked out by deducting the base value from the later values. So far as the level of Hb, was concerned, the net-gain worked out for the E.G. was statistically very significant at the end of sixth week as compared to C.G. In other words there is a substantial gain of 1.6gm per 100cc of blood from the initial period to the end of intervention. In terms of percentage point this difference of 11.18 was also very significant. The difference in the C.G. was not so significant as it only increased from 8.8 gm. to 9.8 gm per 100cc fo blood. In fact, the maximum gain which C.G. mothers obtained at the end of 6th week, was already obtained by E.G. mothers during the 4th week

BODY STRENGTH : The G.G showed a very significant increase (1.53, Net =0.45, and t-value=5.39) in the rating immediately after first week. Although the C.G. continued to increase from the 3rd week onwards to have positive perceived body strength, however, its increase was gradual as compared to E.G where it was progressively greater It may be noted that the C.G. remained in its perception of body strength between poor to fair , while the E.G overcome the poor perception and remained fair between 2nd to 4th week and from 5th week it came in the range of good rating and eventually it increased the good rating (M-3.02) at the end of 6th week. Thus the result shows that the body-strength also increased as a consequence of the package of Ayurvedic Services

CHEERFULNESS : The dependent variable had a 4 point rating scale and the entire sample ranged from a mean score of 1.17 (poor) within 24 hours of delivery, to 2.94 (good) at the end of 6th week. Both the groups rated themselves as poor upto the end of 1st week, however, what the C.G. achieved in the 3rd week (M=1.69) the E.G. attained at the end of 2nd week itself (1.68), thereafter there was a progressive increase in subsequent weeks - although slowly in C.G. and with rapid pace in E.G. so much so that C.G. reached an average rating of 2.82 at the end of 6th week, the E.G. has already achieved M=2.94 rating (good) at the end of 5the week. In any case, the intervention, i.e. package of Ayurvedic services, did have a positive impact upon such a psychological nature of variable as the cheerfulness of the puerpera and the difference in the cheerfulness is significantly greater in the E.G. than in the C.G. Thus, the theory of overall psychosomatic promotion of health is corroborated by this intervention.

PUERPERAL SEPSIS : It was gratifying to note that no case of puerperal sepsis was recorded in the Experimental Group, while in the Control Group four cases of puerperal sepsis, out of the total sample of 51 mothers, were recorded during the first week fo puerperium. The cases of puerperal sepsis were moderate in nature. Most probably due to intervention of this package of Ayurvedic services, the immunity of puerpera has been increased, that is why the bacteria causing puerperal sepsis could not affect the mothers of the Experimental Group.

The effect of each independent variable upon the individual dependent variable.

The overall effect of intervention, i.e. a package of Ayurvedic Services, upon each of the five dependent variables, namely, weight, haemoglobin leve, body strength, cheerfulness and absence of puerperal sepsis, has been examined. It has been found that the E.G. has benefitted considerably and significantly in restoring its health on all the parameters when compared to the C.G. In the light of these findings it was in the fitness of things to have an analysis with a view to examine the effect of independent variables upon the dependent variables. For this reason, the effects of parity, age, occupation and socio-economic status have been examined separately upon the individual dependent varibale. Further, to find out the maximum effect of independent variables upon these dependent variables (except puerperal sepsis, as no case was recorded in the E.G.), each independent variables was also examined throught its sub-groups. It was found that the mothers of the secondary para in the E.G. were benefitted signifcantly as compared to primi and tertiary para subgroups, in respect of gain in weight, perceived body strength and haemoglobin level, while the rating point of cheerfulness was assessed as better among the mothers of secondary as well as tertiary paras.

In regard to the subgroup of age, the body weight had increased remarkably (i.e. 1.71 kg.) in the age-group of 19-23 years as compared to other subgroups in age. While the effect of body strength and cheerfulness was significant in the subgroup of 29 years, the level of Hb was found maximum, i.e., 76.85 percent (about 11 gm percent) among the mothers of 24-28 years subgroup in age.

In so far as the effect of S.E.S. was concerned, the mothers of upper S.E.S. subgroup regained their weight and body strength in a shorter period after childbirth. Further, the quantum of increase in weight and in body strength, i.e. 1.69 kg and 3.03 rating point, respectively was statistically significant in upper S.E.S. as compared to the middle S.E.S. So far as the question of cheerfulness was concerned, the level of cheerfulness was almost equal in both the upper and middle S.E.S. although the Hb level was measured more i.e., 77 percent (11gm per cent) in the middle S.E.S. in comparison to the upper S.E.S.

The main objective of this study was to promote the maternal health status and to assess the efficacy of the intervention, i.e,, a package of Ayurvedic services int he management of puerperium Considered from this perspective, the findings of this study have demonstrated that the package has indeed, been effective in the early restoration of not only health, but in regaining a better health status also.

SUGGESTIONS AND RECOMMENDATIONS

The foregoing analysis of data and discussion of results in the preceding Chapter have evidently indicated that the major objectives of the study have been achieved. The

findings of the study also reveal the effectiveness of this package of Ayurvedic services, in terms of regaining the body weight, perceived body strength and subjective cheerfulness, unrease in level of haemoglobin and absence of puerperal sepsis. Based upon the findings fo the study, certain suggestions and recommendations have been made here under for the consideration of and implementation by the Policy-makers, Planners and Health Administrators and Managers as well as future researchers of I.S.M. and modern medicine :

1. The study has proved effectiveness of the package. However, the optimium effectiveness may be undertaken by other researchers.

2. A multi-centric study on a larger scale be carried out, for further evaluation of this type of package on a wider sample of different subgroups may be obtained.

3. It is note worthy that this package of Ayurvedic services has no side effect/toxic effect upon the human body. Since most of these herbs are being used traditionally in the countries of South-East Asia, specially in India, and are also easily available and acceptable to the people of this country, it has a vast potentiality for its use in the region. The policy-makers, planners and health authorities are advised that the publicity through Information-Education and Communication (I.E.C.) be carried out to promote and propagate this package of Ayurvedic services for the welfare of puerpera

4. This package of Ayurvedic services is cost-effective as compared to the prevailing system of allopathic medicinces.

5. This package or an improved package of Ayurvedic services be included in the Programme of Child-Survival and Safe Motherhood (C.S.S.M.), so that the goal of "Health for All--by 2000) AD." May be achieved. This is important because a "Healthy - Mother" is the main member in the family to intiate and maintain the individual health.

6. For implementing appropriate additional strategies, it is suggested that the 50 per cent of the available beds for Obstetrics/Lobar/Gynaecological Department in each modern hospitals be provided to an Ayurvedic Section in the begining, so that this package of Ayurvedic services be introduced successfully. For smooth functioning and proper superviston, the Graduates/Postgraduates of Ayurvedic System of Medicine be appointed in sufficient numbers with the facility of providing this package of Ayurvedic Services, free of cost

7. It was observed during the course of intervention of this package amongst the mothers of Experimental Group that the amount of mothers milk was increased quantitatively and qualitatively. Accordingly, it is recommended that a separate study to assess the lactogenic effect in the lactating mothers of this package may be conducted and for this purpose an additional budget may be allocated in the next plan.

8. In view of significant gains in body weight, body strength and subjective cheerfulness the study has demonstrated its usefulness of early recovery of maternal psycho-somatic health during the period of puerperium. Its real positive impact upon mental health may be gauged through another study involving behavioural scientist.

DROPSY

Editor Note :

In last months the cetizen of Delhi and other part of country was in great worry by desarster DROPSY. Due to the toxic effect about 60 pepole have died while over 2500 people fell ill with various complications, Dropsy is not a epidemic disease. It does not spread by any microps. It is a toxic effect of argemone oil adultration with mustard oil

The adultration is a result of greed and selfishness to attain richness and gain lexurious things in a very shot period at the expense of life of the public.

Which is a metter of concorn for all those who are related with any way the consumer protaction law should be implement properly and hard punishment should be for the crime.

Defferent views on dropsy of defferent persons are as under:-

Dropsy : Toxic Effect of Argimone Maxicana

Dr. Abdul Haseeb

A condition cheracterised by ocdema. Vesculear changes due to increase permiablity and cordiac insufficiency, resulting from the ingestion of argemone seeds and their products. Experts views are that very least amount is enough to toxieity.

Argemone seed is a resemblence to mustard or Rye, Seed, which is knwon as SAILKANTHA is bengali SATYANASHI in Punjab & U.P. , DARUDI in Gujrat, BHARAMDONDI in Maharashtra. Argemone is easily identified which flowrish in the months June & July when the crop of mustard have been harvested. There is no question of mixture in mustard seed. There is some evidence that the toxieity of the oil may be reduced during storage its is highest during the rain in July and August and lowest in april.

Early oedema is associated with increased Capillary and late oedema and rapid serious effusion into to the pericardium, lungs, pleural Couity and peritoneal cavity are associated with Cordiac failure. There is generalized acute Vaso dilatotion affecting the capillaries and small Vessels especially of the skin and heart muscle. Haemarrhage may also occure from mucous membranes. There may be secondry mormocytic orthocromic anaemia. Loss of appatile, nausia and diarrhoea followed by the ocdema. It is observed that the Sever lose may, however begin suddenly and end totally in a few days.

Oedema is present in all cases, other signs vary in intensity from one case to another and from one out break to another. The oedema appears rapidly which is soft and easily pilled and mostly confined to the legs. It becomes worse of the patient is allowed to walkout occesionally, there may be general anasarca with effusion into the pleural and pericardial cavities.

The patients is chiefly concerned with the Severe dyspnoea which is constant and worsened by exertion. the blood pressure is low especially the diestolic and the pulse is fast. In the severe cases the heart is dilated and apex beat displaced to the left, Apical Systolic muranur are common the E.C.G. show evidence of myocardial damage. Acute heart failure may develop. Enlarging tender liver. Peripheral Vaseular changes are present in most cases. Dilated Vessels give the skin an irregular bluish mottled appearance, which may be present from the onset in Severe cases. Tender of calf musecles are prominent signs, in some case. The kne jarks may be absent, mild fever, Nausia is rule may be absent, Vomating, watery diarrhoea is common.

Opthalmologically complication is very late when the other symptoms of disease have subsidies and patient assur regarding the disease has been cured.

However, after six & eight weeks the other sign & symptom of the disease have disappered the toxic compound develop glucoma. Toxis compound also moved in the eye blood vessels and result retinal haemorrhages.

Dieagnosis is easy in recognised outbreak but may be difficult in isolate cases. Detail knowledge about the diet of paient is important. Bed rest is essential. Mustard oil and their product should be excluted from the diet and symptamatically treatment recommond.

'CURRENT METHODS TO CHECK ADULTERATION, DIAGNOSE AND TREAT DROPSY IN ADEQUATE'

Express New Services Sept. 22, 1998

The ban on mustard oil is off from Wedneday but does that mean that the wave of disease that the adulterated oil let loose on the Capital has died away?

Both Food and Civil Supplies Minister Poornima Sethi and Delhi Chief Minister Sahib Singh Verma say that with the ban on sale of loose oil. The adulteration of which had caused over 70 deaths in 45 days. All possibilities of a dropsy relapse have beenplugged for good.

But doctors and scientists at the Indian Council of Medical Research feel otherwise. They have called for setting up of a nationwide food adulteration and toxicological survellance network. At a recent meeting, they expressed an urgent need to upgrade technologies of packaging, as also of detection of food contaminants for use of public health authorities and industry.

They declared current methods to check adulteration and also methods to diagnose and treat dropsy inadequate.

ICMR director-general N.K. Ganguly said there was urgent need to use available advance technology to detect food contaminants and conduct research to upgrade detection and packaging methods for use by public health authorities and industry.

Prof Ramalingaswamy, a medical scientist, said that dropsy is an avoidable and emerging disease. He said an advanced detection kit based on methods of molecular biology should be developed. He said the existing systems to detect food adulteration were time-consuming and can some times yield false results.

Dr. Ravi Mallu, MP, called for developing spot-testing methods to check adulteration.

Dr. Rajesh Chawla, president of the Delhi Medical Association, said that Delhites need not fear any more. He said that the people have stopped using the oil, as is clear from the fact that the number of cases have fallen. He said if the testing is done properly then there is no chance of there being another epidemic.

As for the clinical side of the epidemic, data with Dr. S.K. Mittal and Dr. Vinod Kumar and also investigations by scientists at the Institute of Pathology, Delhi, revealed the need to develop a special antidote against the toxins causing dropsy. They said that new treatment protocols were needed for dropsy victims.

The doctors were of the view that the recent dropsy victims need to be followed up for at least six months for monitoring levels of toxic metabolites in the blood, urine and blood tissues.

The doctors said that in some patients of dropsy, the toxin was not fully excreted by the body even after 96 hours and was retained by vital organs. According to them the toxin was absent in lactating mothers and infants who were being breast-fed.

Prof Ganguly said the medical and scientific community had been caught by surprise when the need for diagnosis and treatment of dropsy arose at the outbreak of the epiedemic. He said there was urgent need to devise comprehensive protocol to deal with such situations in future.

Accouding to doctors treating dropsy patients at the height of the epidemic, that began to manifest from August 5, there wa no cure for dropsy They could only go by certain symptoms like swelling in the legs, even in manifestations like sores, stomach pain. All that they could downs to keep the patlents on a protein-rich diet and treat them for complications especially those fo the kidney and the eyes.

While dropsy will continue to be a medical challenge for researchers, oil traders themselves dismiss the epidemic as being again to a hooch tragedy. Deaths caused by consumption of illicit Liquor does not prompt anybody to ban liquor. Hence to look at all oils with suspicion because of some incidence of disease is unfair, they say.

They epidemic and the cause have placed two new tasks before the government and the medical community – a new incurable disease called dropsy and a new cause viz adulteration by argemone. The question is whether they will find a cure and a way to prevent another epidemic and how fast.

स्नेह विष ड्राप्सी

डॉ० डी० डी० शर्मा मुख्य चिकित्सक (एस्कोर्ट चेरिटेबिल)

ड्राप्सी ने सारे देश में भय का वातावरण बना दिया है। इसको आयुर्वेद ग्रंथों में किस नाम से या किसके समकक्ष रखा गया है, यह एक विचारणीय विषय है। सर्व प्रथम बात बलासक रोग की चर्चा करते हैं। कई आचार्यों ने बात बलासक को DROPSY माना हैं। अष्टांग संग्रह में इसके निदान के लिए लिखा हैं।

नित्यं मन्दज्वरो रूक्षः शूनकस्तेन सीदति।
स्तब्धागड श्लेष्मभूयोठो नरूवात बलासकी

अर्थात इससे पीड़ित रोगी को मंद ज्वर रहता है, उसकी त्वचा में रूक्षता तथा अंगों में शोथ रहता है। रोगी को अवसाद रहता है और अंग जकड़े रहते हैं।

माधव निदान में व्याख्याकार ने अपने विमर्श में वातबलासक को ड्राप्सी कहा है तथा उसके लक्षण जैसे शोथ, दृष्टिक्षय, ज्वर तथा कफज लक्षण होते हैं ऐसा कहा है तथ रोग आक्रमण के सप्ताह भीतर ही द्रव के संचय से शोथ आरंभ हो जाता है। यह शोभ गुल्फ संधि से होकर धीरे-धीरे उपर बढकर पूरे शरीर में फैल जाता है, चलने-फिरने से शोथ अधिक हो जाता हैं। द्रव्य धीरे-धीरे फुपफुसावरण तथा हृदयावरण में भी संचित होने लगता है, जिससे हृदय और फुपफुस में विकृति के लक्षण उत्पन्न हो जाते हैं।

इसी प्रकार सुश्रुत संहिता के उत्तरतंत्र अध्याय में भी व्याख्याकार ने अपने विमर्श में वातबलासक को ड्राप्सी लिखा है। जैसे सुश्रुत संहिता में लिखा हैं -

प्रलेपकं वातबलासक कफादिकत्वेन वदन्ति तज्ज्ञाः। सु अ/३९/५८

अर्थात सुश्रुत आचार्य प्रलोपक ज्वर और वातबलासक को कफ की अधिकता से उत्पन्न हुआ मानते हैं। आगे कहा है कि बात का अर्थ वायु और बलास का अर्थ कफ हैं। इस प्रकार वातबलासक वातकफोल्वण होते हुए भी त्रिदोषज हैं। क्योंकि इसमें पित्त की भी सत्ता रहती हैं। यह तन्त्राचार के वचन से सिद्ध है - वायु : प्रकुपितो श्लेषाणसीर्यो भी विद्यावति।

इसी प्रकार कई अन्य चिकित्सा के लेखकों ने वातबलासक को ड्राप्सी माना है। जैसे : चिकित्सा तत्व दीपिका (श्री महावीर प्रसाद पांण्डेय), कायचिकित्सक (श्री तारांशकर वैद्य), चिकित्सादर्श : सम्पूर्ण (प. राजेश्वर दत्त शास्त्री

सुश्रुत चिकित्सा में वातबलासक ज्वर शोक के रोगियों में होता है। ऐसा लिखा है अर्थात् शोथ पहले से होना अनिवार्य है। इसको चतुर्थ सन्निपातिक ज्वर माना है, जिसमें बात और कफ की अधिकता रहती हैं।

इससे आगे जाने से पूर्व मै एक परिवार का वर्णन करता हूँ जो इस रोग से पीड़ित हैं। परिवार के चार सदस्य रात को खाने में धारा नामक तेल से बना भोजन करते हैं। भोजन करने के २-३ घंटे के पश्चात् आध्यमान, वमन-विरेचन के लक्षण उत्पन्न होते हैं, तथा ४ दिन के पश्चात् पादों में शोथ आ जाती हैं। मेडिकल में जाने पर ड्राप्सी का निदान हुआ। मेरे पास परिवार बाद में आया। उस समय पांव में शोथ तथा पुरूष तथा बच्चों को मंद ज्वर भी था।

इस घटना क्रम से यह सिद्ध हुआ कि भोज्य पदार्थ का प्रभाव शीघ्र हुआ, अर्थात भोज्य पदार्थ मे विष, अन्न विष था या फिर जीवाणु संक्रमण।

सुश्रुत कल्प स्थान में भिन्न-भिन्न विषों के भिन्न-भिन्न प्रभाव में वमन, रेचन, आंखों की पुतली का प्रसारित या संकुचित होना, अंधापन, बधिरता, स्वेद, प्रलाप, आक्षेप, पक्षाघात, कम्पन, मूत्र की विवर्णता, नाड़ी की तीव्रता अथवा मंदता आदि लक्षण दिए हैं।

इसी प्रकार चरक चिकित्सा स्थान में विष के वेग के बारे में लिखा हैं। जैसे प्रथम वेग में प्यास की अधिकता, मोह, मुँह से लार निकलना, वमन, आदि। तृतीय वेग में शरीर में पकने, कब्ज, शोथ, कोद आदि लक्षण लिखे हैं।

सुश्रुत कल्प स्थान में दूषीविष के लक्षण दिए है, मद, वमन, अतिसार, अरोचक, हाथ-पैर-मुख में शोथ, उदर मे जलवृद्धि, धातुक्षय, मूर्च्छा, विषम ज्वर, तृष्णा आदि।

विष के लक्षणों और वेग से तथा रोगी के लक्षणों में काफीसमानता है। इससे यह निश्चित हुआ कि भोज्य पदार्थ में कोई स्थावर विष था।

स्वर्ण क्षीरी (सत्यानाशी) तेल विष है या नहीं, यह अलग विष हैं।

जलोदर के विषय में आचार्य सुश्रुत ने लिखा है कि जिसने स्नेहपान किया हो, वमन-विरेचन-अनुवासनवस्ति, लिया हो, उसके बाद तुरंत ही शीतल जल पीले तो उसके जलवाहक स्रोतस दूषित हो जाने से जलोदर हो जाता है।

जलोदर की अवस्था बाद की है, इससे पूर्व शोथ शास्त्रगत होता है, जिसका मुख्य कारक स्रोतावरोध है। स्रोतावरोध के कारण ही भोज्य विष महास्रोतस को भी अवरूद्ध कर देता हैं, जिस कारण जलोदर की उत्पत्ति हो जाती है। वैसे हमारे शास्त्रों मे जलोदर को जीर्ण अवस्था माना हैं तथा यह भी कहा है कि सभी उदर रोग अधिक समय बीतने पर जलोदर को प्राप्त हो जाते हैं।

व्याख्या :- सीलनयुक्त स्थान और नमीमुक्त वायु।

- सार रहित भोजन विशेषत: क्षार-रहित भात (जिनमें मिल के चावल का जिन पर से भूसी के साथ सार वाला भाग, छिलका भी निकल जाता हैं) सेवन करने से
- दूषित द्रव्यों से मिश्रित तैल
- दूषित मछली
- बासी, सड़ा, गला, ठंडा भोजन

लक्षण - उत्क्लेश, वमन, विरेचन, आध्मान, मंद ज्वर, पैरों में शोथ, जो धीरे-धीरे हाथों, चेहरें तथा उदर पर फैल जाती हैं। रोग आक्रमण के एक सप्ताह के भीतर धातुओं में द्रव के संचय से शोथ प्रारंभ हो जाता है। यह शोथ कार्य करने, चलने-फिरने पर तथा सांयकाल को अधिक हो जाता हैं। शरीर रूक्ष हो जाता है, कभी-कभी चेहरे पर अधिक रूक्षता आ जाती है।

- अरूचि, संधि शैथिल्य, कफ या कफज विकार,- द्रव संचय धीरे-धीरे फुप्फुसावरण, उदर आवरण कला, हृदयावरण कला में भी संचित होने लगता है, जिससे फुफ्फुस और हृदय विकार तथा जलोदर होने के लक्षण उत्पन्न हो जाते हैं।

नेत्र ज्योति कम होना या नष्ट होना, दुर्बलता, भारीपन, सर्वांग पीड़ा, श्वास की मंदता

चिकित्सा :- रोग के नाम-भेद में विभिन्न मत हो सकते है, लेकिन जो लक्षण रोगियों में उत्पन्न

हुए , उनमें कोई मतभेद नहीं है, वैसे भी शास्त्रों में कहा हैं कि -

क्किारानाम न जिह्वीवात् कदाचन।
नाहि सर्वविकारणां नामंतोऽस्ति ध्रुवा स्थिति:।।

अत: रोग की प्रकृति और उसकी अधिकता और कारक की विशेषता का ध्यान करके चिकित्सा भी की जा सकती है। जो इस प्रकार हैं :-

१. सामान्यत: क्रियायो में निदान परिवर्जनम् अर्थात् कारणो का त्याग किया जाए यानि दुषित तेलों का उपयोग बंद किया जाए।

२. ज्वर की अपेक्षा शोथ दूर करने का प्रयत्न करना चाहिए।

३. साधारण मूत्रल औषधियों तथा मृदु विरेचन बीच-बीच में देते रहना चाहिए।

४. रोगी को सुखे तथा खुले स्थान पर **औषध ा व्यवस्था -**

१. रस (i) शोथारि रस वसंत (ii) स्वर्ण वसंत मालती रस (iii) हृदयार्णव रस (iv) विश्लेश्वर रस

२. वटी (i) अरोग्य वद्धिनी वटी (ii) प्रभाकर वटी

३. व्यभाव (i) पुनर्नवाष्टक क्वाथ (ii) दशमूल क्वाथ

४. लौह (i) पुनर्नवामण्डूर (ii) शोथारि लौह (iii) चन्दनादि लौह (iv) शिलाजित्वादि लौह

५. आसव-आरिष्ट (i) पिप्ल्यासव (ii) लोहासव (iii) पुनर्नवारिष्ट (iv) अमृतारिष्ट

६. तैल-मालिश हेतु i. चन्दनादि ii. पुनर्नवादि तेल

७. लेप (i) दशांग लेप (ii) शिरीष, सहजंन, संभालु, धतूरा, एरण्डजड़, मलेय का लेप (iii) सहजनां, देवदारू, असगन्ध, ढाक के बीज, आक की जड़ और गोमूत्र में पीसकर लेप करें।

८. अनुपान (i) पुनर्नवा स्वरस (ii) गिलोय स्वरस (iii) अर्जुन छाल स्वरस (iv) बिल्व पत्र स्वरस (v) मधु

९. सामान्य योग (i) पिप्पली चूर्ण ४ रत्ती ४ मात्रा, पुनर्नवा स्वरस + मधु (ii) पुनर्नवामण्डूर १ gm, अरोग्यवर्द्धिनी ४ रति, शिलाजीत ४ रति, प्रभाकर वटी २ रति, ३ मात्रा, मधु + गिलोय स्वरस, पिप्ल्यासव ३ र., अनुपान जल ३ र. २ भोजन पश्चात्

१०. ज्वर (i) सर्वज्वरहर लौह (ii) गिलोय सत्त्व

११. जलोदर जलोदरादि रस २ र. २ प्रात =साथ तृणपंचमूलक्वाथ से (ii) वारिशोषण रस २ र मरिच चूर्ण २ र. प्रात: सांय २ (iii) वद्धमान पिप्पली

१२. पथ्य - गोदुग्ध सर्वश्रेष्ठ पथ्य है। ताजे फल, सब्जियां, इनका रस, गेंहू का दलिया, साबुदाना, परवल, अदरक, लहसुन, मूंग की दाल, धान का लावा पथ्य है।

इसके साथ विश्राम भी आवश्यक तथा लाभदायक है।

अपथ्य - चावल, सरसों का तैल (दूषित) तीक्ष्ण द्रव, गर्म मसाला, मिर्च, कडवी वस्तुए (काली मिर्च, सोठ, पीपल को छोडकर) सड़ा गला शीतल भोजन न खाएं

- सीलन वाला स्थान त्याग दें।
- नमक बिल्कुल न दें।

पाठकों से निवेदन है कि अपने विचार या जानकारी अवश्य दे ताकि ड्राप्सी का आयुर्वेदिक रोग नाम या उसके समकक्ष रोग की जानकारी आयुर्वेद जगत तक जनता को दी जा सकें।

ड्राप्सी और आर्जीमोन एक आयुर्वेदिक दृष्टिकोण

डॉ० डी० एस० राठी

आचार्य चरक ने उदर रोग चिकित्सा के अर्न्तगत पृष्ठ संख्या 389 में जलोदर शब्द का प्रयोग करते हुए कहा है कि अत्याधिक स्नेहपान से जल वह स्त्रोत अवरूध होकर जलोदर उत्पन्न होता है, और यह उदर रोगों की अंतिम अवस्था मानता है, उपद्रव युक्त जलोदर 15 दिन में रोगी के अरिष्ट लक्षण पैदा हो जाते है व मृत्यु हो जाती है। इसके 8 भेद माने हैं।

ड्राप्सी शब्द का अर्थ 'शोथ' है। यह भी एक प्रकार का उदर रोग है, जिसमें आँखों पर, पेट पर व पैरों पर जल व कफ दोष के अवरूध ा होने से 'शोथ' रोग होता है प्रचार माध्यमों से जानकारी मिलती है कि सरसों के तेल में आर्जीमोन मेक्सिकाना (सत्यानाशी), मोबाइल आयल व कुछ विषैले तत्व पाये गये जिससे 'ड्राप्सी' नामक रोग एक महामारी के रूप मे पाया गया है।

सत्यानाशी के पर्याय आयुर्वेदानुसार कंटुपर्णी, स्वर्णक्षीरी, बड़ी कटैली है, यहपौधा जनवरी-फरवरी में पाया जाता है। जबकि सरसों मार्च-अप्रेल मे पकती है। प्राचीन समय से यह जंगली प्रजाति का पौधा विषैला तो है, परन्तु उपयुक्त मात्रा में औषधिय गुण युक्त हैं। स्वयं सरसों के साथ इसका बीज नहीं मिल सकता अक्सर यह जमीन पर अपने आप हवा चलने से बिखर जाता है, क्योंकि इसमें डोडे पक कर फूटते हैं। अत: यह मिलावट एक षड्यंत्र मात्र लगता है।

'देहाती चिकित्सक व जड़ी-बूटी' नाम पुस्तक के मतानुसार यह बीज रक्तशोधक, त्वक रोग, आमबात गठिया, पागल कुत्ते के काटने के विष में 1 तोला मात्रा पानी में पीसकर देने से वमन, विरेचन द्वारा विष को बाहर निकालता है। इसकी शाखा तोड़ने पर पीले रंग का दूध निकलता है, जिसे देहातों में आँखों की लाली व दर्द दूर करने के लिए अंजन के रूप में प्रयोग करते हैं।

सरसों के तैल मे मिलावट का रहस्य अभी पूरी तरह नहीं खुल पा रहा है। एक सवाल है? क्या यह षड्यंत्र है? पूरे देश में सरसों के तैल में प्रतिबंध लगाने से क्या समस्या हल हो सकती है? क्या यह महामारी फैलाने के बीच में कोई देश की एकता व अखंडता पर आँच है, खतरा है? क्या अभी कोई नया रहस्य छुपा हुआ है।? उपरोक्त सवाल के जवाब अभी नहीं हैं।

आयुर्वेदिक स्नातकों की मजबूरी स्पष्ट दिखाई देती है। जबकि आयुर्वेद मे शमन व शोधन दोनों चिकित्सक्रम उपलब्ध हैं। आपातकालीन स्थिति में रोगी निकलने के बाद उपद्रव के रूप में अन्धापन पाया जा सकता है।

ड्राप्सी चिकित्सा :- लोकनाथ रस, आरोग्य वद्धिनी वटी, पर सी. सी. आई. एम. दिल्ली द्वारा लाभ पाया गया है। मैटिरिया मेडिका इंडिया, आर० एन० खोरे II P-504 द्वारा अपामार्गक्षार का प्रयोग विशेष चिकित्सा के रूप में अपनाया है यूरोप के डा० डब्लू डायमक ने अपामार्ग पौधे से क्वाथ बनाकर दिन में 3 बार देने से असख्य मरीजों पर सफल प्रयोग किया है।

आयुर्वेद के कुछ विद्वानों-मूत्रल व दस्तावर औषधि प्रयोग से ड्राप्सी पर सफलता प्राप्त की जा सकती है। आचार्य चरक ने गॉमूत्र में क्षार का प्रयोग पृष्ठ संख्या 389 उदर रोग चिकित्सा अध्याय में लिखा है।

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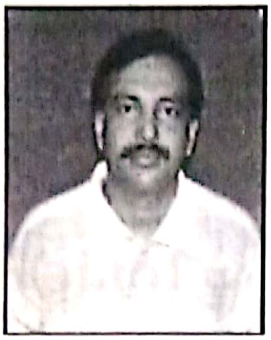

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(१) डॉ० उमेश शुक्ला (२) डॉ० अरुण गुप्ता (३) डॉ० अजय कुमार शर्मा

परिभाषा :-

पूमान सूयते अनेन कर्मणा इति पुंसवतं कर्म :

अर्थात जिस कर्म के द्वारा गर्भ में ही स्त्रीलिंग का परिवर्तन कर पुरुष उत्पन्न किये जाते है। उस कर्म का नाम पुंसवन है। यह कर्म इच्छानुसार पुत्र या पुत्री की प्राप्ति के लिये किया जाता है स्त्री या पुरुष दोनों में आयुर्वेद में बतायें हुए कर्मों के सदानुष्ठान द्वारा तब तक परिवर्तन किया जा सकता है जब तक गर्भ में स्त्रीलिंग, पुलिंग या नपुंसक लिंग की अभिव्यक्ति नही हो जाती ।

भ्रूण (Foetus) के लिंग की अभिव्यक्ति Ist Trimester में विशेषकर IInd Month में हो जाती है। अत: पुसंवन कर्म का प्रयोग गर्भ धारण की निश्चित तिथि 2 मास तक करवाया जाता है। देशकाल का विचार कर और देशकाल की अनुकूलता देखकर आयुर्वेदोक्त कर्मों का सुमुचित प्रयोग करने पर अभिष्ट फल प्राप्ति होती है। परन्तु यदि यही कर्म अनुचित देश और अनुचित समय में किया जाये यतो अनिष्ट फल होता है।

पुंसवन कर्म हेतु शास्त्रोक्त विधिया :-

1. स्त्री एवं पुरुष दोनों का पूर्णरूप से संशोधन कर स्नेहन, स्वेदन, वमन, विरेचन बस्ति आदि सामान्य आहार सेवन कराऐं।

2. रज: स्त्राव के चौथे दिन से पुत्र की इच्छा रखने वाला दम्पति युग्म दिनों में 4,6,8,10,12 पुत्री की इच्छा रखने वाला दम्पति अयुग्म दिनों में 5,7,9,11 सहवास करें।

3. पुंसवन कर्म पुष्य नक्षत्र में करवाने से विशेष लाभ होता है।

4- पुत्रेष्टि यज्ञ का विधान विस्तार चरक शरीर 8/11 शास्त्रों में बताया गया है जो पुत्रोत्पत्ति में विशेष योगदान देता है।

5- बटांकुर वट शुंग, दो धान्य माष उडद या दो पीली सरसों दही के साथ पीसकर पुष्य नक्षत्र में स्त्री पीये।

6. जीवन, ऋषभ, अपामार्ग, सहचर-अलग-2 या एक साथ कल्क बनाकर दूध में पक्का कर स्त्री पुष्य में पीये।

7. कुडप कीटक एक प्रकार का कीडा या एक शफरी सिधरी मछली को एक अंजली जल में डालकर पुष्य नक्षत्र में पीयें।

8. सुवर्ण या रजत या लौहे की एक अत्याधिक छोटी पुरुषाकार प्रतिमा बनाकर अग्नि में तपावें और लाल वर्ण की होने पर दही, दूध या एक अंजली जल में छोड़कर पुष्य नक्षत्र में सारा दही या दूध अथवा जल प्रतिमा के साथ पुष्य नक्षत्र में पी जावें।

9. पुष्य नक्षत्र में चावल के आटे को जल में पकाकर निकलने वाली भाप को स्त्री सूधें या इसी जल को दक्षिण नासा पुट में डाले।

आधुनिक मत : - Sex Determination

प्रत्येक मनुष्य के शरीर के प्रत्येक कोषाण Cell के Nucleus में 46 Chromosomes 23 Pairs होते हैं।

Chromosome विशिष्ट संरचना है जो कि Nucleic Acid और Nucleoproteins (1) DNA (Deonyribo Nucleic Acid) (2) RNA (Ritonucleic Acid) के तंतुओं के बने होते हैं।

मनुष्य शरीर के 23 जोड़े Chromosomes दो प्रकार के होते हैं:-

(अ) Somatic Chromosomes (22) Pairs

यह एक पीढ़ी से दूसरी पीढ़ी में वंशानुगत गुण धर्मों Hereditary Characters का वहन Transmission करते हैं। (ब) Sex Chromosomes, only one pair इसी के द्वारा भ्रूण Foetus के लिंग Sex का निर्धारण होता है।

4. स्त्रियों में Sex Chromosome के जोड़े में 2 बढ़े एक जैसे "x x" होते हैं। अर्थात "x x"

5. पुरुषों में Sex Chromosome के जोड़े में २ अलग-अलग Chromosome होते हैं जिन्हें "x" Chromosom और "y" Chromosom कहते हैं। अर्थात पुरुषों में Chromosom 'xy' होते हैं।

6. स्त्रियों के मासिक स्त्राव के समय निकलने वाले सभी अंडो Ova में 'x' Chromosom होते हैं।

7. पुरुषों के वीर्य में कीटाणुओं- (Sperms) में कुछ 'x' और कुछ में 'y' Chromosom होते हैं।

8. स्त्री-पुरूष के संयोग Fertilization के समय स्त्री का Ovum और पुरुष का Sperm आपस में संयोग करते हैं। संयोग Fertilization में यदि स्त्री का 'x' और पुरुष का भी 'x' Chromosome संयोग करते हैं जो भ्रुण स्त्रीलिंग का होता है। इसके विपरीत यदि स्त्री का 'x' और पुरुष का 'y' Chromosome संयोग करते हैं तो भ्रुण पुरुष लिंग का होता है। Conception के साथ ही भ्रूण का लिंग निश्चित हो जाता है।

पुंसवन संस्कार संभव है या नहीं ?

आज के युग में Sonography से Sex Determinetion करवाकर Female Child को MTP/Abortion द्वारा गिरा दिया जाता है जिससे समाज में Male और Female की रेटियो में खतरनाक रुप से असमानता बढती जाती है। इस परिप्रेक्ष्य में आयूर्वेद में वर्णित पुसंवन कर्म की विश्वसनीयता एवं प्रभाणिकता के विषय में जन सामान्य में जिज्ञासा बढ़ना स्वाभाविक ही है। हमारे व्यक्तिगत विचार से पुंसवन कर्म द्वारा इच्छानुसार सन्तति लड़का अथवा लड़की प्राप्त की जा सकती है जिसके पक्ष में कुछ तर्क प्रस्तुत हैं-

1,2 पी० जी० अध्येता, स्नातकोत्तर काय चिकित्सा विभाग, राष्ट्रीय संस्थान, जयपुर राज०, 302002
3 विभागाध्यक्ष, स्नातकोत्तर काय चिकित्सा विभाग, राष्ट्रीय आयुर्वेद संस्थान, जयपुर राज०। 302002

1. आयुर्वेद की सभी प्रमुख संहिताओं और ग्रन्थों में आचार्यों द्वारा पुंसवन कर्म का वर्णन किया गया है जो इस विषय के महत्व को दर्शाता है। यदि यह विषय विश्वसनीय नही होता तो इसका वर्णन अनेक संहिताओं में हमारे प्राप्त पुरुषों/आचार्यें द्वारा नहीं किया जाता।

2 आयुर्वेद में वर्णित अन्य सिद्धान्त - तथा त्रिदोषवाद, अग्नि, स्त्रोतस, प्रकृति इत्यादि विभिन्न वैज्ञानिक आधारो पर खरे अतरते हैं। इसी आधार पर पुंसवन संस्कार भी प्रमाणिक संस्कार ही हैं।

3 पिछले 2 दशकों में Satelite/ Computer/Internate एवं विज्ञान के अन्य आविष्कारों ने असंभव बातों को सम्भव कर दिखाया है, जिन्हें कुछ समय पहले तक अविश्वसनीय/झूठ समझा जाता था। इसी प्रकार पुंसवन सस्कार की प्रमाणिकता की वैज्ञानिक आधार पर अनुसंधान करके सिद्ध की जा सकती है।

4. आज के युग में Test Tube Babies/ Artificial Cloming के माध्यम से कृत्रिम रुप से मनुष्य के बच्चे, बन्दर, बकरी, भेड इत्यादि जानवर पैदा किये जा रहे हैं। इसी आधार पर युक्ति संगत है कि पुसवन कर्म भी प्रमाणिक एवं विश्वसनीय है आवश्यकता है केवल उचित शोध कार्यो से इस तथ्य की पुष्टि की।

5. पुंसवन कर्म में प्रयुक्त की जाने वाली अनेक औषधियो का प्रमाणिकरण एवं मानिकीकरण अत्यावश्यक है जिससे उनका शास्त्र सम्मत प्रयोग कर पुंसवन कर्म में सफलता प्राप्त की जा सके।

6 यह सही है कि किपुंसवन कर्म एक विश्वसनीय विधि है जिसके शास्त्रोक्त विधि विधान से प्रयोग काने पर इच्छानुसार सन्मति-लड़का या लडकी प्राप्त की जा सकती है परन्तु यह कर्म किस प्रकार सम्पन्न होता है, क्या इस विधि से Sex Chromosomes का Transmission भ्रूण में चिकित्सक अथवा माता-पिता की इच्छा से हो सकता है, अथवा दैव कृपा से यह कार्य होता है अथवा इस वर्ष द्वारा सन्तति प्राप्त करने में कितने प्रतिशत सफलता प्राप्त की जा सकती है इत्यादि कुछ ऐसे प्रश्न हैं जिनका समाधान पुंसवन कर्म विषयक वैज्ञानिक आधार अपनाकर गहन स्तर पर शोध कार्य करके ही प्राप्त किया जा सकता है। वास्तव में पुंसवन कर्म सम्बन्धी Multi Dimensional Detailed Researches की जानी आवश्यक है।

7 कई बाद ऐसा देखने मे आता है कि पुंसवन कर्म असफल हो जाता है अर्थात् वांछित रुप से लड़का या लडकी पैछा नहीं होती है। हमारे विचार से यह आयुर्वेद पुंसवन कर्म का दोष नहीं है। यं सम्बन्धित चिकित्सक/RMP नीम हकीम का दोष होता है। जो अज्ञानतावश सीमित ज्ञानवश अमर्यादित या अव्ययस्थित रुप से पुंसवन कर्म करवाते हैं। और पुत्र पैदा करवाने के दावे भी करते हैं। और और पुत्र पैदा करने के शर्तिया इलाज भी करते हैं। परन्तु अभिष्ठ की प्राप्ति ना होने से हमारे आयुर्वेद विज्ञान का दोष नहीं है। यह हमारे सिमित ज्ञान का ही दोष होता है। परन्तु लोगों में आयूर्वेद और आयूर्वेद के पुंसवन कर्म के विषय में अविश्वास पैदा होता है। इस बात से हमें सावधान रहना है।

8 कई बार यह भी सुनने में आता है कि अमुक स्त्री मन्त्र-तन्त्र से पुत्र पैदा करवाती है, कोई साधु विशेष जडी बूटियाँ देता है जिनसे पुत्र पैदा होता है, कोई ज्ञानी पुरुष अभिमन्त्रित जल पीने को देता है और साथ में ताबीज भी पहनने को देता है जिससे पुत्रोत्पति होती है। यह सभी Folklore या Traditional Methods ट्रेडिशनल फार्मूले हैं जो सफल भी होते देखे जाते है। परन्तु इनकी वैज्ञानिकता या प्रमाणिकता के विषय में कुछ का पाना कठिन होता है।

संक्षेप में यही कहा जा सकता है कि आयुर्वेद में वर्णित पुंसवन कर्म एक प्रमार्णित विधि है जिसके द्वारा इच्छानुसार सन्तति प्राप्त की जा सकती है। इस कर्म की वैज्ञानिकता का आधार स्पष्ट करने के लिये विभिन्न Research Trials किये जाने उपेक्षित हैं।

सन्दर्भ :-

1. चरक संहिता - शारीर स्थान अध्याय 8/4-19
2. सुश्रुत संहिता - शारीर स्थान अध्याय 9/32
3. अष्टांग संग्रह - शारीर स्थान अध्याय 1/60
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TREATMENT OF INFERTILITY-A PRACTICAL APPROACH

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What is Infertility ?

Infertility is a disease of the reporductiver system that impairs one of the body's most basic functions: the conception of children. Conception depends upon many factors: production of healthy sperm by the man, healthy eggs by the woman; unblocked fallopian tubes, sperm's ability to fertilize the egg, ability of the fertilized egg (embryo) to become implanted etc.

What Causes Infertility ?

Infertility affects about ten percent of the reproductive age population and it affects men and women equally. About one-third of infertility cases can be attributed to male factors, and about one-third to factors that effect women. For the remaining one-third of infertile couples, infertility is caused by a combination of problems in both partners or, in about 20 percent of cases, is unexplained. The most common male infertility factors include azoospermia (no sperm cells are produced) and oligospermia (few sperm cells are produced). The most common female infertility factor is an ovulation disorder. Other common cause is blocked fallopian tubes, which can occur when a woman has had pelvic inflammatory disease or endometriosis.

How is Infertility Diagnosed?

Couples are gererally advised to seek medical help if they are unable to achieve pregnancy after a year of unprotected intercourse. The doctor will conduct a physical examination of both partners. Usually both partners are interviewed about their sexual habits in order to determine whether intercourse is taking place properly for conception. More specific tests are then recommended. For women, these include an analysis of body temperature and ovulation, x-ray of the fallopian tubes and uterus, and laparoscopy. For men, initial tests focus on semen analysis.

Hos is Infertility Treated?

Most infertility cases 85% to 90% are treated with conventional medical therapies such as medication or surgery. In vitro fertilization and similar treatments account for less than 5% of infertility services. The treatment depends upon the problem identified egg -ovulation problems,semen abnormality etc.

Treatment of Ovulation Disorders

Approximately 30-40% of infertile women have ovulatory problems. Medications can be used to stimulate ovulation in women who rarely or never ovulate (anovulation) and to treat women who have no menstrual cycles (amenorrhea). They can be used to increase the frequency of ovulation in women who ovulate infrequently. They are sometimes also prescribed to treat luteal phase defect.

The most commonly used medication to induce ovulation is clomiphene citrate Clomiphene is taken for five consecutive days early in the menstrual cycle. If ovulation does not occur, the dose of clomiphene can be increased over the next few cycles.

Human menopausal gonadotropin (hMG) and human follicle stimulating hormone (FSH), are injectable medications given over a period of 5-12 days to produce growth and maturation of ovarian follicles (which contain eggs). The dose used to produce maturation of the follicle is individualized for each patient and may vary from cycle to cycle. Usually several eggs produced with the use of gonadotropins. Multiple pregnancies occur in approximately 20% of gonadotropin cycles.

Hormonal therapy with a variety of medications can temporarily correct ovulatory problems and increase a woman's ability to become pregnant.

Surgical procedures

In women, anatomical abnormalities are also a common cause of infertility. Most structural damage to the reproductive organs results from either previous pelvic surgery, infection or endometriosis. Any of these conditions may cause scarring or closure of the fallopian tubes.

Most often, the diagnosis is determined on the basis of x-ray (hysterosalpingogram) and/or a

laparoscopic evaluation. If confirmed, therapeutic modalities may include a variety of surgical procedures, including operative laparoscopy, operative hysteroscopy of microsurgical reconstruction via laparotomy.

Laparoscopy

Laparoscopic surgery is done through a thin, illuminated telescope that is placed through the abdominal wall. It may be simply diagnostic or therapeutic. Advances in istrumentation such as lasers, endoscopic video cameras and microlaparoscopes enable experienced surgeons to perform even complicated reconstructive procedures on an outpatient basis.

Microsurgery

Although endoscopy, has largely replaced the need for open abdominal surgery, occasionally the need does arise for such surgery, called laparotomy. Microsurgical reconstruction of the pelvis, in particular, always requires laparotomy.

Surgery can be used to correct problems that partially or completely impair fertility Surgery alone can be sufficient to enable conception and pregnancy to occur. Depending on the nature of the underlying problem(s), additional medical therapy may be necessary to enhance the chances of successful pregnancy.

Artificial Insemination with Husband's Sperm (AIH)

Artificial insemination is the term used for the placement of sperm in the female reproductive tract by means other than intercourse. It can lead to a pregnancy for many infertile couples.

It is used to treat couples who are infertile because of a male factor. For example, semen abnormalities such as poor sperm count, motility or morphology, retrograde ejaculation, improtence or severe hypospadias. Some men may store their sperm in a frozen state prior to vasectomy, chemotherapy or testicular surgery. Should they decide to father children, artificial insemination with the thawed sperm is then done. Intrauterine insemination may also be indicated in certain cases of female infertility as, for example, when there is a cervical disorder which prevents natural conception. It is also used in cases of unexplained infertility. with Intrauterine insemination (IUI), a concentrated suspension of sperm is introduced through the cervix directly into the uterine cavity. This allows large numbers of sperm to reach the fallopian tubes, where fertilization can then occur. This procedure requires that the sperm be "washed" first. Sperm washing is performed under strictly sterile conditions and a variety of saferguards are maintained to insure that semen samples cannot be switched.

Therapeutic Donor Insemination (TDI)

Couples whose infertility is due to a significant sperm abnormality in the male sometimes choose to undergo insemination using sperm from an anonymous sperm donor. It is an option in a number of circumstances: when the sperm count is very low, when no sperm are present, or when sperm repeatedly fail to initiate pregnancy. It may also be used in cases where both male and female are carriers of a genetic disorder or a female is severely Rh immunized and the male is Rh positive. Donnor insemination is also an option for single women. In therapeutic donor insemination (TDI) the donor's sperm is inseminated into the women's cervix or uterus at the time of ovulation enabling the women to conceive.

Cryopreserved (frozen) sperm is alwyas used. Semen is frozen in liquid nitrogen at a temperature of 196C, where all sperm activity is essentially halted until thawing takes place. After thawing most, most return to the pre-freeze state. The sperm donor tested for HIV and other infectious diseases at the time of sperm donation. The sperm is then frozen for six months. The donor is then retested and, if his testing for infectious disease remains negative, the frozen sperm is then made available for use. Donors are also screened for genetic abnormalities and Rh factor, in addition to infectious diseases as mentioned above.

IVF and other Assisted Reproductive Technologies

In vitro fertilization (IVF) was originally developed to treat women with absent of nonfunctioning fallopian tubes. In its modernized form, it is now successfully used to treat couples with other fertility problems including male factor, endometriosis, ovulatory dysfunction, and unexplained infertility.

What is IVF?

Normally, one egg is released each month from the ovary and picked up by the fallopian tube. Sperm, after entering the vagina by sexual intercourse, travel up through the uterus into the tube, where they

may encounter the eggs and result in its fertilization. The fertilized egg (called an embryo) then travels through the tube into the uterus. In IVF, fertilization occurs outside of the body in a laboratory dish (in vitro). Mature eggs are removed from the ovaries and incubated with specially prepared sperm. The resulting embryos are then transferred back directly into the uterus several days later. In many (though unfortunately not most) cases, implantation of one or more of these embryos into the uterine lining will occur, resulting in pregnancy.

Gift : Gamete intrafallopian transfer (GIFT) is a procedure related to IVF. Laparoscopy is used to retrieve the eggs, which are then mixed with sperm and immediately transferred into the fallopian tube, where fertilization may occur. Candidated for GIFT must have at least one normal fallopian tube and no significant male factor. *ZIFT and TET*: Zygote intrafallipian transfer (ZIFT) and tubal embryo transfer (TET) are variations of IVF in which the embryo transfer is done via laparoscopy into the fallopian tubes three days following egg retrieval.

To Summerize the quick facts about infertility :-

* Infertility is NOT an inconvenience; it is a disease of the reproductive system.
* Infertility affects about ten percent of the reproductive age population and it affects men and women equally.
* Most infertility 85% to 90% are treated with conventional medical therapies such as medication or surgery.
* In vitro fertilization and similar treatments account for less than 5% of infertility services.

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बन्ध्यत्व

डॉ० ललित रस्तोगी

सन्तानहीन व्यक्ति अकेला, एक ही डालीवाला, फूलरहित आश्रयहीन, किसी को सहारा न देने वाला, पुत्र या पुत्री रूपी फलरहित, धर्मार्थ काम मे सूना, व्यर्थ जीवन वाला होता है। ऐसा आयुर्वेद शास्त्र मे माना गया है। जबकि सन्तान वालो का जीवन मंगलमय, प्रशंसनीय, धन्य एवं शक्तिशाली, बहुल शाखा वाला माना गया है।

सम्प्राप्ति व प्रकारः-

बीज के दोष से, आघात या शस्त्र द्वारा विकृति से, नपुंसकता से, बीजस्त्रोतसों की विकृति, अवरोध आदि के कारण स्त्रियों तथा पुरूषों में बन्ध्यता उत्पन्न होती है। इसके अतिरिक्त जनन अंगो की रचना सम्बन्धी विकृति या अनुपस्थिति के कारण सहज प्रकार का बन्ध्यत्व तथा कालज बन्ध्यत्व भी होता है।

दूषित वीर्य के लक्षणः–

प्राचीन वैद्यों ने वात, पित, कफ, रक्त व त्रिदोष के भेद से पांच भूत, देव एवं अभिचार के भेद से तीन तथा एक सहज बन्ध्यत्व माना है। इस तरह कुल नौ प्रकार बन्ध्यत्व माना है।

वात- के कारण दूषित होने पर इनका वर्ण श्याम–अरूण तथा रोगी में विशेषतः मैथुन के समय तोद–भेद आदि वेदनाएं होती है।

पित- दूषित होने पर, वर्ण नीला–पीला तथा दाह आदि लक्षण मिलते है।

कफ- दूषित होने पर वर्ण–श्वेत तथा कण्डू, अंगगौरव आदि लक्षण होते है।

रक्त- से दुष्ट होने पर उनमें मुर्दे के समान गंध एवं पित के लक्षण बढ़े रहते है।

कफ वात- के कारण शुक्र अथवा रज गाँठदार, पित–कफ के कारण दुर्गन्धित तथा पूयमिश्रित एवं पितवात के कारण क्षीण तथा अल्प होते है। सन्निपात से उसमे मल मूत्र की गन्ध आने लगती है।

स्वस्थ शुक्र- देखने में स्फटिक मणि के समान, नीली झाई युक्त शुक्ल वर्ण का, सौम्य, मात्रा में अधिक एक सी० सी० में एक करोड जीवित गिनती में, गतिशीलता ७० से ८० प्रतिशत तथा सामान्य आकृति ७० से ८० प्रतिशत होना चाहिए, गाढा, घी, तेल व मधु के समान छूने में चिकना, पिच्छिल, गाढ़ा व मुलायम तथा सूंघने में मधु की गन्ध वाला होना चाहिए।

शुद्ध और स्वस्थ आर्तव- लाक्षारस के समान अथवा खरगोश के रक्त के सामन वर्ण व धब्बा नहीं होना चाहिए। वह कपड़े पर धब्बा नहीं छोड़ता।

बन्ध्यत्व की चिकित्सा से पूर्व स्त्री व पुरूष दोनो की अलग–अलग पूर्ण परीक्षा कर लेनी चाहिए। प्रायः स्वस्थ दिखने वाले, मैथुन में सक्षम व्यक्तियों में बन्ध्यत्व का ६५% कारण पुरूषो में मिलता है। कभी कभी वे कारण स्त्री व पुरूष दोनों में विद्यमान रहते है।

पुरूषगत कारणों में स्थानिक कारण प्रायः कम ही मिलते है। अधिकतर शुक्र की न्यूनता, उसमें उत्पादक शाक्ति की कमी, मेदोरोग, मधुमेह जीर्णावस्था में, दौर्बल्य, चिरकालीन विष प्रभाव एवं अंतः स्त्रावों की विकृति आदि कारण होते है। इसके अतिरिक्त अत्याधिक मैथुन करने से शुक्राणुओं को प्रगल्भ होते का पूरा समय नहीं मिलता।

स्त्रीगत कारणों में जनेन्द्रिय का अपूर्ण विकास, गर्भाशय स्थानच्युति, गर्भाशय ग्रीवा का शोध या व्रण, योनिगत अम्लाधिक्य डिम्ब का अपूर्ण– विकास, चिरकालीन विषप्रभाव, अवदुग्रन्थि तथा पीयूषग्रन्थि के अन्तःस्त्राव की न्यूनता होती है।

उपक्रम- दोष व कारण के विपरीत चिकित्सा की जाती है। दोषज–विकृति एवं तज्जन्य अवरोध में स्वेदन स्वेदन करके आवश्यकतानुसार पंचकर्म से शुद्ध करके दोषानुसार बृंहण, बल्य व गर्भस्थापक योगो से चिकित्सा करें। पुरूषों में यदि शुक्रमेह, शीघ्रपात आदि रोग हो तो पहले उसकी चिकित्सा करें। यदि स्त्रियों मे रजोविकार हो तो पहले उसे ठीक करके गर्भस्थापक योगों को देना चाहिए। शारिरिक विकृति एवं सज्जन्य अवरोध मे शल्यविद के सहयोग से चिकित्सा करनी चाहिए। कुछ स्त्रियों मे औषधियों के सेवन के साथ गर्भाशय का लेखन भी करना होता है।

वातज में- निरूहण, अनुवासन तथा बृंहण, बल्य, मकरध्वजवटी, च्यवनप्राश आदि योग देने चाहिए।

पितज में- विरेचन, लौह के योग, आमलकी रसायन आदि देने चाहिए।

कफज में- वमन, त्रिफला, लौह तथा भल्लातक के योग तथा वसन्तकुसमाकर रस आदि देने चाहिए।

रक्त में- रक्तपित्तहर औषधियों का प्रयोग करना चाहिए।

भूतज देवज व अभिचारज में- रसायन चिकित्सा व दैवव्यपाश्रय चिकित्सा करनी चाहिए।

सहज- असाध्य रोग है।

सन्निपातज में- चित्रक, हींग व खस से साधित घृत का प्रयोग पीने व उत्तर बस्ति दोनो के लिए करना चाहिए।

यदि परीक्षा करने पर स्त्री–पुरूष दोनो पूर्णातया स्वस्थ होगे तो उन्हें सयमी जीवन व्यतीत करनें परामर्श दें एवं अधिक संभोग निषेध कर देना चाहिए।

MENOPAUSE AND HRT

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Editor Note :

The article re-produced from the Indian council of Medical research (I.C.M.R.) bulletin, vol 28, No 1, January 1998. The authors of the article are Dr. Rashmi s. Shah Assistant Director, Dr. Lalitas s. Savar dekar, Research officer & Dr. Shanta M. Chitlange, Assistant Director. Institute for research in reproduction .

All women who live beyond the age of 55 to 60 yr and many of a younger age, experience a period of transition from the reproductive to the nonreproductive stage of life of which the most strilking feature is the cessation of menstruation ie the menopause. Menopause is defined as the permanent cessation of menstruation resulting from loss of ovarian follicular activity. The mean age at menopause has remained constant at 50, despite increase in longevity. In more than 75 year the postmenopausal years comprise one-third of a woman's life. By the year 2000, the average life expectancy for women in developing countries is expected to be 65 to 70 The worldwide population of post menopausal women is expected to be 1.2 billion by the year 2030, of which 76 per cent will be living in developing countries, This sharp increase requires serious consideration of the health needs of this age group in developing countries. Although the term menopause and climacteric have generally been used interchangeably, menopause refers to a woman's last physiologic bleeding episode and is only part of the climacteric. The climacteric (or perimenopause) is the period of transition from the reproductive to the nonreproductive stage of life and thus usually begins several years before (premenopause) and extends for a number of years (postmenopause) after the menopause. The climacteris is characterised endocrinologically by evidence of decreasing ovarian activity, biologically by decreasing fertility and clinically by alterations in menstrual pattern and by a variety of symptoms,

Demography

The median menopausal age is 50-51 year with a range of 39 to 59 year. Undernourished women appear to have menopause 4 years earlier compared with those who are not Of all the known possible risk factors associated with menopause, cigarette smoking is perhaps the most well documented. Smokers have menopause on an average one to two years' earlier than non-smokers. No other factors have been consistently related to menopausal age. Reproductive history, including early menarche, parity, upper socio-economic class, higher educational status and oral contraceptive use have been suggested to be associated with later menopause, but the associations have not been consistent.

The menopause is defined to be premature if follicular regression occurs before the age of 40 years Women who experience premature menopause, either spontaneously or following surgery or radiotherapy are more prone to the distressing symptoms and long-term sequelae of the menopause.

Endocrine Changes during Climacteric

Menopause occurs due to ovarian senescence which occurs due to exhaustion of ovarian follicles. Oogenesis starts as early as the third week of gestation, reaches a maximum at twentieth week and subsequently declines till menopause. The foetal ovary contains approximately 7 million primordial follicles which reduces to 2 million at birth and approximately 3,00,000 at puberty. Ninety percent of primordial Follicles undergo atresia and only 10 per cent ovulate ie approximately 400 ovulations in a woman's reproductive life. The ageing ovary reflects the decreasing capacity of the residual follicles to secrete estradiol which decreases from 300-500 pg/ml to less than 25 pg/ml. In postmenopausal women estradiol is derived primarily from the peripheral aromatization of androstenedione to estrone to estradiol, which increases from 1 per cent in premenopausal to 1.5-4 per cent in postmenopausal women. This androstenedione is also converted to testosterone. Decreasing estradiol levels and increase in ovarian testosterone increase the androgen/estradiol ratio. The decreasing levels of estradiol result in 10-20 fold (*ie* 75-200U/1) increase in FSH, and 2-3 fold (*ie* 60-90 U/1) increase in LH.

Excessive increase in FSH is also due to lack of inhibin secretion by the ovary which has a FSH suppressive action The periodic pulsative releases of FSH and LH are due to increased responsiveness of pituitary to gonadotrophic releasing hormones. Later in menopause the FSH and LH levels decrease but still remain above the fertile cycle levels. Progesterone levels also decrease. A decline in serum prolactin levels consistent with decreasing estrogen is also seen.

Menstrual pattern during Climacteric

The falling levels of estrogen result in menstrual changes. As women come closer to the menopause, menstrual periods often become irregular and are usually less frequent. In some women there is transient polymenorrhoea, mainly due to a reduction in the follicular phase. The menopausal transition-*ie* the time from the onset of irregularity of the menstrual cycle to the final menstrual period=lasts for an average of 3.8. years

Short Term Symptoms

At climacteric, ovarian estrogen and progesterone production fall to low levels which in some women is associated with a series of signs and symptoms due to the physiological consequences of sex steroid deficiency. Deficiency of estrogens may result in atrophic changes in the genital tract leading to vaginal dryness, atrophic vaginitis, dyspareunia and the development of vasomotor manifestations such as hot flushes, excessive perspiration, palpitations, headache and vertigo. The women may also suffer from psychological symptoms such as increasing nervousness, apprehension, lack of concentration, irritability, depression and insomnia. These symptoms comprise the menopausal syndrome. The prevalence of menopausal syndrome varies widely not only between individuals in the same population, but also between different populations. Also, it i has been difficult to distinguish between symptoms that result from loss of ovarian function and those from the ageing process or from socio-environmental stresses of the mid-life years. Some of the more common symptoms are described below.

Vasomotor symptoms

Hot flushes, night sweats, insomnia, palpitation and headaches are usually attributed to vasomotor instability Of these, the hot flush is the specific symptom of the menopause. The hot flush is described as a sudden reddening of the skin over the head, neck and chest and is experienced as an explosion of heat followed by profuse sweating. The flushes usually last from a few seconds to several minutes. They ocfdur at verying intervals from every 10-30 minutes to once a week or more.[12] They occur more frequently at night. Insomnia usually occurs as a secondary effects of sleep disruption caused by night sweats.

The prevalence of hot flushes associated with menopause varies in different cultures. For example, the prevalence has been reported to be nil in Mayan women, 10-22 per cent in Hong Kong women, around 17 per cent in Japanese women. 23 per cent in Thai women, 45 per cent in North Ameican women and up to 80 per cent in Dutch women. Although some studies have shown inconsistencies in the reported prevalence of these symptoms, in genreal, flushes and sweats are more common in European and North-American women than in other populations. A high intake of dietary phytoestrogens (estrogen like compounds found in plants) has been sugested as a possible expalnation of the lower frequency of menopausal symptoms in Japanese as compared with Caucasian women

Recent studies suggest that menopausal symptoms occur due to an imbalance of the endogenous opioid system. Endogenous B-endrophin and other opioids regulate nuclei in the brain stem which in turn may influence not only the temperature regulating centre but also vessel wall functions. The endogenous opioid system is regulated by several factors and after some time a new equilibrium is achieved and symptoms subside.

Urogenital atrophy

The epithelium of the vagina and of the urethra and bladder respond to estrogens. If estrogen concentrations are insufficient, these tissues atrophy. The vaginal epithelium loses normal rugose appearance and becomes attenuated, pale and transparent. The depth of the vaginal vault is shortened and the upper third begins to constrict. Atrophic vaginitis can result from marked atrophy of the lining of the vagina. Vaginal atrophy can cause vaginal dryness, burning, pruritis, dyspareunia and prolapse. The pH of the vagina increases, thereby promoting the growth of bacteria which may result

in vaginal infection. Atrophy of the mucosa of the lower urethera and bladder may lead to urinary symptoms such as urgency, frequency, dysuria, nocturia, incontinence, as well as the development of urinary tract infections.

A Swedish study that interviewed 900 menopausal women found that 29.2 per cent complained of urinary incontinence, 13 per cent gave history of repeated urinary tract infections, 15 per cent complained of pruritis and vaginal discharge and 38 per cent had vaginal dryness and dyspareunia. Loss of interest in sexual relations was found in 32.7 per cent of women . There is marked variability in the onset and severity of atrophy of the urogenital tissues This is in part due to variations in the rate of ,decline of estrogen production, which may be acutely or chronically muted by factors that increase either prehormone production or efficiency of conversion of prehormone to estrone. symptomatic in months, other others may take years to develop symptoms or urogenital atrophy, and some may never develop such symptoms.

Other complaints

Some frequently mentioned symptoms of menopausal syndrome are depression, irritability, nervous tension, palpitation, headaches and fatigue. Changes in B-endorphins and other opioids that occur during this period lead to an influence in the nervous transmitters of the GABA-system and serotonin system. These changes may explain in part why many women experience psychic and psychologic symptoms around the menopause. Thining of skin, loss of hair and brittle nails are also some of the changes evident during this period. However, it is unclear to what degree each of these symptoms is related to estrogen withdrawal, ageing and or environmental stress.

Studies are ongoing at the Institute for Research in Reproduction (IRR), Mumbai, to evaluate the prevalence of menopausal symptoms in women in an urban setup and to determine their attitude towards hormone replacement therapy. (HRT). Climacteric women attending the Family Welfre Clinics of IRR were interviewed with the help of a precoded questionnaire. Date collection included age at menopause, menstrual history during the transition period, vasomotor and genitourinary symptoms, history of sexual activity and frequency and their attitude towards HRT. Preliminary analysis of responses of 100 perimenopausal women revealed that the mean age at menopause was 45.08 years. The age of the women interviewed ranged from 40 to 60 yr. Hot flushes, sweating and insomnia were complained of by about 25 per cent of women. The most frequent complaints in this age group were fatigue and muscle-joint pain (48%); 84 per cent of women interviewed were not aware about HRT. When asked whether they would be willing to take long-term HRT, only 16 per cent of women agreed. The common reason for refsual to take treatment was on account of vaginal bleeding (3.4%), while 15 per cent felt that menopause is a normal phenomenon and hence no treatment should be taken.

Management of the Menopause

During the current decade, the management of menopause will become a National health concern as milions of baby boomers reach this stage of life. Medical intervention at menopause should be regarded as a programme of preventive health care in the same category as family planning. In this context HRT has found its place in the treatment of symptoms and some harmful effects of menopause.

In general, there are three indications for which HRT is used. These are (1) vasomotor and genitourinary symptoms related to estrogen deficiency, (ii) prevention of osteoporosis eg estrogen therapy reduces the rate of bone mass loss in postmenopausal women to the premenopausal rate thus reducing the number of fractures, and (iii) prevention of cardiovascular morbidity and mortality. To derive maximum benefits of HRT for prevention of osteoporosis and cardiovascular disease, treatment should be started at menopause and continued for at least 5 to 7 year.

There are many controversial issues surrounding this therapy due to conflicting data from epidemiological studies *viz.* (i) what hormonal agent or route of administration is best? (ii) what is the best regimen, sequential or continous? (iii) how long to continue the therapy? (iv) should very old women be started with HRT? (v) does HRT increase the risk of cancer? *etc.*

Hormone Replacement Therapy

Estrogen can be given in a variety of routes. In practice, the oral, transdermal, subcutaneous and vaginal routes are commonly employed.

Each has benefits and disadvantages. Selecting the appropriate drug and route and also duration of therapy would depend on whether the woman desires long-term systemic treatment for the premature or sequelae of menopause or wishes to merely have relief of climacteric symptoms, whether she is willing to experience bleeding, the presence or absence uterus, the presence or absence of risk factors or osteoporosis, cardivovascular disease, the availability and cost of the preparation.

Oral HRT.

Synthetic estrogens (ethinyl estradiol) are not used for HRT because of their enhanced thrombogenic effect. Natural estrogens are used. Oral estrogen preparations are relatively inexpensive, easy to administer and easy to discontinue. The disadvantages are that some woman experience nausea and compliance cannot be guaranteed. Oral ingestion produces a first pass hepatic effect. Although no increased risk of venous thrombotic disease has been documented it may be prudent to use transdermal estrogen in women who have experienced deep vein thrombosis. The commonly used oral natural estrogen are estradiol valerate, conjugated equine estrogen (main component is estrone sulphate) and piperazine estrone sulphate. (Table I).

Table I. The commonly used estrogen preparations for HRT

Oral	Estriol succinate 2 mg. (Evalon) estradiol valerate 2 mg (Progynon) Conjugated equine estrogen, 0.625 mg 1.25 mg (Premarin)
Transdermal	Estradiol (Estraderm TTs 50,100μg)
Subcutaneous	Estradiol (25,25,100 mg)
Vaginal	Conjugted equine estrogen 0.625 mg in 1 g base (Premarin) Estriol 0 1 per cent (Ovestin)

Progestogens

When estrogen alone is taken for a long time, there risk is of endometrial hyperplasia and endometrial carcinoma The risk is related to both the duration and dose used. Progesotgen supplementation for about 12 days in each month restricts endometrial proliferation and ensures periodic transformation of a proliferative endometrium into a secretory one. The progestogen commonly used sequentally for 12 days each month with the protective doses for endometruim per day are listed in Table II.

Table II. Protective doses of progestogen for HRT

Progestigen	Protective dose
Dydrogesterone (Duphaston)	20 mg
Medroxy progesterone acetate (Provera, Farlutal)	10 mg
Norethisterone (Micronor)	1.05 mg
Levonorgestrel (Noegest)	150 μg

Unfortunately the additional of cyclical progestogen leads to withdrawal bleeding and premenstrual syndrome like fluid retention, breast tenderness, irritability, headaches and depression. The androgenic progestogens (norethisterone and levonorgestrel) will lower the concentration of HDL cholesterol. if the daily progestogen dose is reduced to norethisterone 1mg and levonorgestrel 150 μg, the changes in lipid profile are minimal. Estrogen and progestorgen may be prescribed separately or as a combined preparation (Table III). In a woman with an intact uterus if a combined preparation is not available a natural estrogen should be prescribed daily together with dydrogesterone or medroxy progesterone for 12 days of each calendar month. The compliance among postmenopausal HRT user may be poor because of heavy or prolonged withdrawal bleeding but the problem can be overcome Progestogen therapy can be avoided in hysterectomised women.

Table II. The commonly used combined preparation for HRT

Nevelle	Estradiol valerate 2 mg Levonorgestrel 75 μg
Prempak C 0.625	Conjugated equine estrogen 0.625 mg levonorgestrel 75' μg
Prempak C 1.25	Conjugated equine estrogen 1.25 1.25 mg Levonorgestrel 75 μg

Continous combined regimen

The aim is to give continuous combined estrogen and low dose progestogen to render endometrium atrophic ultimately inducing amenorrhoea. However many women discontinue the use of this combination within first 6 months because of irregular bleeding Continuous combined therapy is currently a subject of extensive research.

Tibolone

Tibolone has weak estrogenic, androgenic and progestogenic actions and may be used in postmenopausal women. The dose is 2.5 μg daily and is used mainly for the relief of vasomotor and psychological symptoms However 15 per cent of

postmenopausal women have irrgular bleeding. It is also expensive.

Non-oral HRT

There is no first pass hepatic effect and nausea is avoided. The transdermal estradiol patch is self adhesive and delivers estradiol over a period of 3-4. days at a constant rate of 50 μg per 24 h. One patch is applied twice a week on a dry hairless area of the skin, below the waist line. A new area should be selected for each application. The patch is easy to apply, easy to remove and has a shorthalf life, The drop out rate on account of local skin reacion is around 5 percent. It is relatively expensive.

Subcutaneous estradiol implant

Subcutaneous pellets of crystalline estradiol release the hormone over a period of more than 6 months. The commonly used dose is 50 mg every 6 months which is adequate for **bone conservation.**

The disadvantages are that implantation requires a surgical procedure under local anaesthesia every 6 months and in case the woman wants to discontinue, it is difficult to remove the implant. A small number of women may have recurrence of menopausal symptoms despite adequate levels of serum estradiol. The anterior abdominal wall, about 5 cm above and parellel to the inguinal ligament is the common site for the insertion of pellets.

In the presence of an intact uterus the patient needs to take oral progestogen for 12 days in a month along with non-oral HRT.

Vaginal estrogen

The therapy is useful in women who have been postmenopausal for some years and wish to have relief of vaginal dryness, atrophic vaginitis, urethritis of dyspareunia. The commonly available vaginal creams are conjugated equine estrogens (0.625 mg in 1 g of base and estriol 0.1 %)

Non hormonal Therapy

In the last decade, efforts have been directed to find non-hormonal alternatives to prevent postmenopausal osteoporosis for women who prefer not to use hormones or where estrogen is contraindicated. These include:

(1) A moderate level of physical activity especially weight bearing exercise appears to have a beneficial influence on peak adult bone mass although it does not prevent osteoporosis.

(ii) Calcium is an essential element for normal bone health A life long supplementation with calcium in a dose of 800 mg/day is recommended as complementary therapy. Calcium intake in childhood and adolescence may be a determinant of peak bone mass. Calcium does not substitute for estrogen in preventive therapy in postmenopausal women. Vitamin D helps calcium absorption in the gut and reduces the rate of bone loss.

Certain vitamins (B1, B2, B6, B12, Vit A, Vit C, Vit,E) along with minerals have been shown to be effective in alleviating the menopausal symptoms *eg* hot flushes, palpitation, depression, anxiety. *etc.*

(iii) Calcitonin is effective in prevention of bone loss, but it is expensive and is only available as nasal spray and in injectable form.

(iv) Sodium fluoride has been known to increase bone density but studies are limited due to its adverse effects.

Osteoporosis and Estrogen Replacement

Osteoporosis is characterised by decreased bone mass and increased susceptibility to fracture most commonly of the wrist, the spine and the hip. Estrogen replacement therapy is very effective in preventing osteoporosis and reducing the risk of the associated fractures.

For conservation of bone in awell built, menopausal woman with no risk factors, the minimal effective dose of estradiol valerate is 2 mg and of conjugated equine estrogen is 0.625 mg daily. The minimal effective daily dose for bone preservation in a small built, thin , sedentary regular alcohol/tobacco user who has undergone bilateral oopherctomy is likely to be higher and these factors must be borne in mind while prescribing HRT.

The greatest benefit is obtained if HRT is given shortly after the menopause prior to signifiant bone loss. However, there is clear evidence that in all stages of the pos menopausal life HRT prevents bone loss. Five years of appropriate HRT reduces the lifetime incidence of the fracture femur neck by 50 per cent and of vertebrae to a greater extent.

Cardiovascular System and HRT

Mortality from coronary heart disease (CHD) like myocardial infarction among women increases

with adancing age. Changes in serum lipids after the menopause suggest a relationship with estrogen deprivation. Total serum cholesterol decreases. Several epidemiological studies have demonstrated that with 4 or more years of oral estrogen therapy in both normotensive and controlled hypertensive women, the risk of CHD is reduced by more than 50 per cent as compared to "never users". There are no data available on CHD and HRT from developing countries.

Mechanisms of action of estrogen for cardioprotection

A 35 Cent reduction of LDL cholesterol results in 50 per cent reduction in cardiovasular disease. However, estrogen reduces LDL cholesterol by only 10 per cent. This may explain about a third of the cardioprotective effect of estrogens. It also increases HDL which is believed to be protective against arteriosclerosis. Estrogen also increases the coronary blood flow as demonstrated by many angiographic studies. It also acts as an antioxidant and there is a favourable effect on haemostasis. Unlike synthetic estrogens, natural estrogens do not have any significant effect on the blood presure. In only 2 or 3 per cent of HRT user there is an increase in blood pressure.

When Should Treatment With HRT Begin?

In the past women over the age of 60 years have been denied HRT in the belief that they are too old and their skeleton is too osteoporotic to benefit from estrogen replacement therapy. Recent studies using conjugated equine estrogen 0.625 mg daily plus calcium showed an increased bone density in both the spine and the femur neck after two years of treatment. Garnett *et al* reported similar benefits with 75 mg estradiol implants in women over 60 year of age after one years of treatment. The increase in bone density was greater in women who had more severe disease and it was concluded that implants are more effective in the treatment of established osteoporotic disease. In the elderly woman with osteoporotic fracture, hormone therapy is advocated as it decreases the risk of further fracture.

In fact Black has convincingly argued for delaying the start of HRT for prevention of osteoporotic fractures. Reasons given for waiting until a later age include (i) the possibility that hip fracture risk can be more precisely estimated at 65 or 70 yr than at 50 yr of age; (ii) that treatment duration will be shorter and therefore, more cost effective if begun later, and (iii) the uncertainity associated with long-term treatment can be eliminated.

HRT and the Risk of Cancers

Breast carcinoma

Epidemiological studies on the risk of breast carcinoma are to some extent contradictory. The overall message is that extended use of estrogen therapy entails an increase risk being 1.3 - 1.6. The risk increase with the duration of therapy. Patients who develop breast carcinoma after estrogen therapy are usully detected with early stage tumours probably due to the close monitoring which they undergo during therapy. Women with a strong family history of the disease may be at a higher risk for developing breast carcinoma after estrogen therapy. Progestogens do not appear to have any protective efect. Breast cancer surveillance is recommended for women taking hormones at the same frequency as women not taking hormones. They should have regular breast examination and regular three yearly mammography from the age of 50 years.

Endometrial hyperplasia and carcinoma

Estrogen use of 10-15 yr may have increased risk of endometrial hyperplasia and carcinoma (RR 10) compared with women who have never used it but declines once estrogen is stopped. Use of progestogen along with the estrogen reduces the risk of endometrial cancer. Indeed the action of progestogen counteracts the cancer inducing effect of the estrogen on the endometrium.

Endometrial screening in HRT users

If on transvaginal ultrasonography the endometrial thickness is more than 4 mm, there is a need for tissue sampling either by biopsy or by dilatation and curettage. For patients on continous combined therapy, screening is recommended generally once a year.

Studies of ovaries in Europe and No information is available from de veloping countries. Several studies to find a link between HRT and cervical cancer were undertaken but rsults have been inconclusive.

There is no evidence that one form of estrogen is superior to another.

To summarise, it is known that short-term treatment of menopausal

women with HRT for the symptomatic relief of climacteric complaints is effective, safe and generally well accepted. However, use of long-term HRT (for 7 yr or more) is still controversial. In clinical practice, the beneficial effects of long-term HRT on women's health mainly on osteoporosis and cardiovascular disease, must be carefully weighed against a possible increased incidence and mortality from breast cancer. It is necessary to provide accurate and individual information to women about the advantages and disadvantages of using HRT. Educating potential users will enhance compliance, especially if wimen make this decision themselves, fully informed hby their physicians. Woman who agree to take HRT should have careful follow up monitoring so as to abtain maximum benefit fot this therapy while minimizingany risks or side-effects.

MASEEH-UL-MULK
LATE HAKEEM AJMAL KHAN SAHIB

Editor Note :

Maseeh-ul-mulk Hakeem Ajmal khan was multi dimensional personality. He was great freedom fighter, founder of A & U Tibbia college as well as great physician of Unani system of Medicine A dedication to Ayurvedic and Unani system of Medicine and effort to safe gaurd of its graduates as under :

The year 1910 was milestone in the medical profession of Hakeem Ajmal Khan. Incensed by his efforts to popularise the Unani medicine the Bombay Medical Association called upon the Government to legally prohibit all indigenous systems of medicine, which in its view, had hardly any validity. It also demanded compliance of strict standards before issuing permission to establish a clinic which was tantamount to a total ban on the practice of Hakeem and Vaids in future. The Government, introduced a bill on 21 Nov. 1911 in the Bombay legislative Council for the Registeration of Medical Practitioners. According to the proposed Act. No Hakeem & Vaid could be enlisted or was a degree holder from a recognised university in India.

The Bill aimed at creating a Medical Council to control the medical practitioners and was empowered to remove from its register the name of any physician, No unregistered physician was considered to be "legally" or duly qualified medical practitioner"and was, therefore, Unqualified for the position of medical officer in any hospital or dispensary. In fact it sounded a death-knell of all the Hakeems and Vaids. Hakim Ajmal Khan reacted sharply to this move and declared a constitutional war against the Bombay Government by mobilising public opinion against the Bill. As a result of this Indian members opposed the Bill tooth and nail in the Council and condemned the Government for proceeding with such a move against the indigenous systems of medicine supporting the cause of Indian system. But the Government made it known to the

1868-1927

house that it was not impressed with the practice of the Vaids and Hakeems. However, the Governor of Bombay Sir George Sydenham Clarke Suggested that if the Hakeems wished " to be seriously considered, they should organise themselves, submit to some form of training and use some method of differentiating between those who are Hakeems and those who are not. Soon after the Bill was referred to a select committee for consideration, Hakim Ajmal Khan toured the country and lobbied extensively against the Bill. He asked the Hakims and vaids to put up a joint front to oppose it by convening meetings and conveying to the Governor of Bombay, their disapproval of the Bill.

The Hakeems and vaids all over the country voiced with Hakeem Saheb for the withdrawal of the Bill and recognition of Indian Systems of Medicine-Hakeem Sahab himself convened meetings in Delhi and Bombay and demanded that the Vaids and Hakeems should also be given representation on the proposed Medical Council. He further demanded that the Hakeems and Vaids should be kept at par with the certified medical men such an M.D., L.M. & S. of the Universities of Caluctta, Madras, Allahabad and Lahore and other Government colleges and Schools. In 1910 Hakeem Sahib organised the All India Ayurvedic and Unani Tibbia Conference to organise the Hakeems and Vaids to "offer a united Voice to the Government to oppose the anti-indigenous move of the Government through it.

(Dr ABDUL HASEEB)

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MANAGEMENT OF RENAL DISORDER

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The Kidney having a pivotal role in the electrolyte, water balance and maintainance of the normal consistancy of plasma, is considered one of the important most vital organ. Its inflammations though of mild dgree, if presistant, create symptoms which catch the attention of the patient and the physician as well. The deseases of the Kidney as noted in the practice and mentioned in the classical Unani Literature range from lowest to the highest severity. It will be interesting to pointout here that metabolic, hormonal and nephrogenic, genetic kinds of polyuria have been described by the ancient authorities in very clearly understandable way.

Classification of polyuria, in particular of Diabetes and its various kinds has been done and seperate chapters have been maintained for each kind of Diabetes. The word Diabetes itself is Greek (Unani) in origin, though other names have also been in use for this ailment.

No doubt the modern researches have provided the hormonal basis for the causation of diabetes and it is generally now an overall accepted metabolic disorder, as far as diabetes-mellitus is concerned, the diabetes insipidus being to much extent of Hormonal Origin alone. But the Unani Medical Science has much to say about the causation of diabetes, and its lines of treatment. The aim of presenting these lines on Unani aspect of the Management of Kidney diseases will remain focussed on diabetes in particular and clinical approach to the inflammation of Kidney.

General measures and line of treatment (Usool-e-Ilaaj) to a necessary extent will also be discussed. But to start with in view to provide general frame work of the clinical literature related with the Kidney disorders will be introduced as referred in the classicial texts.

It is not possible to offer details on all the aspects and all the diseases of Kidney in this small writing.

The selection of diabetes, even though now a days an established metabolic disorder is being done, to

(1) Bring into light the Unani conceptual frame work of tackling the various kinds of polyuria based on the classical literature.

(2) To introduce a new Unani Oriented approach to the management of deabetes based on Kidney, Liver, and nervous system interrelationship.

The introduce a new Unani Oriented approach to the management of diabetes based on Kidney, Liver, and nervous system inter-relationship.

The number of Kidney diseases as referred in Unani literature by various ancient authorities, vary from six to thirteen in chronological order i.e. from 8th century A.D. to 18th century A.D. and thus it can be judged that Unani literature has been enriched during this period. Rhazes (D 925 A.D.) mentions nearly sixteen diseases whereas Majoosi (9th century A.D.) mentions only six renal diseases. But Azam Khan (18th century A.D.) mentions twelve renal diseases.

Classification of temperamental disorders of the Kidney, inflammations of the Kidney and polyuria have been point of difference.

It will be interested to note here that Majooshi, the author of 'Almaliki' mentions only one kind of Diabetes, the Ziabetes-e-haar by the single name Ziabetes due to accessive heat in the Kidney, the Diabetes mellitus as the only diabetes which means that true Diabetes in his opinion is Diabetes mellitus alone. This is the unique view presented by Majoosi alone, next to him Rhazes classified polyuria into various kinds, nearly eight, Diabetes being one of those.

Avicnna (D 1037 A.D.) while mentioning disease of Urogenital

system, puts diabetes under polyuria in a seperate chapter other than main renal disorders. Avicnna, here in this respect has adopted a mid way for the description of Diabetes and polyuria in general.

The other authors as Jurjani (12th century A.D.) and one of the important latest author of the 18th century, Aazam Khan (18th A.D.) classify diabetes as the diseases of Kidney itself.

POLYURIA(Kasrat-e-bol)

1) INVOLUNTARY -

Due to paralysis (Incompetence) of sphinnctor Urethrae.

2) VOLUNTARY -

(i) with burning (ii) without burning

Without Burning classify into -

(i) with Polydipsia (ii) without Polydipsia.

The last two varieties i.e. with thirst and without thirst are named as Diabetes but the polyuria with thirst is named as Diabetes whereas without thirst or polydipsia is considered to be due to the injury, cold or incompetance of the sphinctor Urethrae.

Rhazes discusses on polyuria in somewhat detail as compared to others and the treatment of various polyurias has been done accordingly

1) polyuria due to heat.
2) polyuria due to Soo-e-mizaj Barid (cold-atemperament)

The above two brief Etiological kinds of diabetes represent Diabetes Mellitus and Diabetes Insipidus in the broad sense.

Concept of Hiddat or Heat has been accepted Uniformly throughout the Unani literature as a cause of diabetes.

The concept of Hiddat or Hararat-e-Kuliya (renal heat) in somewhat more detail is a follows.

The renal heat compells the Kidneys to absorbs more fluids whereas its retention power is reduced and hence the extra fluids are exerted through the bladder. This hot a temperament of Kidney resemble with the fire that is raised, i.e. renal metabolism, which the Kidney itself being low in size cannot tolerate; and absorbs further fluids to normalise its internal environment.

The accessive heat further weaknes the retention power of Kidney, which is prove being relived on use of cold substances e.g. camphor and others alike.

Rhazes further explains about the flow of fluids are taken from the blood vessels, (afferent arterioles through the glomerulus) the vessels take it from the liver, the stomach and the alimentry cancal and these organs falling short of fluids, dry up and they required further fluids to reduce and pacify the polydipsia and a cycle of taking water, their absorption by Kidneys and excretion more than normal in amount, the polyuria is maintained as a syndrome.

Same thing happens in case of Diabetes-insipidus or Ziabetes-e-barid but without heat and cold of the entire body, of the kidney itself, the symptoms of accessive heat being absent.

GENERAL MEASURES FOR THE TREATMENT OF KIDNEY DISORDERS.

1. Rest and avoidance of sexual intercourse, Liver therapy its tonning up.
2. Qai (Vomitting)
3. Diuretics
4. Avoidance of strong purgatives.
5. Use of anti-inflammatory agents
6. Local application of oils, cold water, ice water ad tub baths
7. Enemata (Drug enema)
8. Oral Medication.
9. Paints and pastes, use of oily substances on the Kidney.
10. Use of constrictors of hot and cold nature according to the temperament of the disease and the Humours in all.
11. Use of sexual tonics.
12. Kidney tonics.
13. Rest
14. Fluid Balance
15. Dite.

GENERAL MEASURES FOR THE MAN AGEMENT OF INFLAMMATIONS.

1. Rest
2. Use of anti-inflammatory agents of cold and hot nature locally as well as orally and through enema.
3. Fluid balance
4. Diet
5. Use of locally acting constric-

tors of hot temperament.

6. Constrictors of cold

MANAGEMENT OF DIABETES. ZIABETES-E-HAR (DIABETES MELLITUS)

1. Control of diet through use of special dietic preparations containing barley water, opium wine, extracts of astringent fruits like pomegranate, apple and unriped almoud and unnab.

2. Use of agents curing polydipsia.

3. Use of cold refrigerant agents.

4. Use of the following drugs orally :

Camphor, Bombax moree, Bazre-khas, Bazr-e-hummaz, Dry Coriander, Red rose flower, Gulnar.

5. Local applications (Zimad)

- Sandal abyaz (White sendal), - Sandal Surkh (Red sandal), - Warad ahmar (Red Rose), - Teen-e-Armani, - Bazr-e-Qutoona, - Gulnar (Pomegranate), - Habbul-Aas, - Juft-e-Balloot, - Aquqiyah, - With extract of Buqlatul Humaqa and Baqlatul-Hummaz, - Rain water, - Duhn-e-Ward (Rose oil)

6) Enema

last four drugs added with barley water.

Usara-e-ward (Extract of rose flwer)

Roghan-e- Nilofar

7) - Compounds to be given orally.

- Qurs-e-Tabasheer Kafoori

- Qurs-e-Kafoori

8) Cold bath

Line of treatment for ziabetes-e-Haar or (Diabetes Mellitus)

AS SET BY RHAZES (REF TO FILGHARYOOS)

1. Control of polydipsia by the use of rose flower extracts, inspiring cold air and sitting in cold environment, applying cold paste on the adbomen, renal area, covering liver and the stomach.

2. When the thirst or polydipsia is controlled, enema small sugar, with cold water and further cooling down of the body and cooling the liver which is hot.

3. Purgation:- When the purgation is stopped, use Habb-e-sibr and bulooghazia, vomitting followed by local application fo Khardal.

line of treatment for polyuria due to soo-e-mizaj barid (Cold a temperament of the Kidney) Particularly of old age :

1. Provision of necessary fluids to the body.

2. Use of heavy foods.

3. Oily enemata, gastric tonics having the property to tone-up the Kidnies at the same time.

4. Harira and alike foods.

5. Use of single drugs as Mastagee, Saad Koofi, Khoolangan, Kamoon, Filfil, Saatar.

6. Drinks as wines of various kinds of hot temperament.

7. Use of compound formulations as Majoon-e Falasefa, Majoon-e-Kundur, Majoon-e-Jaleenoos, Jawarish Jalenoos, Anqarduya, Masstoodetoos and Itreefal-e-Sagheer, Iron preparations etc.

Some important opinions of authorities on Unani system of medicine on diabetes as under

Hippocrates : Hippocrates discussing the management of acute deseases opines that if Polyuria caused due to accessive heat in the head. Since the Bulgham-e-Tabaee (Normal Phlegm) is desolved and it causes nesal, and other respiratory passages catarrh on continuation of this ailment.

Hippocrates mentions delusion, folly, numbness of the head, pain and confusion in the head in the patient of Diabetes. Hippocrates proposes the treatment accordingly based on the above grounds. He advises fomentation of the head with regularity, vomitting induced by hot water, massage of the face and forehead after removing the hair of the scalp, use of hot medicated enemata and use of smuffs to the extent that the water flows out from the nose and he mentions it as a cause of diabetes. He further advises to administer bonney water, purgatives, thermocautrization on the forehead, on the occiput and temporal regions.

Rhazes while discussing the local application of antidiabetic paste records one of his cases. He says that the patient was instructed to sit on cold place cov-

emd by cold nature of fresh vegetable leaves spread by ice water and to remain with his back the lower portion keeping in continuous direct touch without moving at all. Rhazes reports that his Kulah (Supra renal gland) was cool down for ever. Here Rhazes points out and instruct his people to observe how the chyle is shifted, mixes and metabolised into blood and the water and runs in these blood vessels spread throughout the Kidney and related parts continuously without any break. And he further ask him to think how the blood and water remain in these vessels in regular flow.

It will be worthwhile to note here that Rhazes uses the trems "Kulah" used for suprarenal gland not the word Kuliya the terms for Kidney alone.

Rhazes describs the absorbtion of digested food here in particular, the carbohydrates their metabolisation, circulation in the blood, the importance of the blood and water and continuation of the blood flow in the urinary vessels. This explanation of Rhazes provide the bases of clear understanding of the role played by the suprarenal gland specific regular flow with continued single state i.e. the current renal circulation and the special role of circulating blood, watery glomerular filtrate and affect of the cold on the suprarenal cortex.

3. Jurjees (Bakhteeshu) (8th century A.D.) Jurjees mentioned that persons those who micturate in the night and without burning, they should refrain from taking vegetable, fruits and drinks etc. He has advocated the use of filfil, Khardal, Oasted meat, Wine (Pure and strong), Iron and black myrobalan, (Halaila-e-Aswad) Rhazes added further a powder made of Kundur, Murr, Balioot, Kazbera, Vinegar and Saad Koofi.

Nearly all ancient authorities on Unani medicine are of openion that sexual weakness is related with one or the other kind of polyuria. They are also convinced that the accessive heat in the body, the head, the liver, the Kidney, Stress and strain, continious insomnia, use of much cold water, accessive intercourse etc. all cause Diabetes.

They are also of opinion that the diseases of liver and Kidney are usualy co-related or occur one after other. The liveris weakened due to Kidney diseases.

COMPLICATION

They are also of opinion that the diseases of Kidney relates to the complications of the diseases of respiratory organs, axillary glands, Heart and lungs in particular.

That ancient authorities are further convinced of the relationship of brain and its part affected by the stress and strain, cold and heat with the causation of diseases of Kidney.

The symptoms of cold, weakness, loosening of the renal parenchyma, reduction in Kidney fat, dialatation and injuries of the urinary tubules are all related with the Kidney disorders in particular with polyuria, thinning of the body, loss of sexual vigour, headache and visual defects.

They compare failure of reabsorbation and retention of the necessary part of the body fluids by te Kidney with sprue and passing the undigested food in the motion.

They are also convinced of the fact that the odour of the breath in diabetes in bad and unliked.

GENESIS AND GLOBALISATION OF UNANIPATHY

1. Dr. (Mrs.) Aliya Aman 2. Hm. Shamsul. AFAQ.

DEFINITION :

Unanipathy is a science of state of Health and disease.

ORIGIN AND DEVELOPMENT

The Unanipathy Originated in Greece. It has a long and impressive record in India. THE FOUNDATION OF UNANI WAS LAID BY HIPPOCRATES (BUQRAT-460-377 BC) IT WAS THE GREECE PHYSICIAN. Hippocrate, who freed medicine from the realm of super station and Magic and gave it the status of Science. The Theoretical from work of Unanipathy is base on the teaching of Hippocrates. After Hippocrate a number of other Greece Scholars enreached and developed the system considerably. Of them Galen (Jalinoos - 131-210A.I) stands out as the one who stabilised its foundation on which Arab Physicians like Rhazes (Zakaria Razi-850-925 AD) and Avicenna (Sheikh-Bu-Ali Sina-980-1037 AD) Constructed an is imposing edifice and developed it.

The system owes its present form to the Arabs, who not only saved much of the grace literature by rendering it into Arabic but also enriched the medicine of the day with many of their contribution. In this process they made extensive use of the available knowledge and experience of such sciences as Physics, Chemistry, Botany, Pharmacy, Anatomy, Physiology, Pathology, Therapeutics, surgery and also that what was best in the contemporary system of Traditional medicine in Egypt, Syria, Iraq, China, India and other middle East and for east countries. Special attention was paid to Medicinal Herbs found in India and several books on the therapeutic qualities of these hearbs were written by Arab physiciaus. Gradually the system setup several schools and Laboratories for imparting instruction in this Science of medicine and established Hospitals and dispensaries in the big and important cities for treatment of the sick.

In India, Unanipathy was introduced by the Arbs and soon it took firm root in the soil. The scholars and physicians of Unani system of Medicine, who settled in India were not, Content with the know drugs but they subjected Indian herbal drugs to chemical trials and as a result of their experimentation added numerus native drugs to their own system, thus further enriching its treasure of Unani Pharmacology. The system found immediat mediate favour with the masses and soon spread and flourished all over the country, and continued to hold an unchallenged way fore a long period.

The Unani Medicine suffered a severe set back along with other Indian System of Medicine like Ayurveda, with the establishment of British rule in India. They pushed forward their own system of Allopathy. Thus, development was hampered due to withdrawl of government patronage But since the system enjoyed faith among the masses it continued to be practiced. This system of Medicine was very much popular among the masses all over the Country. Due to popularity and acceptibility, Unani System survived in the British period. An outstanding Unani physician and scholar of Unani Medicine, Hm. Ajmal Khan (1868-1927) championed the cause of the system in India. The Ayurvedic and Unani Tibbia college and Hindustani Dawakhana in Delhi are two living examples of his immense contributions to the multipronged development of the two Indian Systems of Medicine. The development of Unani Medicine as well as other System of Indian Medicine gained considerable momentum after independence.

The Govt. of India established in 1969, a central council for Research in Indian Medicine and Homoeopathy to develop this

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system of Medicine through scientific research.

In 1978 this research council was split up into different branches of Indian Medicine viz. Ayurveda, Unani, Siddha, yoga, Naturopathy and Homoeopathy.

In order to streamline education and regulating practice in the Indian System of Medicine, the Government of India setup an act of Parliament, Indian Medicine central council Act 1970.

In 1995, government of India also set up a full fledged department of Indian System of medicine & Homoeopathy in the Ministry of the Health and Family welfare, to further accelarate the pace of development of Unani system of Medicine. Now, because of its holistic approach, the cure and abscence of harmful effect, Unanipathy is gaining strong ground as an alter native System of Medicine. Unanipathy as said earlier, is based on Principles put forward by Hippocrates. He was the first Unani Physician to establish that disease was a natural process. He emphasized that its symptoms were the reactions of the body to the disease and the chief function of the physician was to laid the natural forces of the body. He was the first physician from antiquity to introduce the method of taking medical history. His chief contribution to the medical realm is the Humoral Theory Humoral pathology.

The Humoral Theory presupposes the presence of four humours Blood (Dam), Phlegm (Balgham), yellow bile (Sofra) and black bile (Sauds) in the body. The temperament of persons are expressed by the word Sanguine, Phlegmatic, choleric and Melancholic according to the preponderance in them of humours, blood, Phlegm, yellow bile and black bile respectively. Every person is supposed to have a unique humoral constitution which represents his healthy state.

To maintain the correct Humoral balance there is a power "Medicatrix naturae (Quwat-e-Mudabbar-e-Badan) in the body. If the equilibrium of the humor disturbs, the humoral Composition is bound to occur and body get discased. In Unani, great reliance is placed on this power. The medicine used in this system, in fact, help the body to regain this power to an optimum level and this restore Humoral balance, thus retaining health.

DIAGNOSIS :

The diagnostic process in Unanipathy is dependent on observations and Physical examination. Another most important distinctive feature of the Unani is its emphasis on diagnosing a disease through "Nabz" (Pulse), Rhythmic expansion of arteries which is felt by fingers. The Ten condition of pulse observed and percieued during the diagnosis are (a) Quality (b) Force (c) Duration of Movement (d) Condition of the vessel wall (e) Volume (f) Duration of the rest period (g) Palpitation of the pulse. There are other Physical methods of diagnosis which include examination of urine (Baul), for Urinogenital disorders, stool (Baraz), for Intestinal disorders, Phlegm (Balgham) for Respiratory disorders and Blood (Dam), for blood disorders viz Pathogenesis of blood and other Humors, metabolic disorders and liver diseases.

PREVENTION OF DISEASE :

Prevention of disease, as said, is always better than cure. It is as much concern of the system as curing of sickness. Rights in its formative stage it recognizes the influence of surroundings and ecological conditions on the state of Health of Human being. This system aims at restoring the equilibrium of various elements, humors and faculties of the human body. It has laid down six essential prerequisites for the prevention of disease and for the promotion of Health and places great emphasis, on the one hand, on the maintenance of proper Icological balance and on the other, on keeping water, food, and air free from pollution. There essentials are known as "Asbab-e-Sitta Zaroriya' i.e six essential Factors. They are Air, food and drinks, bodily movement, and repose, Psychie movement and sleep and wakefulness and excretion and retention.

THERAPENTIC :

In Unanipathy various types of Treatment are employed, such as Regimental Therapy (Ilaj-Bil-Tadbeer), Pharmacotherapy (Ilaj-Bil-Dawa), Dietotherapy (Ilaj-Bil-Ghiza) and Surgery (Jarahat).

Important techniques in regimental therapy along with the ailments for which they are considered effective are venesection venepuncture (Fasd), cupping (Hajamat), Diaphoresis,( )Diuresis ( ) Turkish Bath (Hamam) Mas

sage (Dalk), Canterization (Amal kal), Purging (Ishal), emesis (Qai) exercise (Riyazat), Leaching. Dietotherapy aims at treating certain aliments by administration of specific diets or by regulating the quantity and quality of food, where as Pharmacotherapy deals with the use of naturally occuring drugs mostly Herbal Plant origin, though drugs of animal and mineral origin are also used. Similarly, surgery has also been in use in this system for quite long. In fact, the ancient Unani Physicians were pioneer in this field and had developed their own instruments and techniques. In Medieval period the surgery was discarded and a very wide gap was present. Now again Surgery in Unanipathy is gaining recognisation, and popularity in Unanipathy. Single drugs or their combinations in raw form are preffered over compound formulations (Poly-pharmaceuticals). Further the Materia Medica of Unani Medicine being vast, the medicines are easy to get for most of them are available locally. The naturally occuring drugs used in this System are symbolic of life and are generally free from adverse effects. Such drugs which are toxic in crude from are processed and purified in many ways before use. Although the general preference is for Single drugs, compound formulations (Poly Pharmaceuticals) are also employed in the treatment of various complex and chronic disorders. Since in this system, stress is laid on the particular Temperament (Mizaj) of the indivisual, the medicine administered are such as go well with the temperament of the patient, thus accelerating the process of recovery and also eliminating the risk of drug reaction.

UNANI SYSTEM OF MEDICINE IN INDIA

Unani System of medicine with its own recognised practitioners, Hospitals, Educational and Research Institutions from an intigral part of our national Health Care Delivery System. As for as Unani Medicine in concerned, today India is the World leader. The Government of India is providing increasing support and financial assistance for the multipronged development of Unani Medicine as well as other indigenous medical systems to draw the fullest advantage of these systems health care delivery to the masses and attain the cherished goal of Health for all.

EDUCATION

The education and training facilities in Unani System of Medicine are presently being monitored by central council of Indian Medicine which is a statutory body setup by an act of Parliament known as Indian Medicine Central Council Act 1970. At present, there are two main Course in Unanipathy. Eligibility for the Degree Course B.U.M.S. (Bachelor of Unani Medicine & Surgery) Course in 10 + 2 with Science (P.C.B.) with Urdu/Arabic/Persian of 10th Standard. The duration of the course is 4.5 years with one year internalship i.e. 5.5 years course. The Post Graduate course i.e. M.D. course of 3 years education.

Post Graduate Education and Research facilities are also available in the subjects of Pharmacology (Ilmul Advia), Medicine (Moalejat), Basic Principles of Unanipathy (Kulliat) and Hifzan-e Sehat Hygiene & Social and Preventive Medicine (Hifzan-e Sehat Wa Samaji Tibb) at Ajmal Khan Tibbia College, Aligarh Muslim University, Aligarh and in the Subjects of Medicine (Moalijat) Gynaecology (Amraz-e-Niswan) and Paediatrics (Amarz-e Atfal) at Govt. Nizaimah Tibbi College, Hydrabad. The Hamdard Tibbi College, Jamia Hamdard a deemed University, New Delhi, has also recently started Post Graduation in Medicine (Moalijat) and Pharmacology (Ilmul Advia).

The Govt. of India, Ministry of Health & F.W. established, a National institute of Unani Medicine at Banglore in collaboration of the State Government of Karnataka. It will be a principal institution of Unani Medicine in the Country, the institute will serve as a demonstrable model of teaching training and research in the system.

RESEARCH

The concept of research was originally percieved by Masihul Mulk Hakeem Ajmal Khan (1868-1927). Dr. Salim-uz-zaman Siddiqui, an eminent pharmacologist, who was engaged in research work, under took the task. He discovered, the medicinal properties of a plant, known as ASROL (Rauwolfia serpentina) in neuro vascular and nervous disorders such as Hypertension, Insanity, Insomnia, Hysteria, Schizophrenia, Psychosomatic conditions etc.

He was the first Unani Physician who introduced this through

Dr. S. Zaman Siddiqui in Europe. The Frankfurt University of West Germany awarded the degree of Doctor of Medicine to Dr. Siddiqui on the presentation of his experimental work on this wonderful Unani drug. The easter alkoloid Reserpine and rescinnamine are the most active Hypotensive agents and the other alkoloids of Adrol are Ajmaline, Ajmalinine, Iso ajmaline, ajmalicine, rauwofinine and serpentine.

The systematic research in various Indian Systems of Medicine including Unani Medicine, under the patronage of Government of India Started in 1969 with the establishment of central council for Research in Indian System of Medicine and Homoeopathy (C.C.R.I.M.H.). In 1978 CCRIM H was split into four research councils, one each for Ayurveda & Siddha, Unanipathy, Homoeopathy Yoga and Naturopathy.

The Central Council for research in Unani Medicine (C.C.R.U.M.) an autonomous organization, under the Ministry of Health and Family Welfare, Department of I.S.M. & H., Govt. of India, is engaged in developing independent and multi dimensional research into various fundamental and applied aspect of Unani System of Medicine. The council is engaged in chemical research, drug standardization, Survey of Medicinal plants literary research, Family Welfare Research, and a Information Centre at the Head Quater.

NATIONAL HEALTH CARE

Unani System of medicine (Unanipathy) is quite popular among the masses. The Unani practitioners, scattered all over the country, from an important part of the National health care delivery structure. According to official figure available there are 35,350 registered Unani practitioners in the country. Out of them 13,116 are institutionally qualified Unani graduates. Besides, a large number of un registered practitioners are dispersed all over the country who practice Unani Medicine on heriditary basis.

Presently, 11 States have Unani Hospitals. The total number of Hospitals functioning in different states of the country are 105. Out of these, 95 are run by Government agencies and 10 by other organisiations. The total bed strength of Unanipathy in the hospitals in 1914.

14 States in the country have Unani dispensaries. The total number of Unani dispensaries in 954. Out of which 780 are being run by Government agencies, 169 by local bodies and 3 by other organisations. Besides eight dispensaries - two in Hydrabad (Andhra Pradesh) One each in Uttar Pradesh (Lucknow) and West Bengal (Calcutta) and 4 in Delhi are functioning under Central Government Health Scheme (C.G.H.S.) which mainly cater to the health needs of the Central Government employes. Establishment of C.G.H.S. Unani dispansaries in other part of country is also under way.

Recently, the department of Indian Systems of medicine and Homoeopathy (I.S.M.& H.) under the Ministry of Health & F.W. has dicided to setup speciality clinics of Ayurved, Unani and Homoeopathy in three Central Government run Hospitals in Delhi to provide integrated health care system.

To begin with, these clinics would be opened in All India Institute of Medical Sciences, Safdarjang Hospital and Dr. Ram Manohar Lohia Hospital.

Accordingly, now A.I.I.M.S. New Delhi will have an Ayurveda, Safdarjang an Ayurveda and Homoeopathy and Dr. Ram Manohar Lohia Hospital a Section on Unani System of medicines.

DRUG CONTROL

The manufacture of Unani drugs is being regulated through Drugs and Cosmetic Act 1940 as amended from time to time. The Pharmacopoeial standards are being finalized in respect of Single and compound drugs. There is a permanent Unani Pharmacopoeia Committee under the Government of India, in the Ministry of Health and Family Welfare, Department of I.S.M.&H., which consists of experts in Unani Medicine, Chemist, Botanist, and Pharmacologists. The Unani Pharmacopoeia Committee has already finalized part-I. of the National formulary of Unani Medicine Containing 441. best compound Unani formulations which has since been published in English and Urdu languages. The part-II, contaning 202 compound unani formulations and part-III. containg 103 copound is in printing process. The 100 compound formulations have been prepared by data for inclusion in IVth part of N.F.U.M. (English Version). Fur

ther work is in proferm.

JOB AND FUTURE PROSPECTS

Graduates of Unanipathy find employment in Government medical services, such as C.G.H.S., State dispencaries, autonomous organisation, voluntary organisation or can opt for private practice and teaching as Unani Medical Colleges are offered by a large number of college under graduates and post graduate colleges.

Today Unanipathy is going popularity all over the world. Research and development for the betterment of the science is going on the future of Unanipathy is very much bright not in the country but also in the global market.

SUGGESTIONS FOR DEVELOPMENT STANDARDISATION AND GLOBLIZATION :

Note : (Kindly suggest how to globalize the Unanipathy in the Universe.)

SUGGESTIONS :

1. There must be our one degree course of 5.5 year duration which includes one year rotatory internship.

2. The Eligibility for the Degree course should knowlege of be strictly 10 +2 with Science (P.C.B.) with Urdu/Arabic/Persian of 10th Standard.

3. The admision to degree course should be strictly based on merit or through competition, as is being done in uttar Pradesh. There must be a join Enterance test separately not along with M.B.B.S. enterance Test (CPMT)/ B.D.S. sclection.

4. The back door/donation/ capitation based entry for admission should be stopped/and strictly banned.

5. The subjects taught in B.U.M.S. course should be in the same pattern as those of M.B.B.S. course along with Unani Subjects. Beside Anatony, Physiology, Biochemistry, Pathology Pharmacology and other subjects, surgery should also be taught to the students for practic in Surgery.

6. Practical training should be given in the teaching Hospital, attached to the Unani Medical colleges.

7. For regular teaching and consultation a book bank i.e. "National Unanipathy Academy" should be established for the better and latest knowledge and development of Unani System of Medicine.

8. The abreviation of the degree awarded must be B.U.M.S. (Bachelor of Unani Medicine and Surgery). Not kamil-e-Tibb-o-Jarahat.

9. The curriculum and syllabus must be scrutinized, revised and update.

10. National/International level and Interpathy level seminar, workshops and discussion should be organised at the Ministerial level.

11. State to State medicinal plants/Herbal tours must be arranged for the students to the Herbal garden, Herbal Museum and Herbaratum, to create in trest in Unani Medicine.

12. Computor based teaching and training along with Audio-visual aided programmes should be included in the course.

13. Natinal Health care Programme and Family welfare Programmes should also included in the B.U.M.S. course separately.

14. Before standardising the education Drugs and Research, standardisation of Unani Graduates (HAKEEMS) must be made essential. There after that, we can achieve the target of Globalisation of Unanipathy.

15. B.U.M.S. courses are offered by a large number of Unani colleges. The notification for admission to most of these institutions come around June to September. Most of these college are not only substandard but running in small rented house, without affiliation to any University or Board. The colleges are running with only permission of C.C.I.M. which is monitoring Unani education in the Country. The mushroom growith of such tyes of (Betel shops) Colleges must be stopped and a total ban/restrication should be imposed for opening new colleges in the country.

16. The Ministry should not grant any aid/facilities to these Unani Colleges untill they are affiliated to the State University.

17. For popularisation and globalisation there is an urgent need to establish Unani Medical O.P.D./I.P.D. facilities in all the Govt. run Allopath Hospitals all over the country.

UNANI MEDICINE FOR GLOBALIZATION

Dr. M. Shamoon
Senior Medical Officer (CGHS)

"KUCHH BAT HAI KE HASTI MIT-TI NAHIN HAMARI"

Dr. Iqbal probably recited these words keeping in view the history and culture of Indians but now a days the Interpretation of these words are proving true in the context of Existance of Unani system of Medicine in India. After got ignored by Britishers in comparision to Allopathic system of Medicine and now by the Govt. of India in comparision to Ayurvedic and Homeopathic systems of Medicine, the Unani Medicine is served and enjoing the whole hearted support of the people who like it most upto their Satisfaction.

I am not going to reveal the history and glorious period of Unani Medicine here but feel it sufficient to remind the readers that modern Allopathic science is nothing but the elaborated form of Unani Medicine. The devoted workers who made extensive researches and development on the foundation of the philosphy of Unani Medicine updated the Allopathy to this climax of present age Medicine. Although father of Unani Medicine known as Hippocrates is the same father of Allopathic Medicine proving the above statement true and there are lot of historical evidences in the support.

During the last few centuries, unfortunately the Unani Medicine's fate have been in the hands of such professionals who did not allow it to cross the imaginary boundries they drawn arround it. Result was ofcourse the restricted or indisposed development in the field. Some of them even made barriers to prevent it going forward barring a few visionaries like Masihul Mulk Hakeem Ajmal Khan who inspired the professionals and started new researches and development but the work of progress again halted after the small span of his life. The work done after him is neither sufficient nor in right direction though the Govt. of India has given it a supportive patronage for the political reasons it seems, because nobody in the machinery looks to take effective steps for its development.

Now time has matured to revolutionaries the whole system keeping its fundas and philosophical approach intact. We have to consider extensively on warfootings three most important factors to establish firmlines for the required goal as undermentioned-

1. **Education :** Education is globally considered as the foundation for all round development of a system. So we have to in Unani Tibbia (Medical) colleges. To achieve this goal we have to consider and decide upon the following factors in this direction :-

A. We have to fix a firm basic criteria for admissions to study the Unani Medicine and should take only those students who have scientific background and attitude to learn.

B. We have to arrange in educational institutions to refresh and to acquire the knowledge and teaching techniques of personnels engaged in teachings, on modern Scientific bases upto the satisfaction of students to prepare them to face the challenges of modern fast running age.

C. We have to abide upon a uniform abrevition of degree or certificate for educational/professional qualification with their clear and relevent full form. We have to remove certain confusions prevailing in this matter to enable the recognition of it at global level.

NOTE :- These are thre decisions to be taken by the Govt. agencies concerned at centre level.

D. We have to prepare the students well acquainted to read, write and speak fluently the languages like English, Persian and Arabic specially and to use electronic media, so that to enable to interact and exchange of their views globally.

NOTE : This is a task for educational institutions and the students themselves to meet the demand of time.

2. Research & Development : Like other factors following are the most important factors to be considered in this regard :-

A. Extensive research in the litrary field including text books and curriculla is required to meet the demand of education on modern lines.

B. Extensive research is required in clinical diagnostic methodology clearing out the Unani system from mysterious stories and legendaries. This methodology should be more

scientific and explainatory.

Note : Both above tasks are to be taken up by research council, teaching institution with their attached hospitals at Govt. and private level which may be set up for this purpose.

C. Research and development in the field of pharmaceutics our goel of research in this field should be to provide clinically well tried on modern lines the drug formulation of drugs without changing in fundas of Unani pharmacological originalities.

D. Propagation and presentation of papers, products, reports and various other information required by the people globally on the subject upto the standard and parameters of modern scientific need.

E. Quality control at all levels upto the satisfaction of modern world.

Note : These four tasks are to be taken up by the Govt. as well as the pharmaceutical industry engaged in the field.

3. **Health Care :** Health care system of Unani Medicine require more and extensive reorganisation in the field. We have to consider the following factors to update this :-

A. Most of the practitioners are treating patients on symptomatic basis and not touching the principal of Unani Medicine established long ago. We have to revitalize the system which is most necessary to root out the disease and to cure it.

B. There should be drug control over the Medicines used in clinics and hospitals established for the treatment in Unani Medicine.

C. We have to prepare data based records of the patients treated in such hospitals whether cured or otherwise.

D. We have to prove the Unani Medicine easy and cost effective in gereral and for the National Health Care System and programmes.

Like above and some other factors we may take effective decisions, firm determinations and maintain the same for a long period to see better results. Only then we can pre-pare, with such a devotion and hardwork to face the challenges of modern age to update the Unani Medicine for its global developments. There is no substitute of these factors if we ignore the Unani Medicine will remain behind the other medical sciences in competetion.

The author is an All India Radio Talker and several talks and articles have been broadcasted and published in reputed newspapers & magzines. The activities of the author are continued for the couse of Unani Medicine in some other than above.

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39. **ROXMED-KID** *Tab.*
40. **SUDEX-BR** *Expectorant*
41. **TITER** *Syrup*

Concept of bars (Vitiligo) in Unani & Modern Medicine

Editor Note :-

Unani Concept of bars is based on changes in IKHLAT spacially in phalegum, while in modern concept cause of vitiligo is not known, but according to some experts it is caused by metabolic errors. It is nearly similar of unani concept. Psoralen is the choice of drug in Unani & modern systemes of Medicine.

Clinical studies in bars (vitiligo) Published as publication no-19, by Central Council for Research in Unani Medicine under auspices of Ministry of Health & F.W., Govt of India.

Unani Concept

Bars (Vitiligo) has been defined by ancient Unani physicians as a skin disease. Its aetiology and treatment has been discussed in detail in the classics of Unani Medicine.

According to Jalinoos (Galen) (130-200 AD) as mentioned in the manuscript Moalijat-e-Buqratiya (10th century AD). the cause of Bars is the weakness of Ouwatul-Mughaiyarah wa Mushabbiha (transformative faculty) in the organs.

Rabban Tabari (810-895 AD) while describing the aetiology of Bars in his famous books firdaus-ul-Hikmat says.

"Fasad-ud-dam (impairment of blood) and Burudat-ud-dam (coldness of blood) are the main causes of Bars. If the digestive faculty of the body cannot digest the food properly the blood of the whole body become impure. When this impurity occurs due to Balgham (phlegm) coldness appears the Bars."

Zakariya-Al-Razi (Rhazes) (850-925 AD) has given a comprehensive description of this disease. Here are a few excerpts from his most esteemed word Al Hawi.

Sometimes Bahaq Abyaz (Vitilgo alba) reaches a stage when greyish hairs grow on the patches. Examine whether it is curable or not by rubbing the affected areas. If the patches do not turn red then prick the lesion, if the whitish fluid comes out, then the possibility of recovery is remote and vice versa."

Bars appears when flesh becomes phlegmatic. thus blood reaching flesh also turns phlegmatic. And this (phlegmatic) flesh becomes so soft as that of mollusca. And the area getting such blood cannot be nourished properly and is changed into phlegmatic substance."

:Bars brings change in the skin and makes it bloodless. Sometimes the flesh beneath the skin also changes in the same manner."

"Bahag" is like 'Wazah' and it does not penetrate deep as does Bars. In bars, hairs also become grey along with the patches, and this greyishness is due to phlegm."

According to Razi if white patches of bars do not turn red on rubbing or when, instead of blood, white fluid comes out on pricking them, the possibility of recovery is remote. If the white patches are limited and nonextensive and the colour of the patches is yellowish or reddish early cure can be expected. Conversely, when Bars is extensive and spreading, and where the affected areas become bloodless and the colour of the patches is cloudy, it is incurable. He also adds that the patches on the feet and head do not respond to treatment adequately.

Shamoon (as quoted in Razi's Al Hawi) says.

"Bars occur due to frequent use of such food articles that contain water in excessive quantity."

Ibn-e-Sarabiyoon (as quoted in Razi's Al Hawi) says:

"IF Bars spread over a large portion of the body or when it becomes highly chronic or when milky fluid comes out on pricking the Bars patch. It is not curable and vice versa."

Ibn-e-Sina (Avicenna) (980-1037 AD) in his medical encyclopaedia Alqanoon Fit-Tihb (7) says:

"The third factor is 'Tashbeeh', Power which converts the nutrients and gives them the shape of tissue. In normal condition, this shaping is perfect by all means according to the characteristics of that particular tissue, by its consistency colour etc. Sometimes this function of 'Ghazia' (metabolism) is deranged as it happens in case of Bars or Bahq. In both the instances the nutrient material reaches the tissues and is retained there but does not take proper shape due to failure of this shaping power."

According to the Unani physicians, the perfectness of the

tissue metabolism depends on four factors.

1. Ouwat-e-Jazeba (Power of ab sor-ption)
2. Ouwat-e-Masika (Retentive power) - the power that retains the nutrients at tissue level so that they may be well assimil lated with the tissue.
3. Quwat-e-Mughairah and Mushabbeha (Transformative faculty) - the power that brings changes and shapes the nutrients into tissue proper.
4. Quwat-e-Dafia (Expulsive power) - the power that excr-etes waste material from the tissue level and throws into the blood stream for final deco-mposition and excretion from the body.

in the above reference, Avicenna says that the defects lie at the tissue level in the function of Quwat-e-Mushabbeha. Therefore, due to failure of this power depigmentation occurs.

At another place, discussing the diseases which can be transmit-ted from parents to the offsprings and from generation to generation, he says:

"There are certain diseases which are transmitted from genera-tion to generation e.g. Bars. baldness, pthysis, gout and leprosy."

Hakim Akbar Arzani (17th century) has also given a detailed account of Bars in his famous book Tibb-e-Akbar/According to him, Bars is a whiteness apearing on the skin. When it spreads all over the body it is called Bars-e-Muntashir (general-ised Vitilogo). Its treatment becomes difficult, if it turns chronic and re-mains progressive. He has given an account of the prognostic factors in Bars. Those lesions where the hairs are not affected and the lesions which become red on rubbing are curable.

Hakim Azam Khan (19th century) in his bood Ikseer-e-Azam says:

"Bars in white patch appears on the outer layer (skin) of the body. It may occur on certain parts or may involve whole of the body and turn its colour white. This type of Bars is known as "Bars-e-Muntashir" (gener-alised vitiligo) weakness of Quwat-e-Mughaiyirah being cause."

Line of Treatment

Bars is a chronic disease and, therefore, all the Unani physicians are of the opinion that its treatment should be started with Tanquiyah-e-Badan (removal of harmful meterial from the body) with Munzij and Mushil.

Hippocrates suggests that after "Tanqiyah". digestive system should be corrected and such diets should be given as are easily digestable and pro-duce more and pure blood. He rec-ommends the diet to be given as per the custom and tradition of that age. He has prohibited milk products. At the same time, he recommends the meat of birds and young goat.He says that unless there is a desire for food, it should not be taken. He also rec-ommends some digestive tonic to be taken two hours after the meals in order to accelerate digestion.

Ibn-e-Sarabiyoon says:

"Avoid cold and moist foods, fish, milk and moist vegetables and fruits. Eat only such foods that pro-duce heat and dryness in the body."

An appropriate dose of Munzij-e-Balgham is administered till "Nuzj" appears. then three "Mushils" (purges) alternated with three "Tabrids" (Cooling agents) are given. After completion of Munzij and Mushil treatment. Majoonat-e-Harra, Ayarijat and Itrifalat are prescribed, and the specific medicines for the malady are advocated. Sometimes the specific Medicines, both oral and topical, are prescribed simultaneously with Adviyah-e-Musakkina (soothing drugs) which accelerate general metabolism.

"Treat Bars in its early stage and Bahaq by applying the medicine on the patches and by exposing the patient (patches) to sun. It will cure Bars."

On another occasion he says:

"Make multiple pricks by needle on Bars patches. It is a very effective measure to cure Bars."

At yet another place he says:

"Divretics are also of much use, because they reduce the plasma of the blood."

Modern Concept

Vitiligo or acquired leucoderma is usually of unknown aetiology and is characterised by depigmented patches of varying sizes and shapes. In vitiligo there are no other struc-tural changes except loss of pigment. It can appear on any part of the body but the common sites are the face, dorsal portions of fingers, hands, waist, legs and feet. Mucous membranes may also be affected. The depigmentation of lips and vagina is also common. In early stages the patches may remain ill-defined. The patches can enlarge and can spread all over the body. Hairs may or may not be affected in depigmented areas. A single white strand of hairs

may be the first sign of vitiligo on the scalp. The distribution of the patches is segmental or generally bilateral and symmetrical. Vitiligo unversalis is rather rare. Alopecia areata is also found with vitilgo, at times especially in patients having an endocrine imbalance or neurovegetative disturbance. The patches of scleroderma are often found on the vitiligo patches. Vitiligo can coexist with Graves' disease and with Hulier's Disease in children, Sutton's disease is found with vitiligo in some patients. In these cases the depigmentation develops around the pigmented moles which is known as 'halo naevus' or leucoderma acquisitum centrifugum' At times vitiligo patches develop along the distribution of a peripheral nerve which is called zosteriform vitiligo'.

The onset is often insidious and the primary lesions remain stationary for years but can flare up at any time in presence of precipitating factors. Generally, it increases in summer in some patients, the haemoglobin of the blood is found low

AETIOLOGY

Exact cause of vitiligo is not known According to Behi et al metabolic errors, dietary deficiency and low serum copper levels may cause this disease. It is also claimed that it is hereditary but this has not been established

Gastrointestinal disorders e.g. intestinal worms, chronic amoebiasis and chronic dyspepsia may be counted as precipatating and additional factors. Mental stress and frequent use of broad-spectrum antibiotics have also been noted as predisposing factors in some cases. Endocrine disorders and auto-immunity are also considered the causative factors. Trauma and constant pressure on the skin may cause depigmentation in persons susceptible to vitiligo.

Several workers developed depigmented areas on the hand and forearms after wearing rubber, which was due to an antioxidant contained in the chemicals and which contains minobenzyl ether of hydroquinone Similarly 54 percent out of 198 were reported to have developed vitiligo after exposure to para-tert- Butylphenol during its manufacture.

Pathology

According to the studies made by Breathnach et al. the melanocytes disappear in vitiligo and they are not replaced by or transformed into an inactive variant, the Langerhans cells. Even at the margins of the vitiligo patches the melanocytes exhibit little or no melanogenic activity. The histopathological picture is still not quite clear but remains complicated by the presence of Langerhans cells. Recently, it has been reported that there is no change in the number of Langerhans' cells in skin of patients with vitiligo.

Intially, the lesions of vitiligo may be limited to the area supplied by individual cutaneous nerves but when they spread and become extensive they adopt bilateral symmetry. Therefore, it has been suggested by some workers that vitiligo results from some neural or neurochromal disturbance which otherwise control the melanogenesis. Further, it has been noted that no somatic sensory defect was present with diminished sympathetic or adrenergic activity in the depigmented areas of vitiligo. It is, however, debatable whether or not the loss of pigmentation can likewise be attributed to damaged peripheral nerves. On the contrary it has not been demonstrated so far that melanocytes and terminal nerves have any relationship in normal skin. Moreover, the depigmentation occurs not from loss of activity but from actual disappearance of melanocytes. It seems convicing that under some influences during foetal life, melanoblasts and Schwann's stem cells are affected, which are unduly susceptible to 'trigger' factors in postriatal life and react by loss of function or degeneration and there is a variety of precipitating factors which have been associated with the onset of vitiligo. It is rather difficult to understand how without some vitiligo

A defect in enzyme tyrosinase is also held responsible for vitiligo. It is suggested that melatonin, a substance secreted at nerve endings, inhibits tyrosinase, and ultimately interfers with pigment formation. But the process of melanogenesis is in fact influenced and controlled by various factors e.g., melanocyte stimulating hormone (MSH) and other hormones.

In vitiligo, the epidermis of the affected parts are deficient in melanin and lacks dopapositive and tyrosine epidermal melanoblasts, However, the aetiopathogeneis of vitiligo is not very clear as more often the disease appears and progresses without any apparent cause. The pituitary gland is suspected because of the high level of urinary melanotropic hormone and absence of this hormone in affected areas Similiary, the association of vitiligo with

hypoadrenocorticism with low level of 17-ketosteroids is held responsible for incrimination of the suprarenal glands. The thyroid gland and the gonads have also been incriminated.

The examination of cerebrospinal fluid in vitiligo cases has shown some changes in the albumin content and cytology. It has been suggested by some workers that the skin of a vitiligo patient contains more sulfhydryl compounds than a normal skin which is supposed to block the action of tyrosinase. It is inhibited by all organic sulphur compounds, cysteine, glutathione thiouracil and the compounds which contain sulfhydryl groups.

Diagnosis

Diagnosis in cases of vitiligo is usually easy and apparent. The true lack of pigment from pseudoachromia may be distinguished. However, it may be, at times, difficult to differentiate true vitiligo from leucoderma or from partial albinism. In the early stages of the disease when the lesions are not so marked Wood's lamp may help in diagnosis. Under this light vitiligo patches appear milky white in other types of depigmentation it gives greyish colour. The other conditions which may cause depigmentation and hence need differentiation at times from vitiligo are naevus achromicus, pityriasis versicolor, syphilitic leukomelanoderma, anetoderma, pinta, depigmentation caused by leprosy, morphosea, lichen simplex, psoriasis, lupus erythematosus and piebaldism, Still other conditions are pseudoleucoderma, pityriasis alba, lichen planus, and occupational leucoderma.

Naevus achromicus does not have hyperpigmented borders which are specific with vitiligo. The patches of pityriasis versicolor (tinea versicolor) are localised on the neck, face, upper extremities, back or front of the chest, and are characterised by light brown macules or pleques with furturaceous scaling, but appears white like leucoderma in subject with dark complexion, Syphilitic leukomelanoderma is very characteristic in appearance and may be confirmed by V.D.R.L. test.

In anetoderma the small, well-defined depressions below the surface of skin are caused by degeneration of elastic tissue due to pressure. inflammation. malnutrition of interference with the nerve supply. The lesions look thin. shiny, inelastic and wrinkled and usually white in colour but may appear purplish due to visible blood vessels through the atrophic skin.

Pinta is a disease caused by a spirochete,marked by an eruption of patches of varying colour that finally become white. The condition may be diagnosed by serological test.

Maculoanaesthetic leprosy, a benign condition, may produce flat, hypopigmented, asymmetrical, well-defined, and anaesthetic patches, generally few in number. Hairs are lost on the patches, and the skin overlying the lesion is dry and rough. The lepromin test is usually moderately positive.

Morphoea or cutaneous scleroderma may occur at any age. In the beginning the lesions are slightly purplish but after few weeks the plaques become thickened, waxy and and ivory in appearance. It tends to improve with time and heals and leads to atrophy in three to 10 years, developing a brownish pigmentation of the area. Morphoea guttata or white spot disease sometimes occurs in zosterian distribution and needs differentiation from lichen sclerosus atrophicus.

Lichen simplex, a chronic condition, generally affects neurotic people under anxiety and stress conditions and the sites which are commonly affected are neck, arms, back of knees, legs, ankles, scrotum and anogenital area. The affected area is thickened and pigmented.

Psoriasis is a common, chronic and noninfectious skin disease charactensed by reddish brown macules. The lesions are found especially on the extermities, knees and elbows, but may also occur on the scalp, upper portion of the back, face and genitalia, The typical distribution is extensor. It appears to be a disorder of keratinization. If a psoriatic lesion is scratched, candle grease scales are removed. This is known as Candle-grease Sign.

Lupus erythematosus occurs in acute or chronic forms. Discoid lupus erythematosus is a slow, progressive disease which appears in coalescent plaques covered with whitish or yellowish greasy scales. It is associated with focal atrophic patches. It shows a predilection for malar areas and bridge of the nose which gives a butterly appearance.

Piebaldism is a condition of congenitally depigmented patches of skin and hairs present at birth. However, it is unrelated to albinism which is a recessive genetic anomaly.

Pseudoleucoderma develops

when diseased patches of skin fail to pigment on exposure to sunlight as compared to surrounding normal skin, and so appear white.

In pityriasis (impetigo pityroides) dry scaly patches are found on children's face pigment on exposure to sunlight as compared to surrounding normal skin, and so appear white.

In pityriasis (impetigo pityroides) dry scaly patches are found on childrens' face. It is a harmless and noninfectious disease, but some workers attribute low-grade streptococcal infection in run down individuals as its cause.

Lichen planus is found as irregular, Violaceous, glistening, flat and pruritic papules which are covered with a thin, horny substance. The distribution is symmetrical, particularly along the flexor aspects of wrists, forearms and legs. Generally, it heals spontaneously within a year or so. Faint striation or white streaks can be seen on the surface of the papules through a magnifying lens. It is usually a chronic disease. Nails are affected in small number of cases and rarely there may be shedding of the nails.

Occupational leucoderma of the hands and forearms has been observed in workers either wearing rubber gloves containing monobenzyl ether of hydroquinone or working in industries where the above mentioned chemical is used in the form of lotions or solutions.

Prognosis

Advances made in histopathological and biochemical studies no doubt have led to better understanding of aetiological factors yet have helped little in its therapy. The factors supposed to be responsible for failure of treatment are

1. Presence of vitiligo on resisant parts e g hands front of wrists, above the ileac crest waist and lips.
2. When hairs on vitiliginous patches become white.
3. Poor nutritional state and helmenthic intestation.
4. Stress conditions (mental and emotional)
5. Old age.

Treatment

The patient and his relatives should be assured that it is a noncontagious disease and has no relationship with leprosy. Most of the patients are curious about the disease and depressed psychologically. Therfore, the psychological care of the patient is also very essential, and is a part of therapy.

Nutritional disorders and deficiencies, and helmenthic infestation should be treated. All the food-stuffs which are supposed to block the synthesis of pigment melanin should be restricted. It is better to avoid spectrum antibiotics as far as possible in vitiligo patients.

For vilitigo patients multivitamins and crude liver extract with Vitamin B complex are recommended .Copper chloride is administered orally in the dosage of 1 to 3 mg daily, or 200 micrograms twice a week intravenously for two to three months. The spread of the disease is generally stopped within this period.

Specific Medicines Therapies for Vitiligo

Psoralea corylifolia (Psoralen, Neopsoralen & Macpsoralen p)

It is used in the form of tablets and ointment. The daily oral dose is from 10 to 20 mg which is followed by exposure to sun. Nervoussness, a sense of heat in body, hypertension and allergy may occur during the treatment as its side effects. If their effects are mild, the therapy can be continued in small doses otherwise it may be discontinued.

Derivatives of Psoralea corylifolia or Ammi majus (Melandinim-P) and croton oil which are applied locally, have photosensitizing action. They produced erythema and at times blisters at the site of application, especially in patients who did not take systemic psoralens previously. Alternative use of croton oil and psoration gives the best results. In case of blister formation some soothing lotion or cream is prescribed.

Methoxsalen is given in a dosage of 20 mg orally each morning two to four hours before exposure to sunlight. It is to be used for months with proper exposure to sun. The topical preparation (Methoxsalen 10%) should be in 1 : 10,000 concentration as it may cause severe photoloxic effects and blisters. Trioxsalen (Trisoralen) may also be given in the dosage of 5 to 10 mg daily, orally. Psoralen-P tablets together with psoralen lotion or ointment are also effective. Each tablets of psoralen P is of 5 mg strength. Four tablets are given in the morning after breakfast in a single dose, or these may be given in divided doses - two after breakfast and two

after lunch. The dosage is adjusted according to age, body weight and tolerance of the patient. Topical treatment with psoralen solution or ointment is gererally started after a week or a fortnight of systemic therapy to minimise local reaction. It may be applied carefully over the depigmented patches only.

Ultraviolet rays: Ultraviolet rays (UVR) activate the process of pigmentation and help in synthesis of melanin, UVR are available naturally in sunlight during early morning and evening hours but artificial UVR are also used in the treatment of vitiligo in selected cases. The exposure time may be increased gradually according to the tolerance or sensitivity of the patients. In certain selected cases, surgical grafting is also recommended.

Colouring dyes: Colouring dyes for temporary covering up of the vitiligo patches are also used, in some patients. They are also available in the market, such as walnut juice, silver nitrate or potassium permangnate. Dioxyacelone is also used in such types of paints which is, however, not recommended by some authors [36].

Protective creams: It is always advisable to apply some protective cream at the periphery of the patch to avoid the hyperpigmentation and irritation of the normal surrounding skin. The solution or the ointment should not be applied on mucous membrances, face eyelids, nasal orifices and scrotum, If any severe reaction is noticed the local application of the solution or onitment may be stopped, and some soothing cream or lotion may be applied. For itching and other allergic manifestations, Antihistaminic theraphy may also be given.

Review of Literature on Vitiligo

Vitiligo and blood groups

The familial occurrence of vitiligo and the association of gastric hypochlorbhydria known to be associated with blood group A in vitiligo patients suggested a possible association of vitiligo and blood grouping . Srivastava and shukla reported a higher susceptibility to vitiligo in persons of blood group B.E.I. Hefnawi et al. and Singh and Shankar reported a higher incidence of vitiligo among persons of blood group AB. Gupta and Gupta found AB and O blood groups to be more susceptible to vitiligo. Seghal and Dube reported higher incidence in groups A and B than O group . Dutta et al. and Kareemullah et al. found no significant difference among the blood groups. It appears that there is no characterstic ABO group marker for vitiligo.

Vitiligo and thyroid diseases

Thyroid diseases in general particularly hyperthyroidism thyroiditis and myxedema are more common in vitiligo patients than in controls. The incidence of all thyroid diseases in vitiligo appears from the literature to be between 1.28% and 30% Hyperthyroidism has been reported to be between 0.9% and 12.2% among the vitiligo patients: Graves disease in from 1% to 12.5% and toxic adenoma in from 2.4% to 3.5% of vitiligo patients. The incidence of thyroiditis in vitiligo has been reported to be from 1.9% to 12.5% of nontoxic goitre 3% to 8.9% and of mayxedema 0.36% to 3.3%.

The incidence of vitiligo in hyperthyroid patients has been reported to be from 0% to 27.7% and in the pateints suffering from groves disease from 1.7% to 6.6% The incidence of Vitiligo in patients with addison's disease is reported to be from 3.1% to 20% Vitiligo appears to be more frequently associated with idiopathic Addison's disease than with tuberculous Addison's disease. The incidence of Addison's disease in vitiligo, however, is reported to be from 0% to 2%.

Vitiligo and pernicious aneamia

There appears to be a significant association between vitiligo and pernicious anaemia. The reported incidence figures range from 1.6% to 10.6% An increased prevalence of pernicious anaemia is found amoung vitiligo patients. The reported frequency ranges from 0% to 9.2% Grunnet et al. reported the incidence of pernicious anaemia to be about 30 times as frequent among patients with vitiligo as in the general population

Vitiligo and diabetes mellitus

Vitiligo seems to be associated with both adult-onset and juvenile-onset diabetes. The incidence figures of 1% to 7.% strongly support the existence of a link between vitiligo and diabetes mellitus. Dawber reported the incidence figure of 4.8 in diabetic patients as opposed to 0.7% among nondiabetic controls. The female and male prevalence figures were 6.1% and 2.9% respectively as against 0.7% and 0.6% in controls.

Vitiligo and alopecia areata

Association of vitiligo and alopecia areata has been reported by several

workers. The incidence of vitiligo among patients with alopecia areata has been reported to be between 1.6% to 15.6%. Alopecia areata was found in from 0.4% to 16% of vitiligo patients. Alopecia areata seemed to more common in females with vitiligo.

Vitiligo and cystinuria

Frati et al. found cystinuria to be present in 4.3% cases of vitiligo with different frequency compared to 3.0% in healthy controls. The relative risk of vitiligo was found to be greater in children with cystinuria.

Adrenocortical function in vitiligo

The urinary 17-ketosteroids are reported as marginally increased in some patients of vitiligo. Vasistha et al. studied 35 patients and reported depigmentation with intralesional injuction in 68% of cases.

Harry Brostoff Jonathan Brostoff suggested that melanocyte destruction due to autoimmune process was diverted towards regeneration of cells by prednisone therapy and the process continued even after cessation of therapy. According to Roger Clayton topical steroids such as clobetasol propionate may either potentiatemelanocyte autodestruction protective mechanism or locally suppress the immunological changes thus allowing inactive melanocytes to become active again and effect repigmentation.

Vitiligo and autoantibodies

Grimes et al. determined the frequency of autoantibodies in 70 black vitiligo patients and controls. Both the groups were screened for antithyroid, antinuclear, antigastric parietal cells, antismooth muscle cells and antimitochondrial autoantibodies. Vitiligo patients were found to have an increased frequency of antithyroid antibodies and that of autoimmune and/or endocrine disease. These diseases includeed hyperthyroidism, hypothyroidism and alopecia areata. Autoantibody positive vitiligo patients had an increased frequency of first and second degree relatives having autoimmune and/or endocrine diseases. These findings tend to support an autoimmune cause of vitiligo in black patients.

Serum copper in vitiligo

Since tyrosinase is a copper containing enzyme. It has been suggested that vitiligo results from a disturbance of copper metabolism. Low serum copper levels have been reported in upto 30% of cases of vitiligo. It has been reported that decreased serum copper levels are more marked in children or in those with vitiligo of less than one year duration. The serum copper levels have been ovserved to rise during treatment with oral meladinine (8-methoxyploralen and 8-isoamylinoxypsoralen) The rise which was not significant at the 5% level was attributed to the 8-methoxypsoralen fraction of the meladinine. El Mofty et al. postulated that psoralens work through metabolisation hepatic copper stores El Hefnawi et al suggested that the psoralens influence the incorporation of copper into the protein to form cerculoplasmin.

Increased seum copper levels have also been reported, Genov et al. reported 30% higher serum copper lelels in vitiligo patients than in normal normal healthy controls.

Serun ceruloplasmin in vitiligo

Ceruloplasmin a copper protien complex bears importance in vitiligo since it is a copper cantaining enzyme. Ceruloplasmin abnormalities have been reported by some workers. Huriez et al. reported that 39% patients had low serum ceruloplasmin levels. A decrease in blood ceruloplas-min following heliotheraphy and clinical repigmentation of vitiligo has also been reported.

Histochemistry and histopathology.

The results of histochemical investigations carried out by Chaudhary et al. indicated that in the vitilignious skin

a. Tyrosine is deficient.

b. The basal cells of epidermis of the affected areas contain less RNA than in the normal skin.

c. Most of the nuclei of basal cells and prickle cells of affected areas are larger in size than those of the normal areas.

d. The nuclei were fragmented and showed relatively weaker reaction for DNA, but the reaction for hyaluronic acid type of polysaccharides and for alkaline phosphatase was relatively stronger in nucleoli.

Gokhale et al. studied skin resistance to electric current and its correlytion with sweat gland histology in vitiligo. They observed histologically definite degenerative changes in the sweat glands when the resistance ratio (using a histogram) was beyond 1.8. Similarly, when the ratio was less than

1 2 the sweat glands showed normal histology. The degree of degeneration correlated with ratio of resistance of skin to the weak electric current in the study. In all the cases, inflammatory process was the cause of degeneration.

Histopathological and histochemical studies after thalassotherapy by Dimiltrove et al. showed that repigmentation started perifollicularly as a consequence of proliferation of the melanocytes.

Pathobiochemistry

The acetyicnoine level and acetylchoile esterase activity in blood vitiligo patients were found lowered by 28.5% to 11.6% respectively Similary Galakhova et al observed that there was 1.5 fold decrease in the concentration of Vitamin B_6 in blood but its excretion with urea was found normal Banerjee et al. observed that the serum Vitamin B_{12} level of majority of vitiligo cases was normal.

Eleonoret et al. assessed the fasting plasma gastrin evels by Ky's augmented histamine test and or histamine infustion test. The plasma gastrin was not significantly different from the controls in patients with normal gastric acid secretion but in five cases of achiorhydria the plasma gastrin levels were significantly higher than those of the controls. The report of fractional gastric analysis by Shukla and Mukherjee showed hypochlorhydria in 49% and apparent achiorhydria in 12% cases.

Cooks et al reported melanoma specific protein in urine (a rare excretion except for) in very active cases of vitiligo and suggested that the protein is a marker of active destruction of naevus reaction may be responsible for the production of the halo phenomenon and for the areas of vitiligo that may be seen elsewhere on the skin. There was no significant difference in the excretion of common urinary phenolic acids in the urine of some vitiligo cases. Different biochemical parameter of liver functions etc. were studied and found within the normal range. However, reversal of A/G ratio indicating dysproteinaemia was present.

Role of diet

Behl is of the opinion that vitiligo is definitely not produced by taking fish and milk together but probably the factor responsible is the diet which is probably poor in protien and minerals. Gastrointestinal disorders, a run-down state of health psychogenic stress and occasionally endocrine disorders, trauma and local irritation do produce vitiligo in individuals predisposed to it. Some indoor environmental factors, habits and occupational factors appear to act as precipitating factors.

Frati and Ddona have observed a substantial decrease in vitiligo after a prolonged diet lacking in cystine, (Cystine is found is eggs and yeast).

Role of Heredity

Primarily vitiligo has been suggested to be an autosomal recessive genetic disorder but the somatic expression is decided by the precipitating factors.

From clinical observations it appears that a neurogenic factor and a cytotoxic agent may be incived in the prognosis of vitiligo as an autosomal dominatant.

Treatment

Vitiligo is treated both by ultraviolet therapy and chemotherapy There are several drugs which belong to psoralen group or its derivatives.

The ultraviolet rays including the sunrays are effective in restoration of pigmenation by stimulating the melanoblasts and thus producing the dopa oxidase, which thenracts on the propigments and restores the pigmentation in leucodermic patches El mofty et al. carried out studies to investigate the biochemical effects of psoralen therapy They found that treatment with psoralen compounds caused definite in serbum copper levels and a reduction in SH (sulfhydril) groups (represented mainly as glutathione). UV radiation and synthetic moth-dopa (dopagit) in doses of 250 mg twice daily for a course of 3-4 weeks produced active repigmentation during the first week of treatment which continued gradually. Sitkavich et al. and Koopan et al have tried B-methasone-17 valerate in dimethyl sulfoxide cream base with satisfactory results. Bleechen treated 32 vitiligo sources of long wave UV light. About 25% cases showed considerable repigmentation. No adverse effects due to the drug were noted.

Elliott has reported this clinical experience with methoxsalen which produced repigmentation depending on total time exposure to sunlight Similary, 0.05% clobetasol propionate was effective in 50% cases of vitiligo to produce repigmentation and the proprietary cream base was found to be comparatively more effective than the cream base.

The results of studies conducted on 73 vitiligo patients by Grinmes et al. suggest that neither the concentration of the drug nor the vechicle is a crucial factor for inducing repigmentation of vitiliginious patches on the face, trunk and extremities. Low Dose B-MOP 8-Methoxyp-soralen (0.1%) was effective as high dose B-MOP (0.5%, 1%0). while causing fewer side effects However, When treating recalcitrant areas (distal extremities). 1% 8-MOP may be the most efficacious preparation for topical photochemotherapy.

The lesions on the exposed parts such as face, neck and hand respoded more satisfactorily than the covered parts of the body and distal parts of the limbs (for example the dorsum of the hands or feet responded much less readily or remained unaffected with the treatment).

Panj treated vitiligo lesions with gentle external rubbing with oil of Babchi for 5-10 minutes and local injection of Babchi oil intradermally along with an intestinal disinfectant.

Falabella has reported successful and cosmetically acceptable repigmentation of some leucodermas by transplantation of minigrafts of normally pigmented autologous skin into them. Harnandez observed temporary repigmentation in vitiligo patients by administring along acting CTH parenterally.

Pushi tried topical application of anacarcin forte (R) oil in 10 cases of vitiligo. Of these, some cases showed excellent results. Intense itching vesication and pustulation were seen in two cases. One case showed urticarial rash.

Antimalarial drugs in vitiligo

Mapacrine, an antimalarial drug was reported as repigmenting agent by Banerjee et al. He further indicated that mapacrine was more effective then chloroquine. Gokhale suggested that improvement may be due to raised levels of corticosteroids caused by antimalarial drugs.

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Role Of Unani Herbal Drugs in Opiate De-Addiction

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The Unani System of Medicine is an inalienable part of the Indian medical scene. It is backed by scientific labours of centuries. It is rich in therapy of many diseases lacking treatment in Western and other traditional systems of medicine. Thus any effort to fight drug abuse medically would be incomplete without a review of the Unani System of Medicine in this regard.

Drug abuse has become a growing problem, especially among the younger generation. As a social rodent it is silently and slowly gnawing at the moral fabric of siciety and has become a social manace. Although this problem has to be confronted at the spiritual and social plane but the medical profession too has and important role to play in preventing and treating drug abuse.

Morphine-like opioids constitute the bulk of abused drugs. The prevent compound of opioids, opium, was unknown to Indians before the arrival of the Unani Medicine in the Indian subcontinent in 12th century A.D. The Unani physicians brought opium from Asia Minor for its therapeutic potential as a pain-killer and as an anaesthetic agent. Opium is frequently used in a number of compound preparations for the treatment of various diseases. The Unani physicians, while introduceing it into the pharmacopoeias (Qarabadeen), knew of its habit-forming effect. They devised the treatment or its toxic effects, including the additional liability, before using it as a therapeutic agent.

A number of methods is employed in the Unani System of Medicine to obviate the ill-effects of opium, particularly additional, Instead of the raw or crude state, opium is used in a treated form known as 'afiyun mudabbar' (treated opium). In compound preparations it is always used with a corrective (muslah) namely: Zafran *(Crocus sativus, Linn.), Darchini (Cinnamomum tamala), Jadwar (Delphinium denudatum Linn.)* Fariyun *(Euphorbia resinifera),* Juntiyana *(Gentian kurroo)* Azaraqi *(Strychnos nux-vomica)* etc.

The Unani literature, very interestingly, mentions *Majoon-i-Azaraqi*, a compound herbal drug, as a cure for opium dependence. It is of added interest that this compound preparation was originally formulated in India by Hakim Muhammed Momin bin Muhammad Zaman, a renowned Unani physician of Moghul period. He described the de-addictive effect of *Majoon-i-Azaraqi* in his celebrated work *Tuhfa-al-Momineen*, a standard source book of Unani Medicine. The original Persian manuscript of *Tuhfa-al-Momineen* in two volumes is preserved in the library of Ayurvedic and Unani Tibbiya College, New Delhi and other manuscripts are reported to be in Karachi, Pakistan.

Since the introduction of *Majoon-i Azaraqi* in the above mentioned corpus it has been incorporated in almost all later pharmacopoeias (qarabadeen), such as *Qarabadeen-i-Zakai* of Hakim Azam Khan (ca. 1780). *Qarabadeen-i-Qadri* of Hakim Mahammed Akbar Arzani (b.1670) and *Qarabadeen-i-Najmul* Ghani of Hakim Najmul Ghani (1859-1899).

Majoon-i-Azaraqi consists of 14 ingredients, i.e., simple drugs of botanical origin. Of these 9 drugs are indigenous to India.

TABLE 1

S. No.	Drug	Botanical Name	Part used
1.	Amla	*Embilica officinalis*	Fruit
2.	Azaraqi	*Strychnos nux-vomica*	Seed
3.	Chilighoza	*Pinus gerardiana*	Seed
4.	Halailah Siyah	Terminalia chebula	Fruit
5.	Heel khurd	*Elettaria cardamomum* Maton, (Dry capsule)	Fruit
6.	Katira	Astragalus heratensis	Gum
7.	Narjil	Cocos nucifera. Linn.	Fruit
8.	Ood-i-Hindi	Aquilaria malacensis	Stem Bud
9.	Quaranful	Eugenia caryophyllata	Dried flower Bud

10.	Sandal safed	Santalum album	Stem
11.	Shaquaqual misri	Trachydium lehmanni	Root
12.	Ustukhudoos	Lavandula stoechas	Flow ers
13.	Zarambad	Curuma Zedoaria, Rosc.	Stem Rhi zome
14.	Gaozaban	Onosma bracteatum	Leaves, flowers

These simple drugs are mixed in honey to form a semi-liquid electuary (Majoon) named after its main ingredient Azaraqi (Strychnos nux-vomica). It is given orally in a dose of 5 to 7 grams twice a day.

Besides, Khan et al., (1986) made a pharma cological evaluation of *Majoon-i-Azaraqi* for its analgesic and anti-inflammatory activity. The study confirmed the Unani reports about it.

Chopra and Bose (1931) reported that Strychnos nux-vomica, the major ingredient of Majoon-i-Azaraqi, of Gentian (Juntiana) can be used totally or largely replace opium during de-addictive therapy without precipitating withdrawal symptoms.

The biological activity and therapeutic uses of the individual ingredients of *Majoon-i-Azaraqi reported* in Unani and modern literature are presented in Table II.

TABLE 1

S. No.	Drug	Biological Activity	
		Unani Reports	Modern Reports
		(11 to 15)	(16 to 36)
1.	Amla (Embica afficinalis	Nervine tonic, Cardiotonic, Refrigerant, Cooling Diuretic	Potentiation of Adrenaline action Antibacterial Antifungal Spasmolytic, Antagonist of Ach. Bradykinin, serotonin, Anticonvulsant, Anticholinergic Anabolic
2.	Azaraqi *(Strychnos nux-vomica)*	Nervine tonic, Antidote to opium narrcosis, Nervine tonic, Anodyne, Febrifuge,	Potentiation of Inhibition of glycine receptors Alcohol
3.	Chilghozah *(pinus gerardiana)*	Respiratory and cardiac stimulant, Anticonvulsant, Antistroke, Antiasthmatic, Antivenom, Nourishing, Demulcent, Resolvent, Stimulant, Anodyne, Brain tonic, Aphrodisiac, Antirheumatic	
4.	Gaozaban *(Onosma* bracteatum, *Wall.)*	Cooling Refrigerant Cardiotonic, Antiarrhythmic Urinary analgesic, Diuretic, Demulcent, Antirheumatic, Antisyphilatic Antileprosy, Antidepressant	Hypotensive (negative chrono-tropic effect) Spasmolytic.
5.	Halailah siyah *(Terminalia chebula*	Nervine tonic, Stomachic, Anticonvulasant, Antistroke, Antidepressant Antiemetic, Antivertigo	Antibacter al, Antifunga Antiviral Diuretic Antihistaminic Antineoplastic Hypoglycemic
6.	Heel khurd (Elettaria cardomomum	Antidote Exhilarant, Cardiotonic, Stomachic, Carminative, Stimulant, Appiestiser, Diuretic	
7.	Katira *(Astrogalus heratensis)*	Cooling. Refrigerant, Demulcent, Urinary analgesic.	
8.	Narjil *(Cocos nucifera,* Linn.)	Nutritive, Cooling, Refrigerant, Diuretic, Antivenom	Antitubercular Insect repellent
9.	Ood-i-Hindi *(Aquilaria malaccensis)*	Nervine tonic Cardiotonic, Exhilarant, Stimulant, Carminative, Antiemetic	
10.	Qaranful (Eugenia Caryophyllata)	Nervine tonic, Cardiotonic, Hepatotonic,	

	Stimulant, Carminative, Antiemetic, Antispasmodic, Antispasmodic, Antistroke.	
11. Sandal safed (Santalum album, Linn.)	Cooling, Refrigerant, Appetiser, Antimalarial, Anti-inflammatory, antiarrythmic, Antihypertensive, Diaphoretic, Diuretic, Cardiotonic, Antigonorrhea, Expectorant	Antibacterial, Antiviral
12. Shaqaqul misri *Trachydium lehmanni)*	Diuretic Aphrodisiac	
13. Ustukhuddos (Lavandula stoechas)	Nervine tonic, Cardiotonic, Deobstruent, Antidepressant, Analgesic, Antineuralgic, Carminative, Mucolytic,	Antibacterial Hyotensive, (negative chronotropic effect) Anti-inflammatory
14. Zarambad *(Curcuma zedoaria Rosc.)*	Antidote Stomachic Cerminative, Aromatic, Diuretic, Antihepatotoxic.	Antineoplastic Antihistaminic Depressant

The incorporation of *Majoon-i-Azaragi* in modern therapeutics of de-addiction should rationally begin with an elucidation of its mechanism of action. The large number of ingredients of the *Majoon-i-Azaraqi* each having multiple pharma cological activities makes this task very difficult. It may be useful to limit the mechanistic considerations to the major ingredient *Strychnos nuxvomica*.

It is apparently paradoxical that an analeptic agent should alleviate withdrawal syndrome, which itself is a hyperexcitatory state. But the following discussion may resolve the paradox. Alternatively, certain undiscovered aspects of patho-physiology of opioid dependence may be involved. Finally. *Majoon-i-Azaraqi* may be exerting it's de-addictive effect not by relieving withdrawal symptoms but by other mechanisms, such as an opioid-antagonistic de-reainforcing effect.

Chronic opiod use suppresses central inhibitory activity and/or augments central excitatory activity by activating homeostatic mechanisms. This, left imbalanced by depressant effect by exogenous opioids, is responsible for withdrawal symptoms. Strychnine produces central excition by blocking inhibitory pathways. So when administered to opium addicts it may reduce the suppression of inhibitory activity and/or augmentation of excitatory activity. This in turn would relieve the withdrawal symptoms. However, it is clear, that a mechanistic line of attack will help little in the scientific evaluation of *Majoon-i-Azaraqi* as a de-addictive preparation.

Majoon-i Azaraqi has been in use for hundreds of years. This fortunately alleviates the necessity of conducting preclinical and clinical phase-I studies. It can be directly evanualted in cases of moderate opioid dependence. This, however, requires a more exhaustive survey of Unani and other medical literature of constructive clinical regimens. Thus a wider literature survery and clinical trial in opioid addictive potential of Unani herbal drugs. They may also provide the information to make a more meaningful mechanistic discussion. Further, they may enrich the patho-physiological understanding of opioid-dependence.

आयुर के व्यापक–अनूठे हर्बल
शैम्पू
लम्बे लहराते खूबसूरत बालों के लिए
आंवला शिकाकाई शैम्पू
आंवला शिकाकाई की कुदरती खूबियों से भरपूर यह शैम्पू बालों को साफ करके असल रूप प्रदान करता है और उन्हें हल्का तथा मुलायम बनाता है. सामान्य किस्म के बालों के लिए खास उपयोगी है.
प्रोटीन शैम्पू
प्रोटीन से भरपूर यह शैम्पू बालों को आवश्यक पोषण उपलब्ध कराता है बालों को उलझने से रोकता है और उन्हें भरपूर मजबूती देता है. यह पतले और कमजोर बालों के लिए निहायत फायदेमंद और असरकारी है.
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Gelusil® MPS

(Aluminium Hydroxide, Magnesium Hydroxide, Activated Dimethicone)

TABLETS/LIQUID

The Xtra efficiency antacid[1]

(11 brands compared)

In Hyperacidity, Gastritis, Dyspepsia

Abridged Prescribing Information

GELUSIL® MPS

Antacid - Antiflatulent combination

Composition :

Each tablet or 5 ml. of liquid contains :

Dried Aluminium Hydroxide Gel I.P.	250 mg.
Magnesium Hydroxide U.S.P.	250 mg.
Activated Dimethicone I.P. (Activated Methylpolysiloxane)	50 mg.

Dosage & Administration: Oral

Tablets : One to two tablets to be chewed half to one hour after meals or whenever symptoms are pronounced.

Liquid : One to two teaspoonfuls (Approx. 5-10 ml.) half to one hour after meals or whenever symptoms are pronounced.

Actions :

Gelusil MPS with its high acid neutralizing capacity and effective dose of activated MPS provides rapid and prolonged relief of symptoms of hyperacidity and relieves symptoms of flatulence. It does not cause acidrebound, constipation or diarrhoea.

Indications :

Gelusil MPS is indicated for symptomatic relief of hyperacidity often associated with dyspepsia, peptic ulcer, gastritis, peptic oesophagitis and hiatal hernia. It is also indicated for relief of flatulence.

Contraindications :

Gelusil MPS should be used with caution in the presence of renal impairment.

Interactions :

Gelusil MPS may interfere with absorption of tet

1. I.J.O. Gastroenterology 1984, Vol. 3., No. 3, P. 141-143 Dr. Narendranathan et al.

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People Who Care

CORONARY ARTERY DISEASE

Edtor Note :

Due to imbalance of calories, Leck of excercise and change in the life style has been increased the percentage in Coronary artery diseases. However the western system of Medicine is devoloping advance Technique as well as new drugs but unable to reduce the percentage in Coronary artery diseases. In fect after thousand years the fundamental principles of Indian System of Medicine are most relevent (even modern scientific time) for prevention of Coronary Artery Disease.

Two Articles, "are Fish Oil Beneficial in the prevention and treatment of Coronary Artery Disease" and "Garlic : How beneficial is it ?"

One of thus is animal Source and other is herbal Source but both are part of our doily food and have great importance for the prevention of Coronary Artery Disease.

Are Fish Oils Beneficial In The Prevention And Treatment of Coronary Artery Disease?

SONJA L. Connor** and **William E. Connor

Amer. J. Clin. Nutr. (1997) : 66, 10208

Reference :- Probe a publication of Himalaya drug co. issue of july-sept-1998

Abstract :- The n-3 fatty acids of fish and fish oil have great potential for the prevention and treatment of patients with coronary artery disease. Unlike many of the phamaceutical agents used in patients with coronary artery disease that have just a single mechanism of action, the eicosapentaenoic and docosahexaenoic acids of fish oil have multifaceted actions. One of their most important effects is the prevention of arrhythmias, with documentation derived from experiments in cultured myocytes, experiments in animals, epidemiologic correlations and clinical trails. Especially important is the ability of these n-3 fatty acids to inhibit ventricular fibrilation and consequent cardiac arrest. Eicosapentaenoic acid has several antithrombotic actions, particularly in inhibiting the synthesis of throboxane A_2, the prostaglandin that causes platelet aggregation and vasocostriction. Fish oil retards the growth of the atherosclerotic plaque by inhibiting both cellular growth factors and the migration of monocytes. The n-3 fatty acids promote the synthesis of the beneficial nitric oxide in the endothelium. Experiments in humans indicate a profound hyolipidaemic effect of fish oil, especially lowering of plasma triacylglycerol. Both very-low-density lipoprotein production and apolipoprotein B synthesis are inhibited by fish oil, Finally, fish oil has a mild blood pressure-lowering effect in both normal and mildly hypertensive individuals. These composite effects suggest ia prominent therapeutic role for fish oil in the prevention and treatment of coronary artery disease.

Introduction

The development of coronary artery disease can be depicted as a three=stage process. First, lipid-rich atherosclerotic plaques grow with the proliferation of smooth muscle cells and the infiltration of monocytes and macrophages from the blood. In the second stage the coronary artery deisease becomes clinically manifest because the plaque grows to obstruct blood flow; in the third stage, the endothelial lining ulcerates and the resulting thrombus leads to myocardial infarction. The n-3 fatty acids from fish and fish oil can inhibit the growth of atherosclerotic plaques, checking the tendency to thrombosis and protecting the damaged myocardium from a fatal arrhythmia.

Fish and fish oils contain the very-long chain and highly polyunsaturated n-3 fatty acids, which are derived from phytoplankton, the base of the food chain in oceans, lakes and rivers. Phytoplankton synthesize the n-3 fatty acids eicosapentaenoic acid (20:5n-3; EPA) and docosahexaenoic acid (22:6n-3; DHA), which are subsequently incorporated into fish, shellfish and sea mammals. These fatty acids have profound biological and biochemical effects in the body. Polyunsaturated vevetable oils containing the n-6 fatty acid, linoleic acid (18:2n-6) had a pronounced plasma cholesterol lowering effect, yet the mechanism of this action has remained obsure. In those early days, it was noted that fish oil, which was also polyunsaturated, had a similar hypocholesterolemic effect. No mention was made of the fact that fish oil contained very long-chaim n-3 fatty acids (DHA and EPA) and that these might act differentyly from the n-6 fatty acids of vegetable oils. It was found that not nly were these n-3 fatty acids cholesterol lowering, but they also had a profound plasma triacylglycerol lowering effect, especially in hyper-triaglyceridaemic patients. More than a decade of research in humans, animals profused organs and tissue cultures have firmly documented the mechanisms of the hypolipidaemic actions of these n-3 fatty acids from fish, and furthermore, have shown that these fatty acids have many other beneficial effects in cardiovascular disease.

Anti-arrhythmic Actions : Fatty fish consumption was shown to prevent cardiac arrest from ventricular fibrillation in coronary patients. This is the cause of death in most patients with coronary artery disease and accounts for 20-30% of persons whose first indication of coronary disease is cardiac arrest. A recently published study compared the effects of eating fish with the incidence of cardiac arrest. There was a 50% reductioni in the ris of cardiac arrest in people who consumed at least one fatty fish meal per week. A typical fatty fish would be salmon. Other fatty fish include sardines and mackeral. Even those who consumed fish that are less fatty such as tuna also benefited because all fish and shellfish contain the beneficial n-3 fatty acids.

This protection against cardiac arrest was due to the n-3 fatty acids EPA and DHA The benefits of eating fish were measured biochemically in the fatty acids of the red blkood cells. If the red blood cells had a relatively low amount of the n-3 fatty acids, 3.3% of total fatty acids, there was a much greater risk of cardiac arrest than in those individuals whose red blood cell n-3 fatty acids were > 5% of the total fatty acids. There was a 70% reduction in the risk of cardiac arrest in those persons with the higher and blood cell n-3 fatty acid content.

In a study conducted, in which men were advised to eat fatty fish or to consume some fish oil capsules, there was a 29% reduction in total deaths and in particular deaths from coronary artery disease.

Thrombosis : The n-3 fatty acids invariable have an antithrombotic effect, particularly a diminution in thromboxane A_2,which proiduces platelet aggregation and vasoconstriction. Platelet aggregation and vasoconstriction. Platelet reactivity and adhesion are considerably reduced after fish oil ingestion. Enhanced fibrinolysis has also been observed.

The function of the endothelium, important in both thrombosis and atherosclerosis, is affected by n-3 fatty acids, The production of prostacyclin is enhanced, endothelial-derived relaxation factor or nitric oxide, which is depressed in atherosclerotic disease, is greatly increased by the n-3 fatty acids of fish oil.

Exprimental atherosclerosis and fish oil :

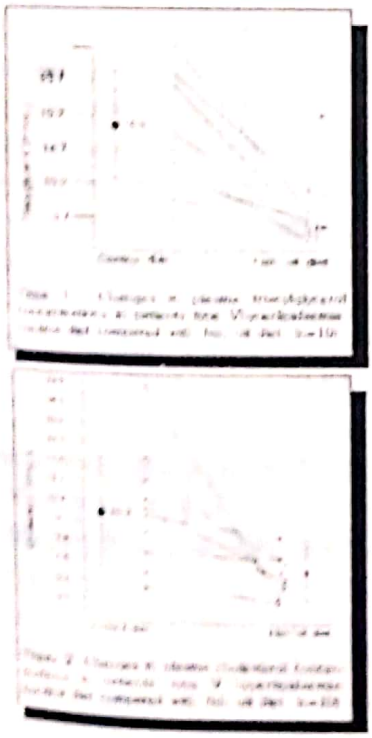
When menhaden oil was incorporated into atherogenic diets fed to rhesus monkeys, aortic plaques were fewer and their cholesterol content much less. The two important cells in atherosclerosis are smooth muscle cells and macrophages. Because of the suppression of cellular growth factors by n-3 fatty acids, proliferation of smooth muscle cells is inhibited. Likewise, macrophage infiltration in to the vessel wall is lessened by n-3 fatty acids. Even the initial lesion of atherosclerosis the fatty streak develops less under the influence of dietary n-3 fatty acids.

Hypolipidaemic action : The n-3 fatty acids lower plasma in very low-density lipoprotein (VLDL) and triacylglycerol concentrations through depression of synthesis of triacylgycerol in the liver. The n-3 fatty acids also suppress postprandial lipaemia, the chylomicron renants of which are considered atherogenic. Effects on LDL and high density lipoprotein (HDL) have been variable. HDL either increases or does not change. Like the drug gemifibrozil, n-3 fatty acids may cause an increase in LDL as they

lower the plasma triacylhlycerol concentration in some hyperlipidaemic states. The n-3 fatty acids of fish have a powerful in hyperlipidaemic and normal patients.

Two different control diets were used for two groups of hypertriglyceridaemic patients, depending on the type of hyperlipdaemia. Patients with type II-b hyperlipidaemia received their usual lowcholesterol, low-fat diet. Subsequent dietary periods for type II-b patients consisted of a fish oil diet for 4 weeks, followed in some patients by a 4 week period of a diet high in a vegetable oil containing a predomiance of n-6 fatty acids. Both of these diets were balanced for cholestreol content (=250) mg/dl) and contained 30% of energy as fat.

For patients with type V hyperlipidaemia, the control diet consisted of a very-low-fat diet (5%) to lower plasma triacylglycerol concentrations maximally. The next dietary interval contained fish oil at 20% or



30% of total energy. Finally, a polyunsaturated vegetable oil diet was also provided, which contained 20-30% of energy as fat and the vegetable oil diets were initially used cautiously in the type V patients to minimize the risk of hepatosplenomegaly, abdominal pain and acute pancreatitis.

The salmon oil diet provided=20 gm n-3 fatty acids/dl for a (2600-kcal) intake, with 30% of total energy as fat. On the other hand, the vegetable oil diet provided=47g linoleic acid and n-6 polyunsaturated fatty acid. Thus, the n-6 polyunsaturated fatty acid. Thus, the fish oil diets actually provided 43-64% less total polyunsaturated fatty acids gram for gram than did the vegetable oil diet. The fish oil diet decreased plasma LDl-cholesterol concentrations in the type II-b patients by 0.7 mmol/l (26mg/dl). Of individual lipoprotein cholesterol changes, the decline of VLDL cholesterol was most striking; but LDL and HDL cholesterol also decreased. Plasma triacylglycerol changes were even greater than the cholesterol changes with the fish oil diet. This occured largely because of the change in VLDL triacylglycerol.

The highly polyunsaturated vegetable oil diet had much less effect on VLDL cholesterol and triacylglycerol. LDL values were similar; in contrast, HDL cholesterol was higher after the vegetable oil diet. Plasma apolipoprotein (apo) changes reflected the lipoprotein lipids changes. In the type II-b patients there were significant reductions in apo B and C-III concentrations in the fish oil period, which paralleled the declines in LDL and VLDL concentrations.

In the type V patients effects of the fish oil diet even more striking (Figures 1 and 2). With consumption of the very-low-fat control diet, initial plasma lipid concentrations in these patients declined considerably but still remained greatly elevated. Many of these patients still had milky-appearing plasma, chylomicrons present in the fasting state. The first change to occur in these patients after the fish oil diet was the virtual disappearance of fasting chyomicronemia, which had been present in five of the patients. During the fish oil diet preiod, total plasma triacylglycerol decreased from a control value of 15.3 to 3.2 mmol/l (1353 to 281 mg/dl), a drop of 79%. VLDL triacylglyerol decreased similarly from 12.3 to 1.9 mmol/l (1087 to 167 mg/dl). Plasma cholesterol concentrations declined to the normal level after the fish oil diet from 9.7 to 5.4 mmol/L (373 to 207 mg/dl).

Most of this total plasma cholesterol decrease occurred as the result of market changes in the amount of VLDL cholesterol.

Fish oil and the inhibition of carbohydrate-induced hypertriglyceridaemia and reduction of postprandial lipaemia after fatty meals: The well-known phenomenon of carbohydrate-induced hypertriglyceridaemia is a physiologic response.

In seven subject, a high-carbohydrate controldiet increased plasma triacylghlycerol concentrations over the baseline diet from 1.2 to 2.2 mmol/l (from 105 to 194 mg/dl. The magnitude of the carbohydrat-induced hypertriglyceridaemia correlated significantly with each individual's baseline triacylghlycerol concentration. was complete by day 5 and resulted almost entirely from an increase in the

VLDL triacylghlycerol fraction, which was more than double during the control diet. A lthough the total plasma cholesterol concentrations did not change,VLDL cholesterolconcentrations approimately doubled: from 0.5 to 0.9 mmol/L (18 to 34 mg/dL) and HDL cholesterol was reduced: from 1.3 to 1.1 mmol/L(49 to 41 mg/dL).

When the fat of the high-carbohydrate control diet was replaced isoenergetically with fish oil, the elevated plasma triacylglycerol concentration was reduced from 2.2 to 0.9 mmol/L (from 194 to 75 mg/dl), a decrease of 61% This decrease usually occured within 3 days. Again, changes in VLDL triacylglycerol concentrations decreased insignificantly during the high-carbohydrate fish oil diet (from 1.8 to 0.4) Total cholesterol concentrations decreased insignificantly during the high carbohydrate fish oil diet because of the drope in VLDL cholesterol concentrations.

Dietary fish oil not only prevented but also rapidly reversed the dietary carbohydrate-induced elevations in plasma triacylglycerol and VLDL concentrations.

The n-3 fatty acids from fish oil and fish have remarkable effect on the synthesis and clearance of triacylglycerol-rich lipoproteins, especially VLDL and chylomicrons. Even LDL synthesis and clearance are affectd. Because of these significant effects of lipoprotein synthesis and clearance, beneficial effects of fish oil have been shown in a variety of hyperlipidaemic states, especially those conditions with hypertriglyceridaemia and chylomicronaemia. Therapeutic implicatiojs for fish oil are especially polítive in tyhpe V, type IV and III hyperlipidaemia.

Fish oil is most effective when administered at 6% to 30% of total energy and when the diet is metabolically controlled. In studies with these conditions, LDL lowering ulually occured as well as profound VLDL and triacylghlycerol lowering in normal subjects and in a wide variety of hyperlipidaemic staes. This lowering of plasma cholesterol concentrations occurs in patients with type V, II-a, 11-b III and IV hyperlipidaemia, the most dramatic results occuring in the type V patients who do not tolerate any other kind of deitary fat. HDL concentrations are not greatly affected by fish oil Lower doses fo fish oil (8-15 g/d) in particular lower plasma triacylglycerol concentrations.

Why plasma LDL and apo B concentrations have at times increased after fish oil when at the same time plasma VLDL and triacylglycerol concentrations decreased is a most challenging question and may relate in fundamental aspect of VLDL-LDL metabolosm Normally, LDL is derived rom two sources conversion from VLDL and direct syntheses from the liver. The catabolism of VLDL is likewise in two directions through intermediate-density lipoprotein (IDL). IDL may be removed by the apo E receptor in the liver or converted to LDL. Animal studies revealed that fish oil feeding increased the proportion of VLDL being converted to LDL.Apparently, the n-3 fatty acids of fish oil produce a small VLDL particle, which is more likely to converted to LDL. More VLDL is converted to LDL and direct LDL synthesis does not decrease, thus adding up to more LDL. Lowdensity lipoprotein turnover studies have shown decreased production of LDL in normal humans given large amounts of salmon oil complared with vegetable oil.

Mechanism of the Hypolipidaemic Effects of Fish Oil : How n-3 fatty acids exert their effects to decrease concentrations of plasma triacylghlycerol and cholesterol have been tested in humans in two different sets of experiments: the inhibition by fish oil of the usual hypertriglyceridaemia that inevitably results when a high-carbohydrate diet is suddenly fed to humans and the effects of fish oil on apo B, VLDL and LDL production rates and turnovers

Fish Oil and the Synthesis and Turnover of apo, VLDL and LDL: The hypothesis that n-3 fatty acids probably resuce VLDL concentrations by inhibiting VLDL synthesis was further supported by studies designed to elucidate further mechanism of the hypotriglyceridaemic effect of n-3 fatty acids.

In a study the isoenergetic substitution of fish oil for the control vegetable fat produced the expected significant reductions in the total and lipoprotein lipid concentrations in all 10 subjects. Total cholesterol concentrations for all 10 subjects fell from 5.1 to 3.7 mmol/L (from 195 to 144 mg/dl), a reduction of 22% Decreases in VLDL concentrations accounted for most of the drop in plasma cholesterol [from 2.2 to 0.6 mmol/L(83 to 21 mg/dL)] LDL -cholesterol concentrations did not change significantly, whereas HDL- cholesterol concentrations fell from 0.8 to 0.6 mmol/L All of these changes were evident in both the normal and the

hypertriglyceridaemic groups.

The hepatic syntheses of triacylglycerol and VLDL is suppressed by n-3 fatty acids from fish oil. The evidence is strong that suppression of VLDL and triacylglycerol synthsis is a primary mechanism of the hypolipidaemic effects of n-3 fatty acids, along with an increased fractional catabolicrate of VLDL.

It has also been observed that fish oils markedly decrease the usual chylomicronemia that follows fatty meals. In other words, fat tolerance is greatly improved. This improvement could result from diminished absorption, slower synthsis, slower entry of chylomicrons into the circulation or alternatively, more rapid removal of the chylomicrons that do appear in the circulation.

Fish oil in Diabetics : In diabetic patients there is enhanced risk for vascular disease, so that the use of fish oil might be particularly desirable if glucose control is not disturbed. For patients with insulindependent diabetes there is universal agreement that glucose control is not hampered. For patients with non-insulindependent (adult onset) diabetes, the results are somewhat conflicting, possibly because such patients are very susceptible to the energy load imposed. The addition of fish oil to the usual diet will be hyperenergetic, thereby disturbing glucose control.

In view of the extremely high mortality from coronary artery disease in patients with non insulin dependent diabetic control dit not diteriorate and significantly beneficial plasma lipid and lipoprotein lowering effects were visible. The other actions of the n-3 fatty acids from fish oil in inhibiting the d evelopment of atherosclerosis, in preventing thromboxane A_2 formation, in increasing endothelial derived relaxing factor and in inhibiting platelet derived growth factor, are additional reasons for postulating a therapeutic benefit of fish oil in diabetic patients. The mild blood pressure lowering effect of n-3 fatty acids is and added benefit.

The intake of n-3 fatty acids from fish should be increased to prevent conronary artery disease. This recommendation could best be met in the form of two to three fish meals per week in context of a low fat diet. The diet should be reduced in fat content to 20% of total energy whereas carbohydrate and fibre intakes should be high. Cholesterol intake should be limited to 100 mg/d. All fish and shellfish contain n-3 fatty acids. The lower the fat content, higher the percentage of n-3 fatty acids that are present in a given or shellfish. Fish, of course, could be substituted for meat in the diet. The goal of this recommendation is to produce an increased content of the n-3 fatty acids EPA and DHA in the blood and tissues of the body. This will occur if there is regular consumption of 200-300 gm fish and shellfish perseed.

For the intersive treatment of various forms of hyperlipdaemia as well as the production of an antithrombotic state fish, oils needs to be used in addition to the consumption of fish. The dose of fish oil might well be from 6 to 15 g/d titrated according to the endpoint desired. For people who are unable to consume fish or shellfish, the use of fish oil would be advisable. For primary prevention 2-3 g/d is desirable. Higher doses, as noted above, should be used for secondary prevention and the attainment of discrete endpoints of plasma lipid and lipoprotein concentrations and platelet function.

In conclusion, N-3 fatty acids from fish and fish oil greatly inhibit the atherosclerotic process and coronary thrombosis by many actions and should be considered by many action and should be considered as and important therapeutic modelity inpatients with coronary artery disease and to prevent coronary disease in highly susceptible people.

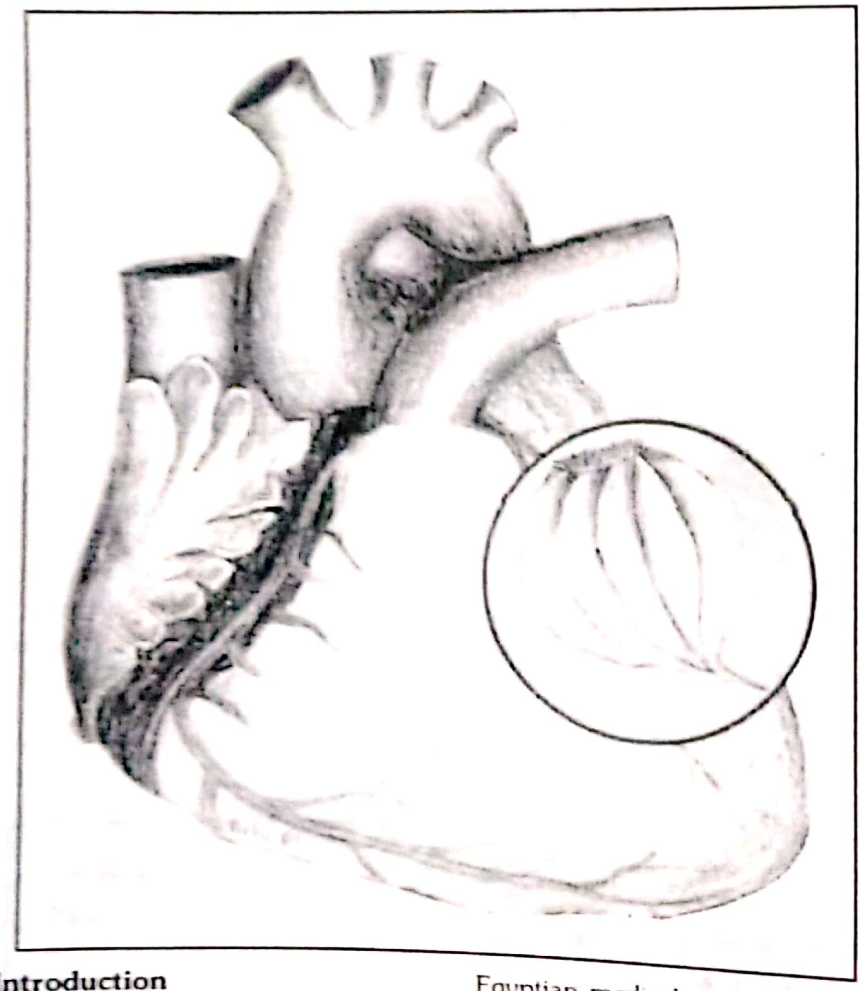
GARLIC : HOW BENEFICIAL IS IT?

DR. S. Khana, and Dr. D. Kumar

Editor Note:-

Probably First of all Chinies was introduce to Golic before. 3000 BC Galic have a great importance as ingrediant of our daily food. as well as Medicinal properties. It is caltiviated as crop Unan, Roam, India, china Ethapia, Kania, Philipines, Brazeld etc. The main constitvent of garlic are 62% Woter, 6.3% Protine 0.1% Fate, 0.8% Febers, 29.8% Carbohydrats 1.0% Menarals 4.3, Calcium phosphonas, Iron form. Hakeems are using as Medicine in various ailments viz stomach disarder, Common cold, cough, joints pain and high blood pressure and as blood purifire. Now, moderm science have been proved its Medicinal properties espocialy to dierease cholestrol level in blood. Alil propile, diesuephaid, Alisin, Alistrone -1 & Aliestine-2 are resporible to control of blood pressure.

The article "Garlic:- How beneficial is it?" written by Dr. S. Khana, Dr. D. Kumar and prublished in cordio thorasic Journal vol-4 No-1 March 198. an I.J.C.P. Group of publication.



Introduction

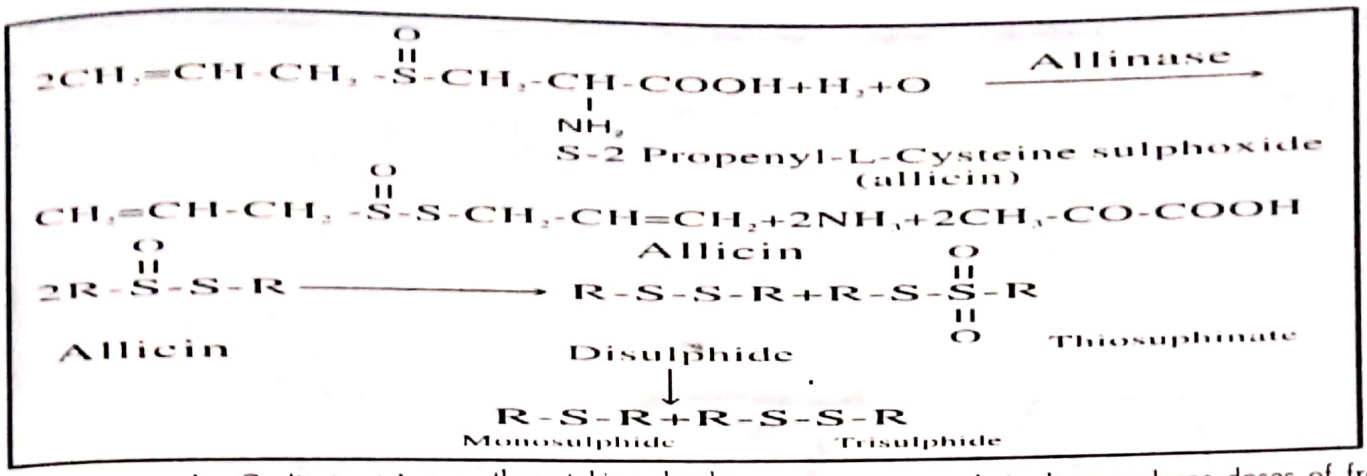
The use of garlic (Allium sativum) for health giving properties is known since ancient times. It is mentioned in 22 out of 800 herbal remedies in the Codex Ebers, an Egyptian medical papyrus of 1500 BC. Bottom, however, referred to its major side effect when instructing his actors to "eat no onions nor garlic, for we are to utter sweet breath". Garlic has been advocated for various ailments including heart disease, headache, bites, worms, tumours, cancers and infections. Recent work suggests that it has a possible role in reducing vascular disease. Popular interest is currently greatest in Germany where garlic prepartions are the largest selling over the-counter drugs. Over one million Germans supplement their diet with a highly concentrated garlic tablets called Kwai. Such is now the importance of garlic in medicinal and nutritional world that the first International Garlic Symposium was held in Lunenburg, West Germany in 1989.

Chemistry

A sulphur containing compound allicin is the principle active agent in garlic. It is responsible for characteristic odour of Garlic, Allicin is formed enzymatically from an odourless precursor allicin, S-2 propenyl (allyl) cycteine sulphoxide by the action of enzyme allinase. The allicin then undergoes nonenzymatic decomposes to give a complex mixture of monosulphide and trisulphide.

Beneficial effects

Garlic is a bulb made up of several cloves. It is cultivated over India. Garlic is used all over the world for flavouroing various dishes. However, its flavour is less appreciated



by some people. Garlic is rich in sulphur, phosphorus, calcium and iron.

Allicin contained in garlic gives it the antibiotic and antimicrobial property. This is part of the volatile oil allyl sulphide on which depends its medicinal properties. Louis Pasteur confirmed the antibiotic effect of garlic in 1858 and in laboratory experiments showed that garlic juice could kill bacteria. In antibiotic tests in the USSR, allicin of the raw garlic has been found to be even more powerful than penicillin. Garlic has the broadest spectrum of any antimicrobial known substance.

Bordia showed that taking large amounts of garlic eveyday helps reducing the bad cholesterol LDL and increases the level of good cholesterol HDL. Makheja et al gave details of an experiment which established that garlic and onion restrict the rise of cholesterol and blood fat levels. A placebo controlled, randomised, double blind four month study in 261 German patients with hyperlipidaemia, suggested that those taking 800 mg dried garlic powder a day (Kwai, with 1.3% allicin) serum concetrations of total cholesterol fell from 6.87 to 6.07 and of triglycerides from 2.55 to 2.12 mmol/l. A smell of garlic was reported (most frequently by spouses) in 21% of treated patients and 9% of those taking placebo.

Research of Geneva University has established that garlic causes dilatation of blood vessels and thus reduces high blood pressure. Dr. V. Petkor of Bulgarian University has established that garlic alone can cause a reduction of systolic 10 to 20 mmHg, Japanese Government officially recognises garlic as a depressor of high BP. Recntly a controlled study has shown that 800 mg dried garlic powder per day (Kwai with 1.3% allicin) taken for 3 months was associated with significant fall of BP from 171/102 to 152/89 mmHg in hypertensive patients with one in eight reporting an odour of garlic.

Dr. Eric Block of the State University of New York discovered in garlic a chemical ajoene which regulated the blood clotting process and was an effective blood thinner[2]. Garlic Research Bureau has accoding to Dr. David Roser gathered evidences that even 2 to 3 gm garlic per day will have a definite effect on clotting activity. A fall in fibrinogen and an increase in fibrinolysis has been reported. Garlic extract reucers the formation of acute platelet thrombus in vivo in stenosed coronary arteries of dogs and synthetic allicin inhibits platelet aggregation in vitro although the mechanisms are unclear.

A recent review3 concluded that where as large doses of fresh garlic (7-28 clove a day) had beneficial effect on cardio vascular risk factor, data for commercial preparation were unconvincing and there was inadequate evidence to recommend garlic supplementation.

Warm blooded persons and those suffering from piles and dysentry should use garlic only on the advice of medical practitioner; garlic can be used by all to meet the all type of health problems form arthritis, asthma, bronchitis, common cold, cholera, diabetes, jaundice, rheumatism, malaria, ringworm, scurvy, TB and typhoid. It is a tonic for sexual debility and impotency also. Russian scientists have successfully used garlic against human tumours.

The potential benefits of garlic seems to be offset by the fact that garlic produces detectable aroma which is not without social consequences, odour blockers have not been effective15. Though it is known that garlic prepartations are useful in treating hyperlipidaemia and hypertension, yet reduction in mortality and morbadity remains to be shown. To conclude, The roll of gorlic is Quit well established since the time immemorial but need more studies to substaintite the known benifits.

ANXIETY

Editor Note:-

The article "Anxiety" is reproduced form Health-up-date Volum 2 issue No-5 of January-1998. The Health up date is a monthly bulletin of Society for health education and learning packages which present different approaches and treatment on particular disease by Allopathy, Ayurveda, Unani, Homoeopathy and nature care system of medicine ?

ALLOPATHY

Anxiety is not disease but a symptom. Most people have anxiety at some time or the other in their life. Usually, it is a normal reaction to a stressful situation and is therefore short-lived. Anxiety can adversely affect your work if it occurs often. It is important to remember that anxiety can exist alone or in combination with other symptoms of several emotional disorders. It is the most common feature of majority of psychiatric illnesses.

How common is anxiety?

Anxiety is one of the most under-reported conditions largely due to ignorance. It is difficult to estimate the number of people suffering from anxiety because most people suffering from anxiety do not consult a doctor. This is mainly because many people believe that only " mentally sick" people need to consult with a psychiatrist. In the United States, an estimated five percent of the total population suffer from anixety. Anxiety is more common among women than men. Some studies have indicated that anxiety may also run in families

It is believed that the number of people suffering from anxiety is increasing at an alarming rate due to pressures of modern life. However, some specialists feel that is no conclusive evidence to prove that anxiety is on the increase. According to them, increased awareness and the desire to live life fully have resulted in more number of people seeking help for anxiety.

Irrespective of whether anxiety is on the increase or not, it is important that you learn to deal with anxiety in order to lead a more productive and meaningful life. Controlling and preventing anxiety will also enhance your coping skills in case of adversity.

Anxiety is often confused with fear

What are the effects of anxiety?

Anxiety affects everyone, especially when there is excessive mental or emotional stress. It normally leads to two outcomes. (a) intense panic and therefore inability to function normally or adapt to the situations or (b) an ability to anticipate the danger and take appropriate preventive measures against it. The first reaction is called "traumatic anxiety" and the second reaction is called "signal anxiety"

What are causes of anxiety?

All the memories suppressed during the infancy and childhood can have an impact on the adult life and result in anxiety. It is usually the result of an exaggerated response to an emotional stress. Emotional ups and downs are a part of everyone's life. However, some people are more adversely affected by emotional stress then others.

Anxiety often develops over a long period of time and is largely dependent on the entire life's experiences. Specific events or situations can precipitate anxiety attacks but only after a basic pattern of an anxious response to life's experiences is established. There are four main factors that influence development of the pattern of anxious response.

Surroundings: The enviroment or surroundings in which you live influence the way you think about yourself and others. It could be due to your experience with family, friends, colleagues, etc. Anxiety is common if you are insecure about your surroundings.

Suppressed emotions. Anxiety can occur if you are unable to find an outlet for your feelings in personal relationships. This is especially true if you suppress anger or frustration for a very long time.

Physical causes : The mind and body are constantly interacting with each other and any change in this interaction may cause anxiety. This is commonly seen in conditions such as pregnancy, adolescence and recovering from an illness. During

these conditions, mood changes are common, and they may lead to anxiety.

Hereditary : Although some emotional disorders may run in families, it is not an important cause of anxiety.

What are types of anxiety?

Conditions that cause anxiety are broadly divided into three categories (a) anxiety states, (b) phobic disorders and (c) post-traumatic stress disorders. The category of anxiety state inculdes three specific disorders: (i) panic disorders, (ii) generalized anxiety disorder and (iii) obsessive compulsive disorder. *This issue includes a brief description of panic disorders, generalized anxiety disorder and phobic disorders. Obsessive compulsive disorder and post-traumatic and phobic disorder will be included in upcoming issues of the Health Update. Stress, one of the important factors contributing to anxiety, and its management will also be discussed in upcoming issues of the Health Update.*

Anxiety states

Anxiety may either be *acute* (of short duration) or *chronic* (of longer duration). It is common for a person with panic disorder to have symptoms of generalized anxiety disorder. Anxiety without panic attacks is called generalized anxiety disorder. Both panic disorders and generalised disorder have similar causes, signs and symptoms.

What are panic disorders?

Recurrent attacks of anxiety or panic along with nervousness are called panic disorders. They are often associated with a feeling of approaching doom. Panic disorders may either begin slowly with a general feeling of tension and nervous discomfort or occur suddenly with an attack of acute anxiety. Although panic disorders are more common in young adults, they may also be present in adolescents.

Panic disorders are usually not related to other mental illnesses and often appear to occur without any *precipitating factors*. Precipitating factors are those factors that hasten the onset of signs and symptoms of a disease. You may not be able to recollect or identify precipitating factors of panic attacks, especially if you have suppressed emotions, which a mental health specialist can help you identify.

What are the syptoms of panic disorders?

Common symtoms of panic disorders include a feeling of panic, *palpitations* (thumping sensation and awareness of the heart beats), pain in the chest, diffculty in, or rapid breathing and a feeling of dizziness or weakness. Most people describe panic as a strange, weird or ghostly feeling as if something very bad is going to happen. *It is important to remember that you may not always be able to identify the cause of fear and nervousness or the consequences of the event you dread.* If you are unable to identify the cause, you are likely to become more desperate and feel that you should do "something" to protect yourself. It may however be diffcult to define what this "something" is.

Detailed below are the main symptoms of panic disorders.

Chest pain: Chest pain due to anxiety is often confused with chest pain due to heart attack or angina. There are four major differences between chest pain due to heart problems and anxiety. The chest pain due to anxiety:

1. Lasts only for a few seconds at a time but may repeat every few minutes or hours;
2. Is not related to exercise or physical exertion;
3. Can occur even at rest; and
4. Does not go away when you stop the physical activity you may be doing when the chest pain starts.

Difficulty in breathing. During an attack of panic, you may begin to breathe more rapidly and more deeply because of the fear that you are inhaling less air. You may also have a strong urge to go out and inhale more air. If the rapid and deep breathing continues for a long time, there may be loss of large amount of carbon dioxide. This imbalance symptoms such as numbness or tingling in the toes, feet or face, lightheadedness and giddiness.

Other symptoms: Some people with anxiety may complain of sensation of heat on the face, sweating goosc pimples and trembling. In addition, there may be pain or hollow butterfly like fluttering feeling in the stomach. During a panic attack, you may be unable to act or think intelligently and as a result feel as if your mind is clouded or confused.

The frequency of panic attacks varies from person to person. Some people may have only a few attacks during the entire life while others may have attacks every few days, weeks or months. Sometimes the panic attacks may stop suddenly without any apparent reason. The severity and

duration of symptoms varies with each attack.

What is generalised anxiety disorder?

Generalised anxiety disorder is a condition where there is chronic and exaggerated worry or tension, often without any provocative factors. Most people with this condition live with fear of disaster and worry about most aspects of life such as health, money, family, work, etc. There may be periodic or recurrent acute attacks of panic with more severe symptoms.

Just as in panic disorder, it may not be easy for you to identify the exact cause of generalised anxiety. Even if you do, it is likely that you may not be aware of how and why these troubles cause the symptoms.

What are the signs and symptoms of generalised anxiety disorder?

There are several symptoms of chronic anxiety. Of these, the most common are:

General irritability : Nervousness, irritability, tense and panicky feeling. A chronic worry that an unknown calamity will soon strike leads to sleeplessness and easy tiredness during the day.

Headache: Muscle tension, especially in the head, neck and back, may lead to headache or a dull and throbbing discomfort. The pain may be present either at the back, top or fronts of the head.

Tremors: Shakiness and trembling of the whole body, especially in the arms and hands.

Increased activity of the autonomic system: Involuntary functions of the body such as breathing digestion, heart beats, etc. are called "*autonomic functions*" as they function independently without outside influence. Anxiety can increase the activity of the autonomic system and therefore lead to increased sweating (especially on the palms of the hand), and flushing of the face. Sometimes there may either be increased dryness or watering in the mouth.

Increased autonomic activity also leads to disturbances in the digestive system. "Butterflies in the stomach" is a very common feeling. Other symptoms include burning sensation in the chest or stomach, fullness in the stomach, which often accompanied by belching, bowel disturbances (especially loose bowels) and increased frequency of passing the urine.

The diagnostic criteria for generalised anxiety disorder.

It is important to remember that the progress recovery of generalised anxiety disorder varies from person to person. Some people may recover with short-term treatment, while others may continue to have symptoms and inability to lead a normal life with varying degrees of severity. Chronic anxiety in young adults often tends to become less severe with age, especially if there is success and stability in professional and personal lives.

How are anxiety states diagnosed?

As mentioned earlier, anxiety can also be one of the major symptoms of other psychiatric illnesses. Your doctor will ask several questions to rule out associated disorders.

It is difficult to diagnose anxiety states by physical examination alone. This is because anxiety is normally not associated with abnormalities in any organs or parts of the body. Also, as mentioned earlier, heart rate may be higher and breathing more rapid without any evidence of heart diseases. Thus, the description of your symptoms, especially those related to mental disturbances and/or conflicts, play a critical role in diagnosis of anxiety states. *It is important that you describe all your symptoms, confusions in the mind, doubts, etc, to the doctor very clearly and without any hesitation.* Unless you are frank with your doctor, he/she may not be able to make a correct diagnoses.

Your doctor is likely to recommend a few laboratory tests to rule out conditions such as heart diseases, overactivity of the thyroid gland, disease of the middle ear, etc.

What is the treatment for anxiety states?

Treatment of anxiety states involves four main approaches. These include (a) psychotherapy (b) relaxation therapy, (c) meditation and (d) medicines.

Psychotherapy: This is used for a large number of methods for treating mental and emotional disorders by psychological techniques rather than through medicines or physical treatment. There are two main types of psychotherapy for management of anxiety states. These include *insight psychotherapy and supportive psychotherapy.*

Insight psychotherapy involves determination of the strength of the inner self that affects (a) the stability of your relationships with family, friends and working environment, (b) motivation for treatment and (c) ability to bear difficulties in life. Your

doctor will first assess your capacity to "explore" within your mind in order to find out if you are likely to respond to this treatment or not. If your problem is related to specific and limited situations, you may be free from inner conflicts with short-term therapy and after your doctor has helped to uncover the underlying problems. Freedom from inner conflicts will relieve the symptoms of anxiety. If the underlying causes are related to neurotic difficulties, psychoanalysis or other similar forms of long-term treatment may be necessary.

Supportive psychotherapy involves discusing your diffculties with your doctor. He/she is likely to reassure you about unrealistic fears and encourage you to face situations and/or circumstances that lead to anxiety. Although supportive psychotherapy will not cure anxiety, it will help you understand the situations that lead to anxiety and change them in order to reduce stress.

Relaxation therapy: Relaxation techniques can be helpful if you are eager to accep suggestions from your doctor and implement them. He/she may teach you specific relaxation techniques. It is important that you practice these techniques under your doctors's guidance intially so that both of you are confident that you are able to practice correct relaxation techniques. It is important to remember that a daily routine of these relaxation techniques is necessary for controlling anxiety. You should also practice them whenever you feel the inner tension rising or when faced with situations that normally lead to anxiety.

Meditation: Transcendental meditation or other simple form of meditaion that are not related to religious rituals of practices are likely symptoms of anxiety. Several research studies world-wide have indicated that meditation functions of the body (such as heart rate, respiration, digestion, etc.)

Medicines: may prescribe mild tranquilizers and antidepressants to reduce the symptoms of anxiety Tranquilizers are medicines that calm agitated or anxious people without affecting the consciousness. Antidepressants are medicines that relieve depression by restoring the balance of chemical substances in the nervous system. Detailed below are some of the common medicines used for management of anxiety states.

Benzodiazepines: There are several medicines in this group of tranquilizers. Diazepan is one of the common medicines in this group. It is a long-acting medicine, is rapidly absorbed in the stomach and begins to act within fifteen to twenty minutes. However, the maximum effect is observed only one to two hours after taking the medicine. Absorption of diazepam injection is very slow and earratic. it is therefore usually not given.

Larazepam, another medicine in this group, is absorbed slowly and gives maximum effect after two hours. Unlike diazepam injection, lorazepam injection is obsorbed rapidly.

Common side effects of benzodiazepines include tiredness and drowsiness, especially in the initial stages. *It is therefore important that you avoid driving vehicles or working near a dangerous machine after taking these medicines.*

Benzodiazepines are addictive, especially if taken continuously for more than three months. They are also not recommended during pregancy and breast-feeding as it may adversely affect the unborn baby and the infant respectively.

Alprazolam: In recent times, this medicine has been used very extensively for management of anxiety and some other mental illnesses. Although its impact on anxiety is similar to those of benzodiazepines, alprazolam results in less severe side effects, especially drowsiness. This is also an addictive medicine.

Buspirone: This is one of the newer medicines for management of anxiety. Although its effect on anxiety is similar to that of diazepem, buspirone does not result in addiction or withdrawal symptoms. Its action is slower and the maximum effect is normally observed after three to four weeks. Buspirone is therefore recommended for chronic anxiety.

Several research studies are resulting in rapid changes in the understanding and applications of the medicines used for treatment of anxiety. It is therefore advisable that you avoid self medication and take medicines as per your doctor's prescription only.

It is important to remember that although medicines can relieve symptoms temporarily, they cannot cure anxiety. You should therefore consult with a mental health specialist to resolve the conflicts and problems

that cause anxiety. Irrespective of how long it takes you to overcome the root cause of the anxiety, you should continue efforts to develop an ability to deal with stress and conflicts more effectively.

Phobic Disorders

Phobic disorders are conditions where you have irrational fears of a specific object, activity or situation. This fear results in a strong urge to avoid them. The irrational fears are called *phobias* and conditions with phobias are called phobic disorders. Phobias have three main features:

1. The fear is disproportionate to the circumstances.
2. You cannot deal with the fear by reasoning or control it with will power.
3. You are aware that your fears are not justified and yet you stay away from the feared object, activity or situation.

Many people have simple phobias such as fear of animals, high places or closed rooms. You can easily manage these fears by avoiding them. However, some phobias are extreme and serious. They result in anxiety and often lead to panic. Several million people worldwide are estimated to have severe pohobias and panic attacks as a result of them.

What are the types of phobias?

There are three main types of phobic discorders. These include *simple phobia* (fear of objects), *social phobia* (fear of functions) *and agoraphobia* (fear of situations.)

Phobias usually do not adversely affect the life in adulthood. This is because the fear is often specific and avoiding the cause of fear may not be critical for professional and personal development. The term "phobic disorder" is used when the phobias result in significant symptoms and disability of varying degrees.

Agoraphobia and simple phobia are more common among women. Agoraphobia and social phobia may be present in several members of a family

What are the symptoms of simple phobia?

An irrational fear of objects is called simple phobia. It normally occurs during infancy and early childhood, which are the early stages of growth and development. Simple phobia may persist till adult life and may appear again after a period of no symptoms. Simple phobia has three essential and one associated features. Essential features include:

- Fear of a specific object or situation that is not related to situations or functions;
- Tendency to avoid situations that you feel can lead to anxiety, and
- Sudden exposure to the object you fear may produce a panic attack.

A likely associated feature is the tendency to seek detailed information on a situation that you fear before actually face the situation.

What is agoraphobia?

Fear of being in a situation where you may either be helpless of humiliated, especially during an attack of panic, is called agoraphobia. People with agoraphobia are scared of being away from help or a secure place such as home They have two types of fears: fear of some specific situations and fear of fear itself. This means that you will anticipate a panic attack. This anticipation or fear of panic attacks leads to more and more such situations. As the frequency of these fears increase, you are likely to behave in a way that proves that your fears were correct. At this stage, you may become scared to go out of the house alone, travel or be in a situation from where you cannot get away quickly. Thus, agoraphobia is a vicious cycle that increases the intensity of the fear itself.

Agoraphoibia is estimated to be ten times more commom among women than men. This is perhaps because the way most women are brought up, they tend to become insecure and dependent. A large proportion of women are over-protected during their childhood, are "taught" not to assert themselves. They are also not often provided with opportunities to exhibit their skills, special talents, etc. or develop confidence.

What are the symptoms of agoraphobia?

Agoraphobia has three essential and two associated features.

Essential features include:

1. Irrational fear of leaving familiar surroundings of the home;
2. Symptoms of anxiety usually appear after an acute attack of panic, which leads to anticipation of helplessness away from home; and
3. Fear of being in crowded and closed spaces and tunnels, or any other situation where access to help is limited.

Associated features include (a) pleading, demanding, manipulative or child like behaviour and (b) a tendency for obsessive behaviour.

What are the signs and symptoms of social phobia?

Fear of behaving in a manner that can invite ridicule from others is called social phobia. It occurs less frequently than simple phobia or agoraphobia. Social phobia has three essential and three associated features. Essential features include:

1. Fear of situations in which you may be exposed to scrutiny or critical observations by others.
2. Excessive anxiety of being criticized or ridiculed when forced to be in situations where others can "inspect" you,
3. Anxiety is mainly due to fear of behaving in a shameful manner in front of others

Associated features include :

1. Awareness that others may recognise signs of anxiety when you are forced to be in situations where they can "inspect" you.
2. Anxiety may adversely affect you behaviour and/or performance, thus increasing the intensity of anxiety.
3. Occasionally you may have generalised anxiety without any apparent cause.

What is the treatment for phobic disorders?

There are four main approaches to management of phobic disorders. These include : (a) psychotherapy, (b) behaviour therapy, (c) medicines and (d) supportive therapy.

Psychotherapy : In this approach to identify the root cause of phobias and analyse them. It is important to remember that the psychological techniques for management of phobic disorders are effective only if you are receptive to these methods of treatment. If you are not, even after identifying and analysing your inner conflicts, you may continue to have symptoms of phobias.

Behaviour therapy : In recent times, this approach, which involves techniques that influenmce and charge your behaviour, has been demonstrated to be very effective. One of these techniques involves desensitizing you from the phobias. Doctor will expose you, one after another, to the images of a predetermined list of situations, objects or conditions that cause phobia. He/She will first begin with a cause that is likely to cause least symptoms and combine this image with one that is associated with pleasant sensations. If these pleasant sensations are strong, they can suppress the anxiety. Doctor may also prescribe tranquilizers for a short duration and teach you simple methods of muscle relaxation that you can practice whenever you are exposed to phobic situations. Once you are "desensitized" to this phobia, the doctor will repeat the exercise with successive phobic images, moving gradually from those that cause least symptoms to those that cause severe symptoms. Another successful behavioural technique is intensive exposure to either the cause of phobia or its image as long as you are able to tolerate the fear until a time when there is no more fear.

Behavioral therapy is more effective for social and simple phobia rather than for agoraphobia. It is however important to remember that the results of this approach vary from person to person.

Medicine : Prescribe a antidepressant, especially if you hav agoraphobia. Just as for anxiety states several medicines are recommende *temporarily* for management o phobias in order to relieve symptoms Once anxiety subsides, it is easier t resolve inner conflicts.

Supportive therapy : Supportive behaviour from the doctor, family and friends can reduce the symptoms and make other approaches of treatment more effective. It is important to remember that the more you avoid what you fear, more intensive is your fear likely to be. Supportive therapy can help you develop confidence to deal with the fears over a period of time.

Irrespective of the cause of anxiety, you can control the symptoms by adopting a positive attitude towards life and developing a regular routine of exercises and relaxation techniques such as meditation.

AYURVEDA

It is amazing that the man lives a life of worry, anxiety and discontentment in the midst of prosperity. This is a contradiction and therefore Ayurveda aims at happy state of life. It lays emphasis on the need to overcome this duality by appreciating the methods and measures to regulate and control obstacles such as desire, anger, pride, greed, etc.

Ayurveda has recognized the individuality of the psyche and body and their inseparable and dependent relationship in the living body. The ancient physicians of Ayurveda have attributed abnormal conditions related to mental functions as *Manovikaras*.

What are the symptoms of

anxiety?

The term *Chittodvega* has special reference to Manovikaras and can be equated with anxiety. It is commonly observed in people who have instability of the mind, fear, tremor, palpitation, short temper, indecisiveness, pressure in the chest, fainting or sinking, pricking pain in the chest and excessive perspiration. According to Charaka, the famous physician of ancient times, these symptoms are due to contamination of *vata*. There is imbalance of two mental doshas (*rajas and tamas)* and abnormalities *vata* and/or *pitta*. The clinical signs and symptoms described in the ancient Ayurvedic literature are as 1) Fear. 2) Diffidence of lack of resolution. 3) Tremor or fine shivering of the hands 4) Palpitations or awareness of the hear beats 5) Irritability or short temper 6) Excessive sweat 7) Increased thirst 8) Dryness of the mouth 9) Dryness of the throat 10) Constricting feeling in the chest 11) Fickle mindedness or reslessness 12) Fatigue 13) Expansion by pulling of the muscies of the face and neck 14) Poor memory 15) Negative thinking 16) Body ache.

What is the treatment of anxiety?

Ayurveda recommends a combination of medicine for internal adminstration and external applications. These medicines are in addition to counselling or treatment of the psyche and behaviour. The treatment processes commonly recommended for management of anxiety include purgatives, enema, nasal instillation, streaming of medicated buttermilk, milk, oil or decoctions on the forehead and application of medicated wet cakes on the head.

Listed below are the compound medicines commonly used for management of anxiety.

1. Five grams of any one of the three medicines including *Brahmi Ghrita, Kalyanak Ghrita or Pahchagavya Ghrita* to be taken twice a day with milk.
2. Twenty to thirty millilitres of either *Saraswatarista or Aswagandharista* to be taken after meals twice a day with equal proportion of water.
3. One hundred twenty five to two hundred and fifty milligrams of either *Smriti Sagar Rasa or Cahurmukha Rasa* to be taken with honey two or three times day.
4. Three to five grams of *Saraswata Churna& Jaggi Brhami Amrit 2 t.s.b.* thrice a day with milk.
5. One hundred twenty five to two hundred and fifty milligrams of *Manasmitra Vataka* to be taken with water or milk thrice a day.
6. Five millilitres of *Kasheerbala Tail* to be taken orally with milk three times a day.
7. *Dhanvantari Tail and Asanvilvadi Tail* is recommended for causing profuse sweating, and therefore removal of toxins from the body.
8. Tonics recommended for anxiety include any one of the following medicines : *Kusumanda rasayana, Chayavanprash, Bahami-Amrit Brahmi rasayana, Asvagandhavaleha or Shatavari Leha*. Depending on the totality of your symptoms, ten grams of any one of these medicines is recommended once a day with milk.

UNANI

Anxiety is known as "izterab" in the Unani system of medicine. It is defined as a "melancholic" disorder that is caused by excessive secretion of *sauda* (melancholic humour) This excessive secretion adversely affects the faculty that controls the nervous system, called *Quwat Nafsania*. There are three main factors that adversely affect the five latent faculties of the brain, called *Quwa khams Batina*.These include : (a) excessive secretion of black bile or melancholic humour, (b) transform-ation of abnormally digested *safravi* (Choleri) or *Balghami* (Phlegmatic) humours into abnormal melancholic humour and (c) transformation in the normal quality of the melancholic humour.

What are the signs and symptoms of anxiety?

In the early stage of the disorder, you may feel discomfort with fear and mild depression. If the condition lasts for a long time, symptoms such as pain in the muscles, headache, shivering of the hands, palpitation, diarrhoea, sweating, breathlessness or difficulty in breathing, dizzinessness unstable walk, a sensation of swinging or hanging in the space, walking on the sky, flying in the air, etc. may be present.

What are the principles of tratment of anxiety?

There are four main Unani principles for treatment of anxiety. These include :

1. Correction of factor that result in excessive production of melancholic humour or change its normal quality through diet, exercises, mental work, habits, etc.
2. Reduction of the load or stress on the faculty controlling the nervous system by sedating it with *Mukhadirat* (sedatives).
3. Taking coctives and purgatives for

black bile or melancholic humour.

4. Strengthening the faculty that controls the nervous systems by giving *Mauqawwi at Asab Wa Dimagh* or tonics of the nervous system.

What is the treatment for anxiety?

Detailed below are the commonly used single and compound medicines for treatment of anxiety including their method of use :

Oil of lettuce seeds or bottle-gourd seeds to be applied on the head.

One or two tablets of *Dawul Shifa* to be taken twice or thrice a day with *Arq kishineez*

One to two tablets of *Hab Jawahar Mohra* to be twice or thrice a day.

Make a fine powder of three grams each of Stoechadosc *(Ustukhudus)* and coriander along with five grains of black pepper. This medicine is recommended with water early in the morning on empty stomach. You need to rest in the bed for half to one hour after taking this medicine.

Make a fine powder of ten grams each of flowers of Babool, coriander and seeds of bottle gourd. This preparation is recommended three grams of the powder with water twice a day.

Boil six grams each of *jatamansi*, Cinnamon and dry ginger in one hundred and twenty millilitres of water. Strain the liquid and add saccharine. This preparation is recommended in the morning on empty stomach.

Make a fine powder separately of five hundred milligrams of camphor and two grams of ammonium chloride. Mix the two powders well and store in a clean and airtight glass bottle and use it as an inhaler.

Make a fine powder of equal proportions of opium, myrrh and cinnamon. Add some water to make a paste. This paste is applied on the cloth and placed on one or both sides of the head just above the cheekbones.

Seven grams of either *Itrifal Ustukhudus or Itrifal Kishneezi* is recommended at bedtime.

Ten grams of *Itrifal Zamani* is recommended at bedtime.

Six grams of *Khamira Gaozaban Amberi* is recommended in the morning before breakfast.

Qurs Musallae is rubbed in water and the paste applied on the forehead.

Three grams of *Barshasha* is recommended whenever you have any pain associated with anxiety.

HOMOEOPATHY

Homeopathy defines anxiety as the result of an insecure mind reacting to circumstances that are apparently adverse to a person but are not openly threatning. The sense of fear is more internal than external. However, it is sufficiently strong to lead to attacks of apprehension.

Everyone reacts with anxiety at some time or the other and this quite in harmony with normal life. Some people, however, begin to have anxiety as a routine than as an exception and therefore adversely affect their life. It is then necessary to consult a doctor who can help overcome the anxiety.

What is the Homoeopathic approach to anxiety?

Homoeopathy offers a wide range of medicines that are effective in the management of anxiety. These medicines are neither sedative nor do they suppress the symptoms. They bring "out" the symptoms and remove them completely. Just an in Allopathy, a Homoeopath will also try to find out the root cause behind anxiety attacks and prescribe appropriate medicines that can overcome apprehensions. You will therefore gain emotional strength.

Just as in all diseases, a detailed case history plays a very important role in selecting medicines that are most suited to you and in a strength and dose that is most effective. It is therefore important that you talk to the doctor very frankly and share all you troubles and prblems. The doctor will of course keep your conversations with him/her confidential. Detailed below are the questions that your doctor is likely to ask you.

Precipitating factor : You should describe the immediate circumstances that occur just before an anxiety attack. These could be emotional shock such as loss of a close friend or family member, poor examination results, setbacks in business or other professions, financial loss, etc. These situations make you vulnerable and you may not be able to cope with even minor ups and downs of life.

Past history : Any emotional setback in the past (such as those described above) can also weaken you resistance to deal with adverse circumstances. This weakness may result in your over-reacting to even minor situations in life. You should also describe if there were specific cases of fright, grief or suppressed emotions in your childhood. This is because these childhood experiences can weaken you persona-

lity and your may therefore not be able to deal with the pressures of life and succumb to anxiety.

Physical ailments : Any long-term illness can weaken you natural defence mechanism. Your are therefore likely to be physically and emotionally weak.

Family background : Children of parents who are prone to anxiety attacks are more likely to adopt the same type of behaviour. These children therefore develop anxious personality as they grow up. Similarly when one of the parents is too dominating or aggressive, the child becomes timid. Such children are more likely to be adversely affected by the pressures of living.

Lack of parental love, loss of a loved one at a young age, neglect due to various circumstances and constraints, etc. lead to lack of confidence in a person. Such people are also prone to become apprehensive and anxious.

Circumstances at school college or place of work : An emotionally insecure or timid person normally finds it difficult to deal with challenging situations such as examinations, interviews, submission of project reports, etc. either at school, college or place of work. Such people find it also difficult to cope with these situations and develop anxiety or panic attacks. Some times teachers and colleagues may harass the weak people, thus reducing whatever littel confidence they have.

Basic nature : basic nature is very important. Some people are basically weak and react with anxiety even to minor situations whereas some others are emotionally strong and remain cool even in the most difficult circumstances. All of us are equipped with "fight or flight" reactions and react according to whichever feature is more domiannt.

Presenting symptoms: Symptoms at the time of visiting the doctor are also very imprttant. You should make notes of any changes in your normal behaviour, unnatural fears, phobias, panic reactions, etc. and describe them to the doctor. You should also describe changes in your general habits usch as likes and dislikes, food habits, sensitivity to weather, etc. Finally you should describe physical symptoms such as diarrhoea, constipation, acidity, skin problems, hair fall, etc. Your doctor will collectively evaluate all you symptoms before prescribing appropriate medicines in the dose and strength that are likely to relieve symptoms repidly and without any side effects.

What is the treatment for anxiety?

Detailed below are some of the medicnies that are more commonly used to manage anxiety.

Arsenic album : This is one of the most important medicines used in the management of anxiety. Symptoms that respond well to this medicine are anxiety over small, trivial situations, associate fear or death or disease, intense mental restlessness and general physical weakness. In addition, there may be dryness of the mouth and you may need to sip water very frequently.

Aconite : This medicine is effective for severe fear and anxiety resulting from past experience of fright or shock.

Argentum nitricum and Gelsimium : Both these medicines are useful in cases of anxiety in anticipation of meetings, interviews, exams, etc. Some people develop loose motions in anticipation of such situations.

Kali phos : This medicine is commonly used for treating insomnia due to anxiety. It is usually prescribed in a biochemic form, which is as tablets in low potencies.

Natrum mur and Ignatia : Both these medicines are very effective in managing anxiety when there is history of grief. It is especially effective for people who are usually reserved and do not express their sorrow. They are more likely to brood over situations and become anxious

Aurum met : This medicine is very effective for people who have anxiety with depression, to the extent that they become suicidal.

Staphysagria : It is effective if anxiety and depression is the result of suppressed emotions or indignation over unmerited insults.

Tranquil : This is a biochemic compound that is effective is treating anxiety without any apparent cause.

The present day life-style predisposes to immense stress and there is hardly a person who can claim to be free of anxiety in some form or the other. Homoeopathic medicines such as Tranquil are very effective in controlling the adverse effects of these stresses.

What are the advantages of Homoeopathy?

Homoeopathic medicines used for management of anxiety have three main advantages.

1. ***No side effects :*** Homoepathic medicines are not sedatives and

therefore do not cause side effects such as drowsiness, dullness of mind, etc. They act by enhancing your potential to fight anxiety and become emotionally stronger.

2 ***Treatment of physical ailments*** : Homoeopathic medicines give an almost immediate sense of well beig and are not addictive. With these medicines you can improve the quality of your life, feel active and fresh and not at the same time not become dependant on medicines.

In addition to prescribing medicines, your Homoeopath will also act as a counselor. He/she will counsel you and your family by making you aware of the reasons behind the behavioural changes and help you to come to term with your natural potential.

NATURE CURE

Cause of anxiety, its types and signs and symptoms of each of these types as per Nature Cure are the same as those detailed in the section on Allopathy.

According to Nature Cure, the blood vessels and nerves of an anxious person become numb and hard. As a result, there is obstruction in the free flow of blood and nerve currents. Thus, the inflow of the vital forces of the body is either reduced or shut down. Reduced flow of vital forces lowers the natural resistance to poisons in the body and other disease causing agents. In extreme conditions when anxiety and associated fear is very intense, the obstruction to the flow of vital forces can lead to death.

What is the treatment for anxiety?

Nature Cure recommends relaxation techniques, supportive behaviour and reassurance from friends and family, exercises and diet for management of anxiety. In case of severe or long-standing anxiety, counseling and other forms of treatment from a mental health specialist may be necessary. It is also important to live in a congenial atmosphere with fresh, air, sunshine, calm and quiet place for relaxation and exercises and eat natural food. Above all, there is a need to develop self-control that will enable you to remain calm in moments of stress and tension.

Self-control : The only sure method to control anxiety is to relax. Try to analyse the conditions or situations that cause anxiety and identify options or solutions. Adopt any one option or solution that your believe is most suited to you. Try to develop a positive attitude.

Support : Support from family and friends may provide temporary relief but it cannot prevent or cure anxiety. Seek their help to identify solutions and implement them. Their suport will also help you take up activities that interest you and help you direct your mind in gainful ways.

Physical measures : Treatment options with air, water, mud and exercises, especially yoga, are very effective for development of positive attitude and for relaxation.

Exercises : Exercise improves blood circulation, especially to the skin clears the blood channels and maintains normal conditions of the nerves. It also reduces congestion to the brain and other organs of the body.

Deep breathing is one of the most effective methods of relaxation. You can do it either while sitting or lying down, with both the nostrils or alternate nostrils. You should learn the correct method of deep breathing from a qualified person. If the technique is not correct, you may not have any benefits. You can practice deep breathing in the morning on empty stomach, just before going to sleep and whenever you feel exhausted, stressed or anxious during the day.

Water and mud treatments are also very effective for relaxation and soothing irritated nerves.

Sleep : Sleeping for six to eight hours in the night will restore the energy you have spend during the day. Regular practive of meditation, *shavasana* (a type of yoga) and deep breathing will help you sleep better. *It is improtant to remember that you should sleep about two to three hours after dinner so that the food is digested.*

Music : Several research studies have persuasively indicated that listening to soft music can relax the mind and hasten recovery during illness.

Diet : Just as for all health problems, Nature Cure lays special emphasis on diet. It is desirable to avoid adulterated and processed foods as they increase the production of "poisons" in the body. These poisons contaminate the blood and therefore irritate and reduce efficiency of various organs of the body. Natural foods are preferable.

Anxiety often leads to indigestion. This is because of (a) improper chewing of the food and (b) reduced production of the digestive juices by irritated organs of the

digestive system. Irrespective of the food intake, you will feel sick most of the times because of indigestion

Avoid excess intake of starch, protein and fat such as oil, *ghee* , butter etc. as they adversely affect normal chemical processes in the body. Eat foods that are rich in potassium, calcium, magnesium and iron. You should also avoid irritants such as condiments and spices, chillies, pickles, etc.

Your Nature Cure doctor may recommend fasting or a juice diet for a few days in order to remove "poisons" from the body.

Further Contact :- D-31 Defence colony New Delhi

आयुर्वेद एंव मनोदैहिक विकार

डॉ० वा० एन सिन्हा

(कायचिकित्सा विभागाध्यक्ष आ० यु० तिब्बिया कालेज नई दिल्ली)

"समदोष: समाग्निश्च समधातु मल: क्रिया
प्रसन्ना त्मेन्द्रिय मन: स्वस्थ इत्य भिधियते।"

धर्म अर्थ काम और मोक्ष (पुरुषार्थ चतुष्टय) की सिद्धि स्वस्थ शरीर एंव दीर्ध आयु से ही सम्भव है। शरीर इन्द्रिय मन एवं आत्मा के संयोग को आयु कहते हैं। और आयु सम्बन्धी समस्त ज्ञान को आयुर्वेद कहते है।

आज के आधुनिक वैज्ञानिक जिस बात की पुष्टी में प्रयत्नशील हैं उनको आयुर्वेद ने सदियों पहले ही सिद्ध कर चुका है कि शरीर का सम्बन्ध मन से एंव मन का सम्बन्ध शरीर से है।

हम जब कभी भी स्वास्थ्य एवं व्याधि की बात करते हैं तो मन का शरीर से एवं शरीर का मन से सम्बन्ध स्पष्ट दृष्टिगोचर होता है। जब कोई दुःख या व्याधि शरीर में होता है तो उसका प्रभाव मन पर पडता है और मन दुःखी होता है, ठीक उसी प्रकार दुःख अगर मन मे होता है तो इसका सीधा प्रभाव शरीर पर पड़ता है।

विगत कई वर्षो से इस विषय पर काफी विचार विमर्ष हुआ है और वैज्ञानिक इस नतीजे पर पहुँचे है कि मन का सम्बन्ध शरीर से एवं शरीर का सम्बन्ध मन से निश्चित रूप से होता है एवं इसका प्रभाव एक से दुसरे पर पड़ता है। लांगले एवं ब्राण्ड (१९७२) ने भी अध्ययन करके बताया है कि मन एवं शरीर अलग अलग न होकर एक ही वस्तु के दो पहलु हैं और एक दूसरे के बिना अधुरे हैं। एक दूसरे के सहयोग के बिना मानव विषय पर अध्ययन सम्भव ही नही है। क्योंकि किसी भी तरह की व्यथा शरीर एवं मन दोनों को प्रभावित करते हैं। कोई व्यथा मन में होती है तो उसका सीधा प्रभाव शरीर पर पड़ता है और अगर व्यथा शरीर पर होता है तो उससे मन भी प्रभावित होता हैं।

इस तरह मनोदेहिक व्याधि उत्पन्न होते हैं।

काम, क्रोध, लोभ, मोह आदि स्ट्रेस (Stress) हैं जो मनोदैहिक रोग को उत्पन्न करने में सहायक होते हैं। अगर हम देखें तों स्ट्रेस जीवन शैली (Life style) है। नित्य हमारी आवश्यकतायें होती हैं, इच्छायें होती हैं और उसे फलीभूत करने के लिए प्रयत्नशील रहते हैं इसी क्रम मे कुछ तनाव आते हैं मन या शरीर उसे सात्मय कर लेता है तो हम सफल होते हैं अन्यथा व्याधि को उत्पन्न करते हैं।

इस तरह स्ट्रेस किसी भी प्रकार का हो व्यक्ति के जीवन का आधार है। स्ट्रेस शरीर एंव मन के लिए सात्म्य हो जाता है तो ठीक है अन्यथा असात्म्य होने पर यही मनोदैहिक व्याधि को उत्पन्न करते हैं। जब हमारा विकास कम था आवश्यकतायें बहुत थोड़ी होती थी जिसे प्राप्त करने मे शरीर या मन को दुःख कम होता था किन्तु हम जैसे-जैसे विकसित होते जा रहे हैं हमारी आवश्यकतायें भी अन्नत होती जा रही है और हम नित्य नयी-नयी मनोदैहिक व्याधियों से ग्रसित होते जा रहे हैं उनमे कुछ व्यधियाँ तो इतना सामान्य होता जा रही है जिसकी हम कल्पना भी नहीं कर पाते यथा: Peptic ulcer, Diabetes mellitsus, Hypeotension, Bronchial Asthma, Insomnia, Anxiety neurosis etc.

उपरोक्त व्याधियों में रोग निवारक औषधि के साथ मेध्य रसायन का उपयोग बहुत सफल सिद्व हुआ है इनमें विशेष रूप से प्रयोज्य हैं ब्राह्मी शंखपुष्पी, यष्टीमधु एंव गुडुची।

कुछ भारतीय औषधि का प्रयोग भी लाभ कर है यथा अश्वगन्धारिष्ट, सारस्वतारिष्ट, ब्राह्मीअमृत, ब्राह्मीवटी, जटामांसी चूर्ण आदि।

योनिकंडू

डॉ० प्रभा शर्मा (रीडर तिब्बिया कालेज)

आयुर्वेदिक ग्रंथों में योनिकण्डू का वर्णन विशेषत: किया गया है। स्त्री रोगों में यह एक सामान्यत: पायी जाने वाली व्याधि है प्राय: सभी उम्र की स्त्रियों में यह व्याधि पायी जाती है यहां तक कि यह बाल्यावस्था में भी हो सकता है। योनिकण्डू के कारण कई हैं जिसमें से प्रमुख है योनिमार्ग की उचित सफाई न रखना योनि प्रक्षालन में क्षारीय द्रव्यों का प्रयोग। योनि के आसपास के बालों की सफाई के लिए प्रयुक्त होने वाले क्रीम, पाउडर या अन्य प्रसाधन नायलोन के वस्त्र जो योनि के संसर्ग में आते हैं। परिवार नियोजन के लिए प्रयुक्त होने वालें रासायनिक पदार्थ तथा यांत्रिक उपकरण, रक्त में शर्करा की उपस्थीति। वृद्धाअवस्था में अंगरसों की न्यूनता वाताधिक्य, कफ की वृद्धि । अत्यधिक मैथुन। मूत्र विसर्जन के पश्चात् योनि का प्रक्षालन न करना । अत्यधिक उष्ण प्रकृति का अन्नपान सेवन करना।

चरक ने इसे अचरणा तथा वाग्भट्ट ने विप्लुसा नाम से योनिरोगों में वर्णित किया है।

इस रोग के प्रमुख लक्षण योनि में सूई चुभने जैसी वेदना योनि में शोथ तथा विवर्णत्व। इसकी चिकित्सा करते समय यह अवश्य ध्यान में रखें कि इसका कारण, क्या है। सर्वप्रथम कारण का निवारण करें। वात एवं कफ शामक चिकित्सा करें। व्रण को मृदु विरेचन दें। इसके लिए दूध में घृत डालकर उसके साथ मधुयष्ठी चूर्ण का सेवन करायें या उष्ण दूध के साथ एरंड स्नेह का पान करायें। या उष्ण दूध से त्रिफला चूर्ण का सेवन करायें। व्रणा को स्फटिका भस्म शुद्व गैरिक, खदिरारिष्ट, नारीअमृत, अभयारिष्ट, इनका सेवन करायें। स्थानीय प्रयोग हेतु - जात्यादि तैल लगायें। शतधौंत घृत में कर्पूर मिलाकर लगायें। नारियल के तैल में कर्पूर मिलाकर लगायें। बादाम या जैतुन के तैल में कर्पूर मिलाकर लगायें। केवल बला तैल लगायें। टंकण, नारियल तैल, कर्पूर तीनों को मिलाकर लगायें। नीम के तैल का प्रयोग करें। दही के साथ पीपरामेंट पीसकर लगायें।

प्रत्येक बार लेप लगाने के पूर्व स्फटिक जल से योनि प्रक्षालन करें या त्रिफला के क्वाथ से योनि प्रक्षालन करें।

पथ्यापथ्य - स्निग्ध एवं लघु आहार का सेवन करें। मैथुन वर्जित, योनि को स्वच्छ रखें। साबुन आदि का प्रयोग न करें।

यदि इन सभी बातों को ध्यान में रखेंगे तो यह व्याधि दुष्चिकित्स्य नहीं होगी।

प्रतिशाय (जुकाम)

डॉ० वाई० एम० भटनागर

प्रतिशाय जनक कारक और कारण संक्षिप्त परिचय – मुख्यतया प्रतिशाय गर्म–सर्द के कारण ही माना जाता है ये गर्म सर्द क्या है इस पर रोशनी डालते हुए जिन कारक या कारणों को सम्मिलित किया जा सकता है सहज रूप में निम्न प्रकार के है।

१ गर्म खाना खाया ठण्डा पानी पी लेना २ पेट में कब्ज होने की दशा में शीत मधुर द्रव्यों के सेवन से ३ ठंड से अक्षहिष्णुता (ठंड बर्दाशत नहीं होने से) ४ फर आदि कपडो से असहिष्णुता अर्थात एलर्जी। ५ धूल से एलर्जी ६ धूप से एलर्जी ७ धुंए से एलर्जी ८ धसके से (छींक भून) एलर्जी ९ चना या मूंगफली के दानों को चबाने से एलर्जी १० मानसिक कारणों से एलर्जी ११ पसीने में ठंडा पानी या लस्सी पी लेने से एलर्जी १२ नाक का मांस या हड्डी बढ जाने से एलर्जी जन्य जुकाम

ये उक्त बारह कारणों से मुख्यतया जुकाम की उत्पत्ति होती है जहाँ जुकाम होने से छींकें आती है। नाक भी बहने लगती है। हल्का बुखार सरदर्द भी जुड़ जाता है। नाक में तेल लगाएं गोदन्ती व लक्ष्मी विलास रस का सेवन करे।

कब्ज की हालत में पेट में गर्मी ऊपर ठंडा पेयादि भी जुकाम का कारण है। पेट साफ करें तथा सितो यलादि का सेवन करे जल ज्यादा पिये

ठंड बर्दाश्त नहीं होने से भी जुकाम हो जाता है इसके गर्म कपडे गर्म घर में तथा अदरक तुलसी व नमक डालकर चाय पिये लहसुन तेल में जलाकर पसलियों व नाखूनों पर लगाए।

फर आदि रूंएदार कपडों का त्याग कर सूती कपडे पहने षड बिंदु तेल नाक में लगाए।

धूल से एलर्जी की अवस्था सफाई द्वारा उड रही धूल आंधी की धूल चलने से उडने वाली धूल कपडा झाडने से उडने वाली धूल से बचने के लिये सूती बारीक कपडे का रूमाल नाक पर बांधे व नाक में देशी घी लगाएं तथा धूल उड़ रही दिशा से हट जाए।

धूप से एलर्जी ठण्डी कमरे से निकल कर एका–एक धूप में आने से जुकाम हो जाता है छाते का प्रयोग करें तथा छाया दार रास्ते का अनुसरण करें।

वातज–पित्तज–कफज–द्वंदज, सन्निपात आदि भेद से प्रतिश्याय गत उपद्रव भिन्न प्रकार के है वातज प्रतिश्याय में शिरोवेदना ऊंचे स्वर के साथ छींक नासा में खुजली आदि लक्षण मुख्यतया होते है। कफज प्रतिश्याय में नाक बंद हो जाना दिमाग ठस्स (भारी) हो जाना शरीर में दर्द आंखों में झपकी तथा मुंह का स्वाद मीठा–मीठा सा हो जाता है भूख कम लगती है थकान सुस्ती चढी रहती है।

वातज प्रतिश्याय में नासा और मुंह में खुश्की प्यास आंखों में जलन ज्वर चक्कर तथा नाक लाल हो जाते है गरम–२ सांसे आती है तथा पेशाब का रंग पीला हो जाता है रोगी बार–२ पानी पीता है

द्वंदज में वात कफ के मिले जुले लक्षण आंगो में तोद भेद जनक पीडा शरीर मे जकडन भारी तथा सिर में दर्द होना।

वात पित्तज प्रतिश्याय में नाक पतली होकर बहना प्यास खुश्की अंग मर्द जलन ज्वर सिर दर्द आदि लक्षण उत्पन्न होते है

बाह्य आभ्यान्तर कारणों से वातादि दोषों के प्रकूपित होने से प्रतिश्याय रोग की उत्पत्ति होती है, लंबे समय तक प्रतिश्याय रहने पर नाक्षा गत मांस पेशियां हड्डी में विकृति उत्पन्न हो जाने पर यह (नजला) का रूप धारण करता है नाक से गले में कफ गिरने से कण्ठ भी रोग ग्रस्त हो जाता है और तीव्रता के चलते खांसी भी हो जाती है अर्थात पूरा श्वसन संस्थान रोग ग्रस्त हो जाता है प्रतिश्याय के पूर्व रूपान्तर्गत छींके आती है वदुपरात नाक चलने लगती है या ठस्स हो जाती है या नाक में खुजली आने लगती है

पेट साफ करना आते आवश्यक है मलाव रोन्ध से गर्म सर्द होकर जुकाम दुगना दचुगन बढता जाता है। तली हुई चीजे नहीं खानी चाहिए तथा मीठा और ठण्डा भोजन या पेय त्याग देने चाहिये।

नासा मे तेल लगाना गरारे करना तथा चने का सेवन लाभकारी है तथा दोष व अवस्थानुसार चिकित्सा करना श्रेयस्कर है।

अश्मरी

डॉ० एस० के० पंचाल
प्रेस सचिव, दिल्ली

प्रदूषण के इस दौर में तथा रासायनिक पदार्थों का प्रयोग, आज देहाती की अपेक्षा महा नगरों में पथरी का रोग आम हो गया है। इस रोग में रोगी को प्रारम्भ में पथरी का आभास नहीं होता परन्तु एकाएक वृक्क में दर्द होने लगता है। जो वृक्क प्रदेश में कमर तथा जांघ को चीरता हुआ सा प्रतीत होता है। तथा अण्ड कोष में खींचाव होता है वमन की इच्छा होती है तथा कभी-कभी दर्द के साथ उल्टी भी हो जाती है। यह पथरी मूत्र में रक्त भी आ सकता है। यह पत्थरी के प्रारम्भिक लक्षण होते है। कभी-कभी यह लक्षण शरीर में गति के साथ पत्थरी के एक स्थान से हट जाने पर होते है, जिस से तीव्र दर्द उत्पन्न होता है। यह पत्थरी वृक्क तथा Gall Bladder में पायी जाती है। तथा कभी-कभी मूत्राशय में भी पायी जाती है तथा कभी-कभी पत्थरी मूत्र नालिका (Ureater) में जब फंस जाती है तो पेशाब रूक जाता है तथा बूंद-बूंद पेशाब जलन के साथ निकलता है जिससे मूत्र त्याग करते समय तीव्र वेदना होती है तथा मूत्र मार्ग में घात बन जाता है। इस में तत्काल नियन्त्रण करने के लिये पानी की मात्रा एक दिन में तीन लीटर तक पीना चाहिए और प्याज पालक दूध पनीर टमाटर तैल मिर्च खटाई शराब काफी चाय बंद कर देनी चाहिए।

पत्थरी मुख्यतया दो प्रकार की होती है जो कफ जनित पदार्थों के अधिक सेवन करने से होती है। यह हर्षल द्रव्यों तथा खान-पान पर नियन्त्रण आदि से शीघ्र निकल जाती है तथा इस में शल्य चिकित्सा (Operation) की आवश्यकता बहुत कम होती है।

दूसरी पत्थरी पित्ताश्मरी कहलाती है जो अत्यधिक तैल मिर्च खटाई चाय शराब आदि के सेवन से होती है जिस से मूत्र में जलन, पेशाब पीली व लालिमा युक्त होती है ऐसी पत्थरी का रंग शहद के रंग के समान होती है जो औषधि से कम टुटती है यह पत्थरी यूरिक एसिड या अमोनियम (Ureater) की होती है यह (operation) के द्वारा बहार निकाली जाती है पित की थैली में पत्थरी तभी बनती है जब पित गाढा हो जाता है और अधिक समय तक (Gall Bladder) में पड़ा रहता है। जिस से पित के कण मांस अण्डे तथा चिकनाई युक्त भोजन आदि ज्यादा प्रयोग करने से बनते है। वृक्क की पत्थरी जब बड़ी या अत्यधिक दर्द देती है। तो उसका एक मात्र निदान आपरेशन होता है। आज कल बिना चीर फाड के जिसे लिथ्रोटीप्सी चिकित्सा पद्धति कहते हैं कम खर्च व बिना दर्द एहसास के एक्स-रे की तरह रेज देकर पत्थरी द्वारा बहार निकल जाती है। इस से रोगी को बिना आराम बिना बिस्तर पर लेटे तत्काल अपने काम पर जा सकता है। आयुर्वेद चिकित्सा पद्धति में आपरेशन की आवश्यकता नही होती किन्तु यह पत्थरी के आकर पर निर्भर करती है अगर पत्थरी छोटी हो तो आयुर्वेदिक दवाईयां देकर बाहर निकालने का प्रयास करते हैं इस में पंच मूल क्वाथ, गोखरू का क्वाथ, या जग्गी चन्दनासव देकर पत्थरी को बहार किया जा सकता है।

A.I.I.M.G.A. (एमगा)ध्येय

डॉ० सुनील जग्गी, डॉ० डी० आर० सिंह

१ हमारे शासन ने आयुर्वेद और होम्योपैथिक यूनानी को जितना सम्मान देना था उतना दिया नही हम लोगों को जितने अधिकार चाहिये थे। हमने मांगे नही लोकतंत्र में सबसे बड़ी विडम्बना है कि यहां मौलिक अधिकार भी मांगने पड़ते है। किसी भी अधिकार को मांगने के लिए व्यक्तिगत प्रयास कोई महत्त्व नही रखता इसके लिए एक मजबूत संगठन चाहिए जो संगठन है एमगा।

२ एमगा निश्चित रूप से इस और विशेष जागरूक है हमारा चिन्तन सही दिशा में उठते कदम है परन्तु भटकाव बहुत है और छल भी अनेक हैं इन सबसे बचकर निकलना टेढ़ी खीर है फिर भी हम नवीन आयुर्वेद स्नातको को एक मंच पर लाकर उनके द्वारा आयुर्वेद यूनानी होम्योपेथी के उत्थान पर संगोष्ठी विचार विमर्श करते रहते हैं

१. उन लोगों के खिलाफ सख्त कार्यवाही की जाएगी जो फर्जी B.A.M.S. आदि लिखकर आयुर्वेद को प्रतिष्ठाहीन कर रहे है।

२ उत्तर भारत में भी एक पंचकर्म चिकित्सालय खुलवाने के लिए प्रयास कर रहे है।

३ सरकार से एक निश्चित अवधि का निश्चित कार्यक्रम बनाकर स्वीकृत करवाना

४ आयुर्वेद, यूनानी और होम्योपैथी के प्रसार को रोकती सरकार की नीतियों को रोकना

५. मेडिकल कालेजों में प्रोफेसर और छात्रों में अच्छे सम्बधों को बढ़ाना

६. मेम्बरशिप - हर एमगा सदस्य सदस्यता अभियान मे सदस्यो से सहयोग लेना।

७ आधुनिक चिकित्सा की भाँति आयुर्वेद यूनानी, होम्योपेथी हस्पतालो, डिसपेन्सरी को खुलवाना

८. सरकार पर दबाव डालकर होम्यो, यूनानी और आयुर्वेद का बजट बढ़वाना और नए चिकित्सालय खुलवाना

'ALCOHAL ABUSE - TREAT WITH NATUROPATHY'

Dr. SATEESH BAJAJ & Dr. SUNIL JAGGI

EDITOR NOTE :

If alcohalism is a social menace it should be eradicate from the Society. Formar Hon'ble Prime Minister of India Late Morarji Dasi and Hon'ble Chief Minister of Haryana. Mr. Bansilal have banned alcohal, but they were not Succeded without Co-operatian of general public.

Doctors are very responsible persons of the society and can play very important role to eradicate this social evil because the patients follows their advise, so it has become very necessary that the doctors should represent good example towards the general public.

Alcohalism is a social menace. One starts with occasional party drink and is often pushed by the social circle once one begins. It is encouraged just for enjoyment and unknowingly one gets habitual of it. Agitations and depressions further support it. Sometime mere prosperity leads to alcoholism.

To nip the bud in time, the best way is the advice of a Psychiatrist but in the later stage, medical help is also required.

The basis of the article is the treatment of an alcoholic with naturopathy in a scientific way. Treating the reasons behind and also the present problems. To start with, the person usually starts drinking by the evening but the treatment starts from the next morning. In the morning, there is hangover due to low leavels of alcohol in the blood. Alcoholic goes for an other drink in the morning which replenishes those low levels and he feels better. The alternative is to detoxify the body as fast as possible so that the symptoms of hangover disappear quickly and the person feels normal. Thus, he requires such diet and other helping treatments which act as fast eliminators of Toxins.

The second phase starts at the time withdrawal symtoms appear. It is anxiety and craving to take alcohol at the daily routine time. At this time he needs anxiolytic and tranquilising diet & treatment. Both these phases are well treated with the help of naturopath.

The elimination of Toxins depends upon lungs, kidneys, skin and Faeces. Normal stools are passed while taking the prescribed diet. If the patient is active enough, he is *advised vigorous exercise for fast breathing and sweating*. If a passive one, he is given dry rubbing of whole body for 20 minuts followed by a steam bath. Bhastrika Pranayam for forced veriation and a wet sheet pack around the waist to increase diuresis. In the evening to tranquilise the patient and for good sleep, he is advised a mud pack on eyes and forehead, full body massage from head towards toes for 20 to 30 minutes either by himself or by some attendent followed by a bath of body temperature water for 20 to 30 minutes. Both these treatments induce a natural and sound sleep at the time the patient is in state of anxiety. For how many days to continue this treatment depends upon the severity of alcoholism. But the treatment starts working from the very first day.

Alongwith these treatments, some additional treatment is required for depressive or agitated cases which is given only in the morning.

In case of depressive, a cold spinal bath of 5 minutes (the cold water is to be poured only on the spine and rest of a back should remain dry) after defaecation, a cold Genital Bath (Touching the prepuce in Males and Labia Majora in females with some soft clot soaked in Cold Water) for 10 minutes is very effective. A mud pack on the sacrum region is also very effective.

In case of agitated ones, a 10 minutes Head Bath with fresh

water (Rest of the body should not get wet) followed by a small Mud Pack at the Eyebrows Centre for 10 minutes and gentle massage with Desi Ghee for two minutes on the temples and eyebrows is sufficient.

The diet advised is an ideal diet which can be alternatively selected from the given schedule but the schedule is not changed. The vegetables and fruits mentioned keep on changing with the season. So the patient is given general guidelines for selection of fruits and vegetables. The Diet Schedule recommended is also designed in such a way so as to help detoxification, nourishment & for sound sleep in the night. The diet is also hepato 'Protective'. It is

VERY SPECIAL :

4-5 glasses of water prior to breakfast to facilitate excreation of Toxic Waste and products of alcohol in through excessive urination and sweating. Also helps in cleansing of bowels. During the rest of the day, 10-15 glasses of water should be taken for the same purpose.

SALADS :

Salads not only act as 'Rechaks' (Eliminators of Toxic matter) but are also rich in Vitamins and minerals. Salads should be taken without pouring extra salt. Cucumber, yellow pumpkin, carrots, radish, beet root are very good diuretics while cabbage, tomatoes, onions work as laxatives. Salads without salt create aversion to alcohol.

MEDICINAL :

There are certain Ayurvedic preparations containing Sarapgandha (Rauwolfia Serpentina), Ashwagandha (Withania Somnifera), Brahami (Hydrocotyle Asiatica) which are good tranquilisers and can be given prior to sleep.

BED TEA :

Instead of Bed Tea, the patient is given Aamla (Emblica officinalis) + Honey + a glass of water or lemon juice with Honey and Water. It is refreshing and energetic.

BREAKFAST :

Should be of sprouted wheat dalia/sprouts with salads/whey/mild + Banana shake/milk + Guava shake.

PRE LUNCH :

Preferabbly vegetables soup/vegetables juice-cucumber/tomato/carrots/beetroot etc. with coriander leaves and ginger to taste.

LUNCH :

Should be of chapati with added wheat bran, unpolished rice, pulses and tubers can be taken but the preference should of green vegetables. Salad is must. Curd can be taken.

EVENING :

Fresh seasonal fruits, particularly the sweet ones are preferred for alcoholics e.g. banana, apples, mangoes, lichi, muskmelon, watermelon, peaches etc. Sweet fruits are preferred against sour or less sweet fruits as they are supposed to sedate the brain. Sweet fruit juices are of more value as the quantity of fruits increases.

DINNER :

Should be of chapati with Bra and plenty of Fibrous vegetables with Salad. Pulses, rice, tubers like potatoes, arbi, kachalu, rataalu and non vegetarian food must not be taken, because all these things lack in fibre and cause constipation & thus retaining the Toxins in the body.

POST DINNER :

Before retiring, the sweet things induce good sleep but these must be natural sones e.g. Gurh, Jaggery, Figs and raisings soaked in water, Dates, Chhuhara, Murabba of Aamla, Carrot, Apple, Harh etc., Honey, Gulkand (A sweet preparation of Rose Petals) sesame mixed with jaggery and a glass of milk.

AVOID :

Maida (Fine wheat flour), Hydroginated Ghee, Chemically treated butter, chillies, condiments, market made things, preserved and processed food, tea, coffee etc.

DON'T TAKE :

Pickles, Paapar, Namkeen, Non-Vegetarain food etc. Precisely the diet rich in salt shillies and condiments is perfect combination with alcohol and increase the demand of alcohol. So, it is not given to alcoholic.

MUST TAKE :

Aamla, Honey, Bran, Sprouted wheat and pulses, yellow pumpkin, Ghia, Torai (Loofa) Simla Mirch, Parval, Kundru, Karondha, Tinda, Cabbage, Chaulai, Kulfa, Sarson, Methi, Paalak, Bathua, Broccoli, Carrots,

Beans of sem, Lobia, Guar, French Beans, Drumstick, Seengari etc. However green chutney containing lahsun, Hara Dhania, Podina, Aamla or Tamarind or dried pomegranate can be taken.

At the end, the whole days treatment schedule is summarised as follows :

1. 4-5 glasses of Luke Warm water.
2. Defaecation.
3. Antidepressant/Anxiolytic treatment.
4. Dry Rubbing.
5. Steam Bath.
6. Break Fast.
7. Prelunch.
8. Lunch
9. Sweet fruit juice.
10. Full massage of the body+mud pack on eyes & forehead.
11. Bath of body temperature water.
12. Dinner
13. Post dinner eatables.
14. Do Shavasan (Total relaxation of body) on the clean bed with some soothing coloured, Bedsheet and coverings.

Once the cycle of taking alcohol is broken for consecutive three four days the aversion to it starts automatically. Though, the treatment works yet it needs to be evaluated further scientifically and needs research.

A BRIEF INTRODUCTION

Dr. Sudesh Kumar Jaggi Dr. Anil Jaggi
Dr. Kuldeep Singh Kukreja

A.I.I.M.G.A. is a society of doctors of Indian System of Medicines & Homoeopathy with wider perspec-tive of medical practitioners, role in the comprehensive context of National Health Schemes. It was founded at Delhi and has gradually expended with firm idelological and organizational background U P, Bihar, Rajasthan, H P, Hy, M P Orrisa, Maharastra, Punjab, Tamil Nadu.

A.I.I.M.G.A. is of the firm view that medical education can be suitably modified to act as a vehicle of transformation of health service and medicine. It can be used as an entry point even in the field of economic and social reconstruction.

A.I.I.M.G.A. unit run health camps in tribal areas, rural and slums areas, immunization camps, school health programme blood donations camps, relief works associated with medical services to society. Academic seminars and symposia are its important work apart from publica tions of informative bulleines and bilingual journal.

A.I.I.M.G.A have given deep thoughts on the reorientation of medical education, health services and drug policy and latest development after supreme court verdict.

AIMS AND OBJECTIVES OF A.I.I.M.G.A.

1. To create a nationwide organi-zation of the medicos of Indian System of Medicines & Homoeopathy
2. To work for all round welfare and development of the medical profe-ssion.
3. To make use the capacities and abilities of medical knowledge for solving the various health problems of the poor section of the society, particularly for the rural and tribal poeples with help of other government and non government organizations working for the cause of society.
4. To develop national code among the mediocs.
5. To promote constructive activities in social and cultural spheres. Utilizing medicos energies in the various fields of national interests.
6. To promote progressive outlook to keep our ecological balances intact. By sharing the knowledge of plants with medicinal values. And promote the plantation of such valuable plants around.
7. To form a common platform on the basis of a common mode of work for all the members of medical community viz. students, doctors and educationists for the re-organization of medical education in the comprehensive context of national reconstruction.

Enroll yourself as an **A.I.I.M.G.A.** life member.

A.I.I.M.G.A welcomes all medicos to units under its umbrella to reconstruct the motherland.

FROM THE " AYURVEDACHARYA" TO THE "CYBERVEDACHARYA"

"Heal The World" is the message being spread by the "Cybervedacharya" across the globe.

Dr. Pratap S. Chauhan

You must be wondering why am I referring myself as "the Cybervedacharya"? So, the simplest explanation is that my three-year-long sojourn on the Internet as an "online"Ayurvedacharya has made me known as the "Cybervedacharya" Something unusual in the ancient world of Ayurvedic practice. I would like to state, I am using Internet as the platform to propagate the ancient Ayurvedic science. During my six years of extensive traveling around the world, for imparting lectures on Ayurveda and treatment of "hopeless" cases, I felt there is a great need to present the pure Ayurvedic science to the world. Although Ayurveda is already a known phenomenon in every corner of the world, thanks to Deepak Chopra and Maharishi Foundation, the world today needs the hidden principles of this science. The world today is abound with incurable diseases like AIDS. Multiple Sclerosis, Cancer, Renal Failure, Diabetes, Rheumatoid Arthritis, Mental disorders etc. Not to forget, the gift of nineties: the biggest disease of our times, "Depression". Here all I can ask my patients to do is just log onto the nearest computer terminal with an Internet connection and send me an email They need no visa or passport to consult me. I am available anytime and anywhere in the world at partap@ayurvedic.org.

Everyday more than thousand people visit my site: http//www.ayurvedic.org, out of which many are my students, who want to study and practice this ancient medicine form. For this purpose, Jiva has set up the world's first Ayurvedic college on the Internet. Similarly, seeing the increasing number of emails regarding consultation made me set up an online health centre. So, now you can see how I did not become the "Cyberved-acharya" on my own, it was the people who needed to share my exper-ience and benefit from the same. Hence they made the "Cyberveda-charya".

There are people who are ready to share my responsiblities on their own. They are not my kith or kin. They are not even my paid employees. They are people who also feel there is a need to spread the science of Ayurveda to heal the world. Take Agnaldo's example. He is a Brazilian boy, who is deeply influenced by the Ayurveda and its principles. He is ready to set up a training centre where his fellow countrymen could also learn the ancient vedic art. He dreams of having Ayurvedic doctors in his country who could do away with the method of treatment through drugs. He believes in his dream and he needs my help to make this come true. Have I met him before? No. Do we have any underlying financial gains in this? None that either of us are aware of. So, where does that bring us? To a global village, where nobody is an Indian or Western but eveybody is a human being. Please do not confuse me with the philosophical leaders and their lectures. I am simply a doctor with a specific knowledge in my field and it is God's gift that my Nation is just not my area of treatment. But the whole world is.

My students include doctors from the US, Ayurveda students, Medical students, from all over the world. They stay here as my students and learn to integrate this form with the form of medicine known to their world. But all of them need not visit me personally to learn this art. The Ayurvedic college comes to the rescue of such students who feel the "need" to know more than what they already do. Take Australia-based Susanne Macrae's example. In a candid interview with me, she shared her opinion on our online Ayurvedic course. Excerpts:

What did you like most about the course?

I liked the ongoing references made to the past subjects learnt to keep reminding me of what we had already covered. The regular usage of *sanskrit* terminology helped me remember the meanings more easily. I liked the way we were asked to do research outside the notes to give the answers, not just take all our answers from the notes. Also, asking for our opinions on issues and seeking our ideas was good.

What did you like least about this course?

That it is finished.**What changes**

would you make to the existing course, had you been given a chance to do so?

No change. It was very intensive for me doing a catch up and I look forward to having a month to complete the next one.

Any additional comments and suggestions?

I was very happy with the course. It is comprehensive, easy to understand and I think excellent value for money. I found it much easier to understand Ayurveda through this course than all the books I have read till now. Your style is straightforward, clear, and concise and lays just enough emphasis on each subject to make it easily understood and remembered.

"Ayurveda online" is a happening process. As is evident from the above interview, where my studentthe above interneew where my student is somebody whom I have never met. Also nowhere does the interview reflect that studying "online" is difficult or cumbersome. May be that's why we have been rated as the top 3.5 percent sites of the World Wide Web. And may be that's why I lecture my students who are in various parts of Sweden, sitting right here in India. The process is not very popular as yet in India. It is called video conferencing, which conducts two-way audio-video interaction. Till now I have conducted a video conference on "Ayurveda in daily life" to a group of students from Sweden-based University of Gavle. From "online chat" sessions, I am moving onto" videoconferencing sessions". Thus using this new and innovative technology to serve my purpose of propagating Ayurveda throughout the world.

Now let's move to the online treatment therapy. By now, all the patients who have been treated by me consider the treatment more as a miracle than a normal course of medication. My being proud or pompous about the art is not going to help anybody, neither my small global village nor my art. Whatever is achieved is possible only due to Ayurveda and just pure Ayurveda. Mix that with a strong belief in God. And here is the most acute prescription in the world ready. One case needs that special mention here is the case of Mrs. Sofia Vidal. An HIV case, she faced acute loss in number of T4 (natural bodily defenses) soon after childbirth. Her baby too was HIV-infected. After undergoing a series of experimental treatment by the best HIV specialists in France, they turned to Ayurveda. The last letter from her husband state that not only has her T4 count more than doubled but she too also has begin to hope for life. This is where the belief matters. And this is where I get the strength to do more.

Adulation for Ayurveda is not a new phenomenon abroad. Last when I came across such a thing was during seven Nation trip to Europe. The recentlyconcluded ten-week long tour of Denmark, England, Spain, France, Switzerland, Latvia, and Estonia, made me realize that there is an acute need of an alternative form of Medicine that would "heal" the people instead of just "curing" the disease. My simple routine abroad comprised giving lectures on Ayurveda in Universities, talks on proper eating and living, and live interviews on television. Due to the TV interviews, the more the people got to know about Ayurveda the more they crowded my lecture sites I was asked by many hospitals of international repute to treat their "hopeless" cases. Cases where even the doctors had lost hope. As we all know, as an Ayurvedacharya I neither possess Godly power nor do I dabble in supernatural

AIR POLLUTION : PROBLEMS AND PERSPECTIVES

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Reference :-
The article re-produced from the Indian Council of Medical research (I.C.M.R.) bulletin, volu 27, No 1, June 1997.

During recent years, attention has been drawn to the complexity of problems of air pollution in large urban centers. Though information is available on many atmospheric contaminants, a number of these contaminants are still unknown. All the activities of a man, the biological processes of living matter and natural phenomena on the earth result in, continuous emission of gases, vapours,dust and aerosols to the atmosphere. Studies on the nature, properties and behaviour of these substances are the challenges to the scientists dealing with various aspects of air pollution.

The major air pollutants are from emission due to the use of fossil fuels.In addition, the emissions from industrial production processes like fertilizer, solvents, pesticides, etc. may be the dominationg sources in some areas. Whatever gaseous exchange takes place in the lower atmosperic region (upto 40,000 feet above the earth surface) is essentially concerned with the air pollution problems. The average composition of lower atmosphere for those natural constant are oxygen (20.94%), nitrogen (78.09%), carbon dioxide,(0.03%). water vapour, ozone, argon, Krypton, and other gases. In addition, there are other variable gaseous constituents of natural origin eg.oxides of nitrogen from electrical discharge during storms sulphur dioxide, hydrogen fluoride and hydrogen chloride from volcanic disturbances, hydrogen sulphide from volcanic disturbances, hydrogen sulphide from seepage of sour natural gas from volcanoes or from the action of sulphide bacteria and ozone formed photochemically. Dust and aerosols of natural origin present in atmosphere consists of salt particles from coal and vegetation, dust of meteorite origin, bacterial spores, pollen, etc.

Pollutants in the Air

A chemical other then those conventionally accepted in the contaminant that can cause an adverse affect to a receptor and which occurs in the atmospher in sufficiently high concentrations to cause an adverse effect is called a "pollutant".

A large number of substances are released on a small scale, as a result of particular industrial processes The atmospheric pollutants, that cause most concern, are those emitted in large quantities, especially as a result of fuel combustion. These are mainly carbon dioxide, carbon monoxide, hydrocarbons, oxides of nitrogen, oxides of sulphur and particulates (including various metals). It is known that fuel combustion in the stationary sources contributed the most of the sulphur oxides and a substantial proportion of particulates and oxides of nitrogen, while motor vehicles are the main source of hydrocarbons and carbon monoxide.

One of the most important factors responsible for air pollution is the ground level concentration of pollutants.These ground level concentrations are the ultimate results of various atmospheric dispersions under prevailing meteorological conditions. Air pollution causes many effects some of which are immediate and obvious. Nearly all these effects could result in chronic degradation of man and his resourcues under specific conditions.The general area into which air pollution effects can be classified are effects on man and other animals; effects on vegetation; effects on material; and effects on climate at the regional and global levels.

The effects on vegetation, material and climate are beyond the scope of this article and not considered here. Several enviromental health issues that are related to a comprehensive assessment of health effects of air pollution, e.g. exposure to tobacco smoke, indoor air pollutants and occupational exposure are also being not considered here.

Implications of Air Pollutants on Human Health

Three lines of evidence are applicable to a consideration of human health effects of air pollutants. These include data derived from animal experiments, from practical

experimental human exposure and from epidemiologic studies of exposed human population both in the community and the work place.

Adverse health effects have been associated with three major types of air pollution related to three major source categories:

1) The sulphur dioxide and particulate complex arising from the combustion of sulphur containing fossil fuels, particularly in fossil fuel power plants.
2) Photochemical oxidants formed in the atmosphere from a complex chemical reaction between hydrocarbons and oxides of nitrogen and carbon monoxide, both of which are largely related to automobile emissions.
3) A miscellaneous class of air pollutants such as arsenic, asbestos, beryllium, cadmium, hydrogen sulphide, lead and mercury which are mostly emitted by localized point sources such as smelters, refineries and manufacturing plants.

Nine general categories of adverse health effects have been related to human exposure to different air pollutants. These include air pollution associated mortality; chronic respiratory disease morbidity; exacerbation of disease in chronically ill person; acute respiratory disease morbidity; effects on ventil-atory function; cancer of the lungs; heart diseases; sensory, neurological and behavioural effects; and effects from persistent metals and other pollutant residues.

Air pollution and associated mortality

Historically the most clear evidence for an association between SO_x/particulates air pollution and death was showed by a number of acute air pollution episode during which meteorological conditions caused several days of air stagnation and increased atmospheric concentration of pollutants. The best known of these episodes are those which occurred in the Meuse Valley of Beigium in 1930, in Donora, Pennsylvania in 1948, in London in 1952 and in New York City in 1953. These air pollution episodes drew the attention of the medical community to the public health consequences of uncontrolled air pollution. The observed relationship of SO_x/particulates air pollution episodes to excess mortality led investigators to examine the possible association of air pollution of lesser magnitude with variations in daily mortality.

Studies on SO_x/particulates type of pollution from various parts of the world in different years imply a relatively consistent association between long-term residence in more polluted communities and increased mortality rates. Population mobility tends to decrease the likelihood of finding the effects of air pollution. There may be some correlation between the occupation and residing in areas of heavy pollution. Therefore, the consistency of the air pollution/ mortality assciations does not imply causality due to several intervening factors.

Air pollution and chronic respiratory morbidity

Identifying the contribution of air pollution to the development of chronic obstructive respiratory diseases introduces difficulties in isolating the effects from other contributing factors. Most studies of chronic respiratory disease and air pollution have indicated a relationship between the prevalence of chronic respiratory symptoms and SO/ particulate complex. Interpretations of an observed associations between air pollution exposure and prevalence of respiratory disease are often complicated by many potentially confounding factors like smoking, socioeconomic characteristics, occupational exposure, migration of populations into-out of polluted areas, etc. When adjustments are made for potential confounders, the association of respiratory disease prevalence with air pollution often becomes consi-derably weak and it is difficult to determine whether the effect is really quite small or whether the effects were over adjusted for confoundir factors. The role of confounding factors become larger when attempt is made to determine lowest concentrations at which air pollution contributes to the risks.

Air pollution and exacerbation of disease in chronically ill person.

An extensive series of studies on the effects of air pollution on bronchitic patients attending chest clinics was conducted by Lawther *et al* , which show that exacerbations of disease were associated with high concentrations of smoke and sulphur dioxide. Further examination of sickness absence records, rates of physicians consultation and daily records of hospital admissions through the emergency service showed associations with periods of heavy air pollution.

Study of the effect of air pollution on persons with chronic

respiratory disease is particularly important from a puhlic health point of view hecause these persons are believed to include a segment of population, extremely susceptible to air pollution exposure. Air quality standards based on protection of public health should be established to provide adequate protection for these susceptible groups. Many investigators have studied the temporal pattern of symptoms status in these persons in relation to concentrations of air pollutants and weather factors.

Air pollution and acute respiratory disease.

An experimental basis for a relationship between air pollution and impaired resistance to respiratory infections has been established in laboratory animals. Mice infected with respiratory pathogens and exposed to SO_2, ozone and urban air pollution have shown increased mortality and decreased resistance to infection compared to infected but unexposed animals. Similarly, several epidemiological studies have observed an increased incidence of respiratory illness in populations living in localities with more SO_2/particulate pollution.

These studies support an association between increased acute lower respiratory tract disease (acute bronchitis, pneumonia and other acute chest illness) in adults and residence in more polluted localities. However, the pollutants or concentrations in the presence of which increased risk of acute illness occurs, have not been established and it is difficult due to many environmental and personal factors, to implicate a specific concentration that contributes to a population risk of acute respiratory illness.

Air pollution and ventilatory function

In the studies reported from England, Japan, USA, Canada and Denmark, geographic differences in various air pollution indices have been related to ventilatory function in school children. Ventilatory function in children is a useful measure of air pollution effects, because cigarette smoking, occup-ational exposure and changes of residence do not generally play a role in the observed effects. Children residing in more polluted areas show diminished ventilatory function when compared with their counterparts living in less polluted areas.

Slightly diminished lung function may not be important, but when other respiratory challenges such as frequent infections, cigarette smoking, air pollution and occupational exposure are added, respiratory health may be seriously compromised. Burrows *et al* observed close relationship between a history of childhood respiratory disorders and prevalence of symp-toms, obstructive airway diseases, and ventilatory impairment in adults. They have also noted that even young adults with relatively mild ventilatory impairment and a history of paediatric respiratory illness show a steeper declining slope in function with age and cigarette smoking than the adults without impairment or history of illness. The fact that air pollution exposure increases the risk of diminished lung function and acute respiratory illness in childhood also suggest an increased risk for subs-equent development of obstructive lung disease in adulthood. Long-term prospective studies, beginning in childhood, are therefore, required to provide definite evidence for these possible relationships. Experimental human exposures are particularly useful in determining the precise concentrations of specific pollutants at which airways of healthy adults can he affected. Experimental studies on healthy human volunteers are very valuable in identifying physiological responses to precisely known pollutant concentrations and in establishing dose response relationships. However, experimental studies may not adequately represent the real atmosphere with its complex and dynamic mixture of air pollutants.

Air pollution and cancer of the lung

The hypothesis that air pollution may be a factor in human lung cancer derives from three types of studies viz. (i) comparison of lung cancer rates in immigrants from one country to another with the rates of native born non-immigrants in both countries, (ii) investigation of urban and rural differences in lung cancer risk; and (iii) qualitative and quantitative differences in air pollution by area and associated lung cancer rates.

The suspicion that air pollution leads to lung cancer remains neither proved nor disproved. The overwhelming influence of cigarette smoking, the contribution of occupational exposures, the scarcity of good measurements of potential atmospheric carcinogens and the long latent period between first exposure and detection of cancer, all contribute to the difficulty of obtaining evidence

for the relationship between air pollution and lung cancer.

Air pollution and heart disease

Cigarettes, diet, lack of exercise, high blood pressure and increased serum lipid concentrations have received the most attention as the environmental risk factors that contribute to heart disease. Evidence that air pollution, particularly carbon monoxide increases heart disease risk also exist. Although there are many uncertainties in these findings, their significance is considerably enhanced by studies on individuals with angina pectoris exposed to CO on freeways or experimentally. The experimental studies show that persons with angina experience chest pain significantly earlier during exercise when carboxyhaemoglobin concentrations reach 2.5 to 3.0 per cent.

Several other reports suggest a relationship between exposure to ozone and damage to myocardial fibres, between exposure to sulphur dioxide and cardiovascular deaths and between sulphate concentrations and exacerbation of disease in elderly persons with heart diseases. Large concentrations of cadmium in air have been correlated with death rates due to cardiovascular diseases.

Air pollution and sensory irritation, central nervous system function ad human performance

The odour of some air-borne substance and irritation to the eyes, nose and throat are the most common and annoying aspects of air pollution. Perception of these effects is very real, but quantifying them is difficult.

Most odourous materials, except for hydrogen sulphide, are difficult to measure at concentrations that are perceived as objectionable. Odour annoyance survey methods[60] are appropriate ways of monitoring for odour and estimating the severity of impact.

Hydrogen sulphide is a common and offensively odourous material, readily perceived by its rotten egg odour. It originates from kraft paper mills, industrial waste disposal ponds, sewage treatment plants, tanneries, coke oven plants and geothermal wells. At higher concentrations, hydrogen suphide may impair the sense of smell and produce unconsciousness.

Aldehydes produced by incomplete combustion of fossil fuels are irritating to the skin and eyes. Formaldehyde is one of the more common aldehydes that irritate the eyes, nose and other portions of the respiratory tract.

Ozone, the major component of photochemical smog, directly irritates the pharynx and trachea, causing a burning sensation in the upper part of the chest. Japanese investigators have described eye irritation, chest discomfort, headache, and various other symptoms in school children playing outdoor on "smog alert" days in various cities in Japan.

Carbon monoxide can alter human performance as well as cardiac function. At small concentrations, effects on various measures of performance, such as time interval discrimination and ability to concentrate, decrements in vigilance tasks and in visual threshold have been reported in experimentally exposed subjects. Apparently the effects of CO can be overcome by sustained interest in the task. However, when subjects are required to perform tedious and monotonous tasks, carbon monoxide can impair performance.

Inhalation of significant amounts of air-borne lead can cause neurologic disturbances and even adversely affect the central nervous system. Children living near a lead smelter were shown to have altered nerve conductance velocities.

It is apparent that these air pollutants can impair sensory organs and human performances. Some of these effects are easily perceived, others are difficult to demonstrate. The long-term health implications of this category of effects are not adequately known.

Air pollution and effects from persistent metals and other chemicals

Certain trace metals, various synthetic chlorinated hydrocarbons and polychlorinated biphenyls accumulate in the body. The accumulation of these substances in the body in a cause for concern. In the case of synthetic hydrocarbons, little is known about the long-term health consequences of increased tissue concentrations, however, based on animal studies there is suspicion that some of these compounds are carcinogenic. Considerably more is known about the toxic effects of increased tissue concentrations of these substances and may increase the risk of toxic effects when other environmental exposure are added. It is necessary to use animal toxicity data for trace metals, in formulating guidelines for protection of public health.

The National Air Pollution Scenario

The Air(Prevention and, control of Pollution) Act 1981 and the Environment Act 1996 form the basis for monitoring and controlling air pollution in the country especially after the Bhopal gas tragedy in 1984. However, even before the promulgation of these Acts, several attempts were made to monitor the air quality with specific objectives from time to time. Data on air quality were available upto 1980 only for the three metropolitan cities of Bombay, Calcutta, and Delhi under WHO/GEMS programme operated by National Environmental Engineering Research Institute (NEERI), Nagpur. A study conducted by the GEMS network on the global distribution of particulate pollution over the period of 1980-84 observed that the daily mean concentration of particulates in New Delhi exceeded the WHO standards of 230 $\mu g/m^3$ on 294 days during the year.

Six of the ten larges cities in India viz. Bombay, Calcutta, Delhi, Ahmedabad, Kanpur and Nagpur, have severe air pollution problems with the annual levels of total suspended particles (TSPs) at least three times as high as the WHO standards. Over 80 per cent of the National Ambient Air Quality Monitoring (NAAQM) stations, for which annual mean concentrations are reported by the Central Pollution Control Board, showed particulates exceeding 75 $\mu g/m^3$. In contrast, the annual average concentrations of SO_x and NO_x were lower in relation to the respective air quality standards. There does not apear to be any clean correlation between a city's population and air pollution. Many medium sized cities have air pollution levels higher than several megacities. The critical analysis of the air quality data of nine urban centres in India from 1978-81 by Chatterjee *et al* revealed that if the TSPs are not taken into consideration, the gaseous pollutants generated by industries and by motor vehicles together failed to produce any significant levels of pollution in any of the nine urban areas. The significance of particulates in urban areas in India is not clear since air in the rural environments also contain almost equally high concentrations of TSPs. Only a small undetermined proportion of TSPs in urban air is anthropogenic.

Until recently the air quality data in India had been traditionally collected in the from of TSPs which is of limited value from the health point of view. Recent studies have indicated that particulate matter having $\leq 10\ \mu$ diameter (PM) could provide a better index of health risks. Hence more data on IM should be generated using sophisticated instruments.

A few systematic studies on the air pollution and its effects on human beings have been reported for urban centres like Bombay, Ahme-dabad, Bangalore and Vado-dara. The blood lead levels of perso-ns in some cities (Ahmedabad, Banga-lore and Calcutta) of the country that still use leaded gasoline, on an aver-age, were higher compared to countr-ies using lead free gasoline.

The most recent World Bank estimates for air pollution/health risks for 36 cities in India indicated that there could be over 40,000 premature deaths, with 7,500 (19%) in Delhi, 5,700(14%) in Calcutta and 4,500(11%) in Bombay, due to exposure to the current air pollution levels in these cities. These premature deaths could have been avoided if the air pollution levels in these cities were brought down to the WHO standards.

These studies have shown the qualitative effects of air pollution especially on high risk population groups. Recently studies on air pollution and its impact on residents of certain critically polluted identified areas of the country have been concluded by the Ministry of Environment & Forests, Government of India. The results of these studies would provide a better understanding of air pollution/health risks relationship based on Indian experiences.

Not many studies have been undertaken till recently in the field of biological air pollution or of the potential biohazards such as bio-allergens. Biological contaminants of air include fungi, viruses, bacteria, insects, vegetable dust, pollen grains, *etc*. Indian studies on bio-allergens have been restricted to only a few town and cities like Aurangabad, Jaipur, Calcutta, Delhi, Bangalore, Gulbarga, Gwalior and Imphal. Studies on bio-allergens will be an important aspect of air pollution in addition to routine chemical analysis.

Conclusions

Animal experiments, experimental human exposure studies and studies on populations exposed to air pollution have provided qualitative and quantitative understanding of the health effects of community air pollution.

The issues involved in

evaluation of air pollution/health risks are complex and difficult. Existing knowledge of air pollution/health damage relationship can be improved extended and tested against new data. Simplifying assumptions can be made more realistic and other factors that modify the effects of air pollution can be evaluated. Progress in our understanding of the effects of air pollution on the full range of biological response in human beings, and measurement of population exposure will be required to resolve the issues satisfactorily.

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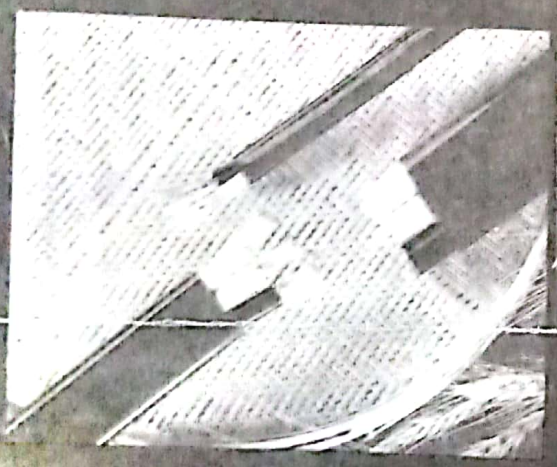

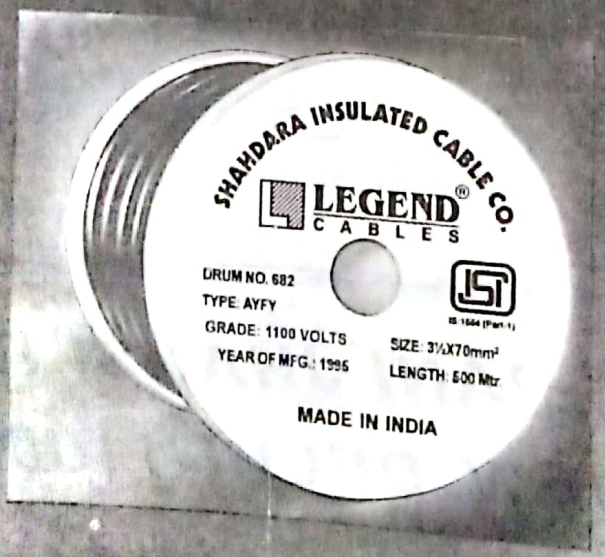

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Full Page

PROBLEMS IN MID CHILDHOOD

Dr. Sudesh Kumar Jaggi,

STUTTERING (Stammering)

It is a defect in speech characterized by hesitation or stumbling and spasmodic repetition of some syllables with pauses. There is difficulty in pronouncing the intial consonants & it is caused by the spasm of lingual and palatal muscles.

Age : 2 years to 5 years.

Cause: Environmental & Emotional stress and get aggravated by reminding the child of his stumling speech by his parents and playmates.

Management : Parents of children between 2-5 years of age should be reasoned with and should not show undue concern they should accept his speech without pressurising him to repeat or making him conscious of his disability.

The older children should be given emotional support and given speech therapy.

PICA

The child may develop the habit of eating non edible substance such as eating wood, plastic etc. Tasting or molding of strange objects.

Age : Infants & children upto 2 years.

Cause: Beyond age of two years the cause is parental neglect, poor supervision or lack of affection. It is common in children of lower socio economic strata, malnourished and mentally subnormal children.

Managements: Lauha (Iron) compounds, Balya (Tonics) Jaggi Liv-Odroop often given in these cases.

ENURESIS

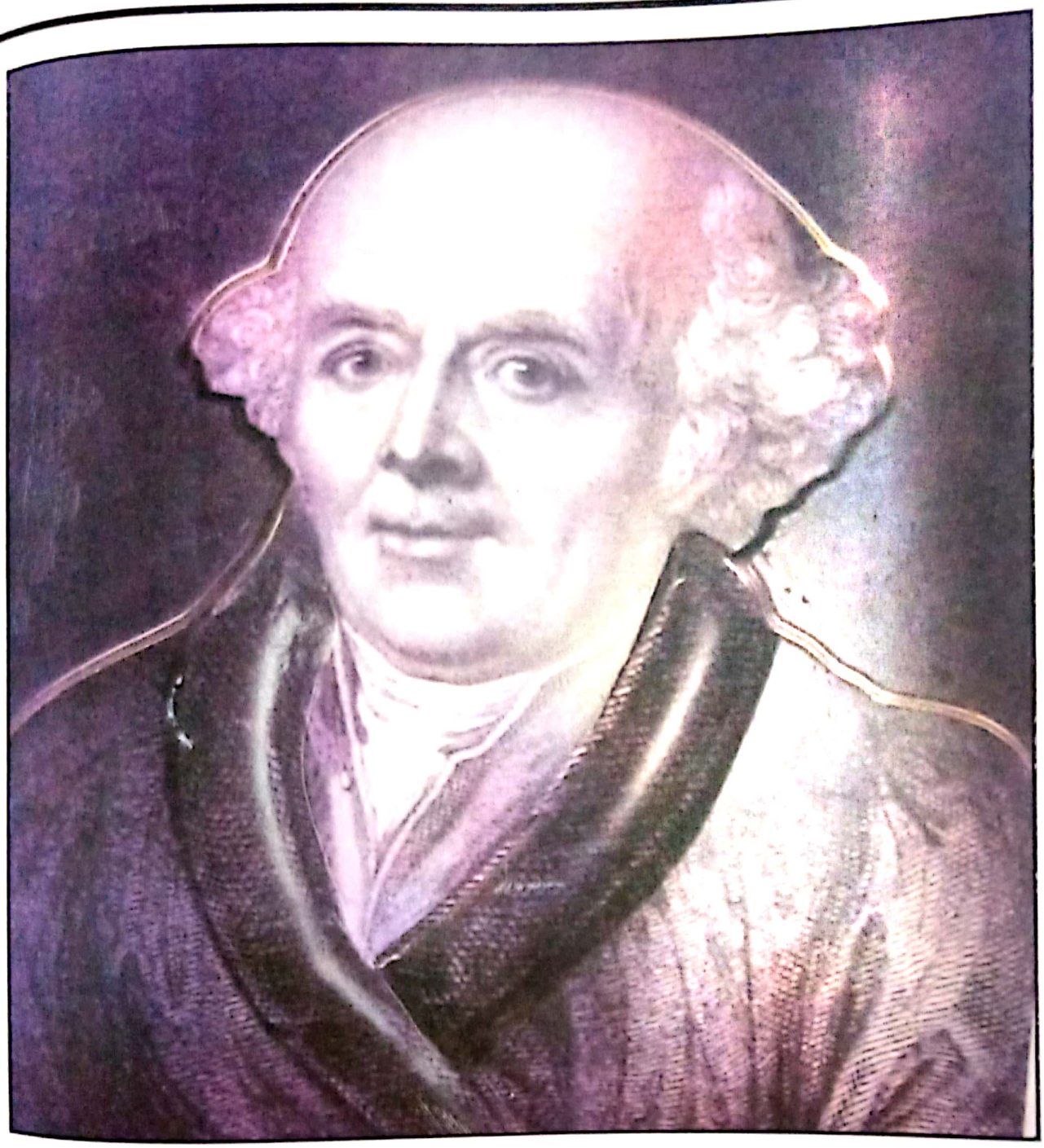
Some children empty the bladder involuntarily and wet the bed at an age beyond which the sphincter control is normally developed. Enuresis can be primary or secondary. In Primary Enuresis there is a delay in the maturation of neurological control of sphincter and such chilren have usually never been dry at night. There is often an organic basis for this problem e.g. Mental Subnormality.

In Secondary Enuresis the sphincter control is developed at the normal age and the child remains dry for several months after which the child again starts wetting bed at night. This may be due to excessively enthusiastic attempts at toilet training by the parents, emotional disturbances in the child or parent-child maladjustment. In some cases Enuresis may represent the sub conscious desire of the child to again care and attention of his parents as in earlier period of infancy or sub conscious resentment against the parents. The children with nocturnal enuresis usually sleep very deeply at night. The signal from the distended bladder indicating the need to empty the bladder do not reach the conscious level of their mind and involuntarily they empty the bladder.

Management : Organic causes such as juvenile diabetes mellitus, anomalies and UTI, nephropathy and neurological-these should be excluded.

* Generally it is self limiting condition,
* Parents should be advised not to nag, criticize or reprim and the child for wetting the bed.
* The bed sheet should be changed quickly without making child conscious of it.
* Child should refrain from taking beverages such as tea, milk or sharbats after 5 O'clock in the evening.
* Child should be habitually made to pass urine before retiring to bed.
* The parents should arouse him fully again after 2-3 hours of sleep and to persuade him to walk unaided to the toilet to empty the bladder.
* The bladder should be trained to retain urine for a longer time. This may be done by making the child to drink large quantity of water during the day and persuade him to delay emptying of bladder as long as possible.

Drug Treatment : In very resistant cases above 6 years of age Imperamine in the dose of 25-50 mg orally at night for 2 months can be given Jaggi Brahmi Amrit, Brahmi Rasyan are ayurvedic drug of choice.



Samuel Hahemann (1755-1843) The Founder of Homoeopathy

" When the ALL blessed created Iron, he accorded the children of men ability to make from it either the Murderous dagger or the gentle plough share, and therewith to slay or to nourish their brethren. How much happier they would make themselves by applying His gift's only for beneficence's sake ! This was the purpose of their Lives, this was His WILL"

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controls bleeding of diverse aetiology

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CENTRAL COUNCIL FOR RESEARCH IN HOMOEOPATHY, AN OVERVIEW

DR. D.P. RASTOGI
M.A., D.M.S., MBS HOM, D.F.HOM (LOND.) DIRECTOR, CCRH

INTRODUCTION

Research means systematic investigations towards increasing the sum of knowledge. In India, we have an apex body under the Union Health Ministry called the Central Council for Research in Homoeopathy (CCRH) which is engaged in the field of research in Homoeopathy and is responsible to initiate, guide and conduct research in various aspects. It may be said that organised research in India has started with CCRH and till date, various research programme have been initiated by this Council falling under the following headings:

A. Clinical Research (including research in tribals areas and epidemics)
B. Drug Proving Research
C. Drug Standardisation [Multi Disciplinary]
D.Survey/Collection of Medicinal Plants
E. Clinical Verification
F. Literary Research
G. Documentation
H. Publications
I Inservice Training Programmes (Workshops/Seminars)

These are being conducted in 51 Unit/Institutes of CCRH Located in various parts of India. Thirty seven(37)clinical project are in progress in six (6) research institutes and thirteen (13) clinical research units. Drug research and drug standardisation activities are being carried out at Homoeopathic Drug Research Institute and two (2) drug standardisation units. For drug proving there are three(3) unit and for clinical verification also there are three (3) units. There is one unit engaged in survey and collection of medicinal plants. Twenty two (22) clinical research units are functioning in areas inhabitated by tribals.

A. CLINICAL RESEARCH

Clinical Research is the major activity of the Council and is Carried out at:

[i] Six Research Institutes, one with 50 bedded hospital at Kottayam, one with 25 bedded hospital at Gudivada, three with10 bedded hospitals at Jaipur, Puri and New Delhi and one at Bombay.

[ii] 15 Research Units located in various parts of India.

Objectives

i] To study the efficacy of homoeopathic medicines in shortening the acute phase, diminishing the frequency, intensity, chronicity finding out the role of miasms,heredi- tary, environment and other factors.

ii] Clinical cofirmation of drug pathogenesis.

iii] Elicitation of new clinical sym-ptoms and evaluation of clinical drug pictures.

iv] To evolve a group of most effective homoeopathic medic-ines with regard to :-

a) identification of their relia-ble indications, suitable potencies,reliablefrequency of administration.

b) determination of their relationship with other e.g. complementary, antidotal, inimicaql etc.

v] To prepare repertorial indices for the above

To achieve the desired objectives on the aforesaid points, this research has been designed as:

1. Disease related clinical research and
2. Drug related clinical research

1. Disease related clinical research

To evolve a group of most effective homoeopathic medicines in a given pathological condition, with regard to ;

i. identification of their reliable indications,
ii. identification of their most useful potencies,
iii. determination of their reliable frequency od administration
iv. preparation of the repertorial indices, and
v. determination of their relationship with
a. other drugs such as which follow well, complementary, cognate, antidotal etc.

b. improvement in symptom sign complex of given patho-logical conditions under this programme, the following 23 clinical project are in progress:

Disease

Drug found effective

1. Amoebiasis

Nux vomica 30,200; Atista Indica Q, 3x, 6x, 30; Holarrhena antidysen-terica Q, 3x,6x; Sulphur 30, 200; Lycopodium clavatum 30,200; Aloes socotrina 30, 200; Arsenicum album 30, 200.

2. **Behavioural disorders:**

Suphur 30,200, IM, 10M; Aesenic album 30,200;Baryta carbonicum 200; Calarea carbonicum 30,200, 1M; Belladonna 30,200, IM; Stramonium 30, 200, IM; Lgnation amara 200, IM; Nux vomica 200, IM; Pulsatilla 30, 200, IM; Lachesis 30, 200, IM; Natrum muriaticum 30, 200, IM; Phosphorus 30, 200.

3. **Anaemia (Iron deficiency)**

Ferrum phosphoricum 3x; Pulsatilla 30; China officinalis 30; Sepia 30, 200; Sulphur 30, 200, 1M.

4. **Bronchial Asthma**

Ammonium carboniucm30; Antimo-nium tartaricum 30; 1M,10M, 50M, CM; Arsenicum iodatum 6,30; Aralia racemose 6,30, 200; Bacillinum 200, 1M, 10M; Blatta orientalis Q, 6; Bryonia alba 30, 200, 1M; Carbo vegetabilis 6,30,200,M, 10M; Cina 30, 200; Grindelia Q, Hepar sulphuris calcareum 1M; Ipecacuanha 3,6, 30, 200 1M, 10M; Kali bichromicum 30, 200,1M; Kali Carbonicum 6,30, 200; Kali iodatu-m30, 200;Lachesis 30, 200,1M; Medorrhinum30,200,1M; Natrum muriaticum 30, 200, 1M; Natrum sulphuricum 30, 200,1M; Nux vomica 6,30, 200; Phosphorus 30, 200,1M;Pothos Q, 30; Pulsatilla 6, 30, 200, 1M,10M; Senega 6, 30; Spongia 6, 30,200; Sulphur 30, 200, 1M.

5. **Cervicitis & Cervical Erosion**

Sepia 6, 30, 200, 1M;Cimicifuga 200; Pulsatilla 6,30, 200, 1M,10M; Kreosote 6, 200; Arsenicum album 200,1M; Alumina 30, 200;Calcarea carbonicum 30, 200, 1M, 10M; Natrum muriatcum 30,200 1M; Mercurius solubilis 30, 200

6. **Diarhoea Inchildren**

Achyranthes aspera,Aegle folia

7. **Dysentery**

Nux vomica 30; Mercurius solubilis 30, 200; Arsenicum album 30, 200; Mer-curius corrosivus 30, 200.

8. **Epilepsy**

Agaricus 200; Belladonna 30, 200; Ca-usticum 30, 200, 1M; Cicuta virosa 200; Cuprum metallicum 200;Lycopodium clavatum 200; Lachesis 30, 200; Natrum muriaticum 200; Sulphur 200; Calarea carboinca 200; Cina 200; Gelsemi-um 200; Nux vomica 200.

9. **Filaria**

Rhus tox icodendron 30, 200; Bryonia alba 30, 200; Apis mellifica 30, 200; Arsenicum album 30, 200; Rhodod-endron 200.

10. **Gastritis**

Arsenic album, Nux vomica, Phosp-horus.

11. **Giardiasis**New project.

12. **Hepatitis** New Project

13. **Human Immunodeficiency Virus (HIV)**

Aconitum napellus 1M,Argentum nitricum 30;Arsenicum album 30;Brynoia alba 30; Calcarea iodata 30, 200; Cnchona officinalis 30, 200; Chininum arsenicosum 30; Hepar calcareum sulphris 30; Medo-rrhinum 200, 1M; Mercurius solubilis 30; Nux vomica 200, Phosphorus 200, Rhus toxicodendron 30; Silicea 200; Sulphur 1M; Syphilinum 1M, 10M; Tubercu-linum 1M, 10M; variolinum 1M.

14. **Hyper low density lipoproteinaemia**

Baryta mur, Bryonic,Calcarea carbon-ica, Kalmia, Lycopodium, natrum mu-riaticum, Pulsatilla, Rhustoxic-xoden-dron, Nuxvomica, Sulphur.

15. **Hypertension**

Allium sative, Baryta,Lachesis, Lycop-odium,Rauwolfia serp., Spartium, Suplphur, Veratrum viride.

16. **Intermittent fever**

Alstonia constricta, Arsenicum alb-um, Azadirachta, China, China arse-nicum,china sulphuricum, Caresalpenia bonducella, Eupatorium perfoliatum, Gelsemium, Ipecac, Natrum mur., Nyctanthes arbor tristis.

17. **Irritable bowel syndroma** alis 30, 200, IM;China arsenicosum 30 Im; Caesalpenia bonducella6; Eupatorium perfoliatum 30, 200; Gelsemium 30, 200; Lpecacuanha 30,200;Natrum Muiaticum 30, 200, IM; Nyctanthes arbortristis 6; Pul-satilla 30, 200; Rhus toxicodendron 30, 200, 1M.

19. **Mental retardation**

Homoeopathic drugs for drugs beha-vioural problems in Mental retard-ation.

20. **Osteoarthritis**

Rhus toxicodendron 200,IM, CM; Lycopodium clavatum 30, 200, IM; Br-yonia alba 200; Sulphur 30, 200, IM;Formica rufa 30, 200; Calcarea carbonica IM,10M, Thuja 200, IM; Arn-ica montana 200, IM; Kali carbonica 200; Syphilinum 1M; Nedorrhinum 1M, 10M.

21. **Prostate enalrgement**

Argentum nitricum,Causticum, Conium,Mercurius solubilis, Thuja.

22. **Renal**

Berberis vulgaris Q, 6, 30; Bryonia alba 200, IM; Cantharis Q,6, 30; Calculus Colocynthis 6; Hydrangea Q; Lycopodium 30, 200, IM; Nux. vomica 30,200; Oci-mum canum Q; Sarsaparilla 30, 200; Terebinthina 30, 1M; Urtica urens 6,30.

23. **Rheumatoid Arthritis**

Bryonia alba 30, 200, IM; Lachesis 30, 200;Maedorrhinum 200, IM, 10M, 50M;- Rhus toxicodendron 30, 200, IM, 10M, 50M; Calcarea carbonicum 200, 1M.

24. **Sickle Cell Anaemia**

In acute phase-Arsenicum album 30; Bryonia albo 30; Rhus toxico-dendron 30; Pulsatilla 30;Kalmegh Q; Chelidonium 30. In chronic phase Bryonia alba 200,1M, 10M, Sulphur 200, 1M; pusatilla 200, Lycopodium 30, 200; Natrum muriaticum 30, 200; Calcarea carbonicum 30, 200; Kalmegh Q; Rhus toxicodendron 1M; Tu- berculinum 200.

25. **Sinusitis**

Kali bichromicum 200; Natrum muria-ticum 30, 200, 1M; Pulsatilla 6, 30, 200, 1M; Sepia 30; Sulphur 30.

26. **Skin Disorders**

[a] **Allergic Dermatitis**

Sulphur 6, 30,200, IM,10M; Graphites 30, 200,1M; Rhus toxicodendron 30, 200; Natrum muriaticum 200, 1M; Sepia 30, 200, 1M; Psorinum 200, IM; Gun powder 6, 30; Mercurius solubilis 30, 200, Im,10M; Urtica urens 6, 30; Petroleum 200.

[b] **Psoriasis**

Lycopodium 200, IM, 10M; Sulphur 6, 30, 200; Petroleum 30, 200, 1M; Hyroco-tyle asiatica 6, 30; Psorinum 6, 30, 200; Arsenicum album 6, 30, 200, 1M, 10M, 5M, CM.

27. **Tonsillitis**

Baryta cardonica 30, 200, IM; Belladon-na 30,200; Calcarea carbonica 30; Lycopodium clavatum 30; Mercurius solubilis 30, 200; Natrum muriat-icum 30; Hepar sulphuris calcareum 30, 200; Mercurius bin iodatum 30; Mercurius proto iodatum 30, 200; Pyrogen 200; Ailanthus Q.

22. **Vitiligo**

Mercurius solubilis 30, 1M; Sulphur 200; Natrum muriaticum 30, 200, 1M; Tuberculinum 1M, 10M.

23. **New Projects**

Upper Respiratory Tract Infection(controlled trials).

2. Drug related clinical research

certain drugs are associated with certain diseases such as :

i. those which have a special affinity for the organ [s] involved in particular conditions or

ii. Which are traditionally/ empirically used or

iii. those identified asa useful by the various Institutes/Units of the Council through research studies.

Such drugs [discussed later] are in order to clinically evaluate them inparticuler disease [s] with regard to:

i. identification of their drug pathogenesis

ii. identification of their most useful potencies.

iii. determination of their frequency of administration

iv.determination of their relationship with

a. other drug such which follow well, complementary, cognate, intercurrent, antidotal incompatible, etc.

b. improvement in sign-symptom complex of particular disease.

some of the drugs assigned for particular disease conditions are given below:

Amoebiasis

Achyranthes aspera. Aegle marmaleos, Arsenicum album, Atista indica Cincho-naofficinalis, Colchicum, Colocynthis, Cy- nodon dactylon, Holarrhena antidyse-nterica, Ipecacuanha, Mercurius corro-sivus,Mercurius solubilis, Nux vomica, Sulphur.

Behavioural disorder

Belladonna, Hyoscyamus, Ignatia, Lach-esis, Natrum muriaticum, Nux-vomica, Phosphorus, Pulsatilla, Stramonium Sulphur

Cervical

Guaiacum, Cimicifuga,

spondylosis

Sticta, Calcrea flouricum, Rhus toxicod-endon, Paris quadrifolia, Phytolacca, ali carbonicum.

Cervicitis & Cervical erosion

Alumina, Arsenic album, Borax, Calca-rea carbonicum, kali

carbonicum, Kreo-sote,Lachesis, Mercurius solubilis, Nat-rum muriaticum, Pulsatilla, Sepia

Diabetes Mellitus

Cephalandra indica, Rhus aromatica

Filaria

Anacardium, Apis mellifica, Belladonna, Bothrops, Bryonia alba,Calotropis, Ly-copodium, mercurius solubilis, Natr-um muriaticum, Pulsatilla, Rhododend-ron, Rhus tox, Sulphur, Vipera

Gall Stones

Fel tauri 2x or 3x

Helminthiasis

Chelone, Cina, Cuprum oxydatum ni-grum, Embelia ribes, Teucrium marum verum, Thymol.

Malposition of human foetus

Pulsatilla 200.

Menorrhagia

Ficus religiose Q, Trilliumpendulum Q, Erigeron, Geranium maculatum, Led-um pal, Cinnamonum,Thlaspi bursa pa-storis.

Microfilera emie

Effect of homoeopathic drugs on Mi-crofilaraemia

Osteoarth

Bryonia, Calcarea carbonicum, calca-rea flouoricum, Cassia sophera, Caus-ticum, Formica rufa,Guaicum, Luc-opodium,Rhus toxicodendron, Th-uja, Viscum album,Viola odorate

Vitiligo

Arsenicum sulphuratum flavus.

Clini-cal Research in Epidemics

The Council has conducted studies in over 28 Epidemics since 1981-97 in various parts of the country. Chief Epidemics covered are the following;

Conjunctivitis, Dengue Fever, Encephalitis, Bacillary Dyentery, Jaundice, Typhoid Fever, Measles, Meningitis, MIC Gas Poisoning, Cholera, Gastro-intestinal disorders, Viral Fever and Kalaazar. , Plague, Malaria, Denguew fever.

Clinical Research in Tribal Areas

Twenty one (21) Clinical Research Units have been established predominantly tribal areas all over the country. These places are located in extremely difficult areas (eg. inacc-esible. social problems etc.). Earlier these these units were intended to gather data of prevalence of diseases, food habits, local custom and beliefs, natural resources and folklore concerning medicine and health besides providing medical care to the locals as bye-way of research. At present these units are conducting drug-related clinical research studies (with the objectives as mentioned earlier under No.2) on nineteen diseases found prevalent in that particular area during the survey.

B. DRUG PROVING

Ever since the dawn of Homoeopathy drug proving has played a very crucial role in its development. The therapeutic application of HomoeoPathic drugs is based exclusively on this edifice. In the Central Council for Research in Homoeopathy it is being conducted at 6 centres situated at Midnapore and Calcutta [West Bengal], Ghaziabad and Lucknow [Uttar Pradesh], New Delhi and at College in Amravati (Maharasthra).

The proving of a drug is conducted by Drysdale's double blind method at least two different places [in India] and on both male and fermales of different age groups. The data collected from diverse sources is critically evaluated and finally compiled at the Central Drug Proving cum data Processing Cell at the Council's Headquarters. After final vetting this data is released in the form of monographs for the use of homoeopathic fraternity in clinical application. Drug Proving Research Programme is a Continuous progr-amme.

So far proving of 45 drugs has been completed. The compiled data in respect of 30 drugs has been published in the CCRH Quartery Bulletin. Monographs in respect of Kali muriaticum, been released. monographs on hydrocotyle asiatica and Atista indica are in the press.

A complete list of drugs proved by CCRH are Abroma augusta, Aegle marmelos, Aranea scinencia, Aranea diadema, Atista Indica, Azadirachta indica, Baryta iodata, Boerhaavia diffusa, Cassia fistula, Cassia sophera, Carica papaya Curcuma longa, Cupr-um oxdatum nigrum, Cynodon dactyl-on, Chelone, Embelia ribes, Formic acid, Hydrocotyle asiatica, Holarrhena antidydsenterica, Kali muriaticum, Mygale, Malaria officinalis, Tarentule cubensis, Tarentula hispanica, Thea chinensis, Tela aranea, Tylophora indiaca, Thymol, Lapis alba, Embelia ribes (Reproving as per instruction of Working Group) Theridion, Termin-alia arjuna Q, Terminalia chebula Q, Acalypha

indica, Glycirrhuiza glabra, Magnesia sulphuricum, Chelone Q, Embelia ribes Q, Terminalia chebule (in potencies), Phyllanthus niruri, Mangifera indica, Nyctanthes arbortristis, Mangifera indica, Cornuus circinata, Ocimum sanctum, Ocimum canum, Ricinus communis, Tribulus terrestris & Rauwolfia serpentina.

C. DRUG STANDARDISATION

Success in homoeopathic prescribing is based as much on the Purity and uniformity of the prepared drug as on the efficient case taking and repertorization. To this end, the Council has set up Drug Standar-distion Units at Ghaziabad and Hyderabed and a HDRI at Lucknow. The assignment compasses a comprehensive evaluetion of the homoeopathic drugs in respect of their physico-chemical, pharmacological, pharmacognostic and histochemical properties. Till date these standards have been suggested for 135 drugs.

The Council has successfuly demonstrated the action of homoeopathic (potentised) drugs on the growth of human and animal viruses.

The Unit at Ghaziabad has laid down parameters for determining the standard of crude drugs, mother tinctures and potencies. The meotho-dology for the preparation of biotherapeutic pharmaceuticals [nosodes] has also been evolved.

D. SURVEY AND COLLECTION OF MEDICINAL PLANTS

Since 70% of the homoe-opathic drugs are of vegetable origin CCRH procures its requirements directly from areas rich in medicinal plants for passing on to its Drug Standardsation Units. Cultivation and ultimately manufacture of Homoe-opathic drugs by the Council is also on the cards for which Tamil Nadu Govt. has leased 12.70 acres of land to our Unit at Udhagamandalam [Ooty].

Intensive planting of Cineraria maritima, a plant useful in opthalmic preparations, is being undertaken. A number of useful plants are also being raised in demonstration plots, such s Apium graveolens, Centella asiatica, Ploygonumfagopyrum,Petroselinum crispum, Cichocrium intybus Polyg-onum puntatum etc.

Revised & enlarged edition of A check list of 369 homoeopathic medicinal plants along with their uses has been published.

E. CLINICAL VERIFICATION

The symptomatoloty of sixty seven (67) drug including twenty five (25) drugs proved at the Drug Proving Research Units of the Council are subjected to clinical verification at Ghaziabad, Vrindavan, Patna [Clinical Verification Units], New Delhi (Regi-onal Research Institute), Lucknow [Homoeopathic Drug Research Instit-ute] Jaipar [Homoeopathic Research Institute for Malaria] and Jammu (Clinical Research Unit.)

Clinical verification not only provides help in confirmation of available pathogenesis but also helps in providing additional data in the form of other clinical symptoms/signs found relieved during the verification trials. The additional symptoms, thus evolved may be inculded in the pathogenesis of that drug after subsequent verification of the same, After sufficient number of symptoms of the proving data of a particular drug are verified, these are published Quarterly Bulletin, Monographs or CCRH NEWS for the use of the profession.

F. Literary Research

The Literary Research Progr-amme is being carried out on Review and Revision of Kunzli's (Kent's) Repertory-additions from Boericke's Repertory in relation to other works.

Under the project Review and Revision of Kunzil's (Kent's) Rep-ertory, the recommendations of the research workers are further subjected to a through scrutiny and approved by the Working Group consisting of experts in field of Repertory. The additions as approved are published in the form of a book. The books which have been published are on chapters Teeth, Mauth, Eye & Vision, and Ear & Hearing, Larynx & Trachea, Respirtion, Cough, Expectoration and chest, Mind, Nose and Throat. Book on Chapter Face is in press. Similar work is in progress on chapters Nervous system and Stomach.

G. Documentation

Documentation deals with specfic types of documents. Its activities are very much interlinked with the research and delvelopmental efforts of the Council. its main

objective is "dissemination of knowledge" which it provides in the form as follows:

i. To prepare complete documentation on subjects of interest to the Council and provide them to the scientists of. the Council to update their knowledge.

ii. To prepare bibliogrphies, reference lists and abstracts of scientific articles on Homoeopathy and allied subjects.

iii. Information service providing relevant information on scientific Queries form the profession and CCRH scientists.

iv. To keep the records of scientific seminars, symposia, workshopsetc. organised or participated in by the Council in the form of audio or video cassettes. At present there are 80 video cassettes which are supplied on demand to the profession.

v. To undertake various publications of the Council.

H Library

The CCRH library was established as a documentation division of national importance in the year 1979. It is having a collection of 8000 books and volume of journals and is subscribing to 60 Homoeopathic and allied medicine journals (Indian as well as foreign) every year. it serves the information needs of the Council's research workers through following services:

i. The library has released cases of the following diseases from journals

a) Cancer b) Renal disease

ii. Current Health Literature Awareness (CHLAS) It is a quarterly publication, so far eight volumes have been released.

iii. Medico Abstracts on a AIDS, Cancer & Dermatology

(b)Rheumatoid arthritis c) Eye diseases d) Diabetes mellitus In collaboration with British Homoeopathic Library, Glasgow e) Psoriasis In collaboration with British Homoeopahtic Libarary, Glasgow

iv. Cumulative index of CCRH Quart-erly Bulletin from Vol. 1-14

v. Press index: an annotated inform-ation

vi. Literature survey of Drug Proving

vii. List of additions of books annually

viii. Bibliography services on demend

ix. Current contents of the journals

I. Publicatuions

1. Monographs

a. Abroma augusta folia
b. Kali muriaticum
c. Cassia sophera
d. Cynodon dactylon
e. Aegle folia
f. Aegle marmelos
g. Hydrocotyle asiatica
h. Atista indica

2.Books

a. A Hand book of Home Remdies in Homoeopathy-Fourth Edition

b. Samanya Homoeopathy Upchar Pushtika (Hindi)-Third Edition.

c. A Checklist of Homoeopathic Medicinal Plants of India-Revised & enl-arged edition.

d. Activites and Achievements of CCRH

e. Additions to Kent's Repertory from Boericke's RepertoryChapter "teeth"

f. Additions to Kent's Repertory from Boericke's RepertoryChapter "Mouth"

g. Additions to Kent's Repertory from Boericke's Repertory Chapter "Eye & vision"

h. Additions to Kent's & Repertory from Boericke's Repertry Chapter "Eye & Hearing"

I. Additions to Kent's Repertory from Boericke's Repertory - Chapter" La-rynx &Trachea, Respiration.Couth, Expectoration & Chest"

j. Additions to Kent's Repertory from Boericke's Repertory - Chapter" Nose".

k. Additions to Kent's Repertory from Boericke's Repertory Chapter " Mind".

l. Additions to Kent's Repertory from Boericke's Repertory Chapter " Throat".

3. Quarterly Bulleti

19Volumes have been published

4. CCRH News 24 issues have been released.

J.IN SERVICE TRAINING PROGRAMMES (WORKSHOPS / SEMINARS)

and also participates in the internationsl/Nationsl Conferences or Seminars by presenting papers on its research activities and aschievements, and by putting up exhibitions.

Fourteen (14) Seminars/ Workshops have been organised so far on subjects such as AIDS, Filaria, Malaria, Bronchial Asthma, Skin Disorders, Cancer, Clinical Verifications and Epidemic Management, Chronic case

serminar, Diabetes mellitlus etc.

CCRH has organised eighteen (18) re-orientation training programmes for the research workers of the Council for review of the work being carried at various Units/Institutes under it.

MYSTIQUE INDIA '96 & 97

The Department of M & H Ministry of Health & Family Welfare particip-ated in exhibitions Mystique India '96 & '97 organised by India Trade Prom-otion Organisation in association with the Ministry of Health & Family Welfare, Khadi and Village Industries Commission and Bharat Nirman at Pragati Maidan, New Delhi. The main purpose was to project a coordinated image of the fruits mankind especially the alternative systems of medicine.

Under the homoeopathic wing various photographs with write-ups

For continuing education of the Scientists and dissemination of the research findings of the Council, the CCRH has been organising Workshop /Seminiars in various fields depicting the origin, history and spread of Homoeopathy in the world and India, Status of Homoeopathy in India, basic principles of homoeo-pathy etc. were put up.

ARTICLES PUBLISHED IN INTERNATIONAL JOURNALS

1. Sunil Kumar, Anil Kumar Srivastava & K. Chandrasekhar. Effects of .Caulophyllum on the Utrri and Ovaries of adult rats. BHJ. 70 (3) 1981 : 135-138.

2. D.P. Rastogi, A.C. Saxena, & Sunil Kumar. Pancreatic Beta-cell regeneration a novel antidiabetic action of Cephaiandra indica mother tincture. BHJ77 (3) 1988 : 147-151

3. V.M. Nagpaul. Proving Planning & Protocol. BHJ 76(2) 1987: 81-84.

4. V.M. Nagpaul, I.M. Dhawan, A.K. Vichitra & D.P. Rastogi. Tarentula hispanica a reproving. BHJ 78(1) 1989 : 19-26.

5. R.K.Manchanda, Ramji J.Gupta, O.P. Bhardwaj, Homoeopathy in the treatment of Warts BHJ 80(2) 1991 : 108-11

6. D.P. Rastogi & V.D. Sharma. Correction of Abbbreviations for medicines used in Boger-Boenninghausen's Repertory 80(4) 1991 : 210-227.

7. D.P. Rastogi, V.P. Singh & S.K. Day Evaluation of homoeopathic treatment in 129 Asymptomatic HIV Carriers. BHJ 82(1) 1993 : 4-8.

8. A. Kumar & N. Mishra Effect of homoeopathic treatment on filariasis a single blind 69 months follow up study in an endemic village in Orissa. BHJ. 83(4) 1994 : 216-19.

A CLINICAL STUDY ON CASES OF PELVIC TUMORS IN RESPONSE TO HOMOEOPATIHC TREATMENT ASSESSED BY ULTRASONOGRAPHY

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EDITER NOTE : -
Part of this paper was presented in the Seventh International Congress of Asian Homoeopathic Medical League held at Brisbane, Australia from 19th - 21st May 1995.

ABSTRACT

The treatment of all kinds of pelvic tumors is chiefly surgical. There have been some claims/reports in the past about successful treatment of pelvic hyperplasia with the help of a few homoeopathic drugs. To scientifically establish such claims and screen the effecits of homoeopathic drugs in cases of benign pelvic tumors a clinical study was conducted at Gaurang Clinic and Centre for Homoeopathic Research, Lucknow. Repeated Ultrasonography after every three months was the main diagnostic parameter employed for the assessment of response in each case.

A total of four hundred and twenty seven (427) well - diagnosed cases of Pelvic tumors comprising two hundred and forty six (246) of Uterine fibroids, one hundred and forty three (143) of Ovarian cysts and thirty eight (38) of Tubo - ovarian masses were registered for treatment/screening during the period 1988 to August 1998. Out of which a total of one hundred and forty eight (148) cases of Pelvic tumors comprising eighty six (86) of Uterine fibroids, fifty four (54) of Overian cysts and eight (8) of Tubo - ovarian masses could be properly followed up for research purposes by repeated ultrasonographic assessment.

As far as their response to homoeopathic treatment is concerned, out of one hundred and forty eight (148) cases of Pelvic tumors sixty five (65) cases were cured (43.92%), forty four (44) are improving and still under treatment (29.73%), seven (7) were improving but left the treatment (4.73%) and thirty two (32) cases are maintaining status quo (21.62%).

Out of eighty six (86) cases of Uterine fibroids (Single and Multiple bogh), Twenty five (25) cases were cured (29.07%), thirty three (33) are improving and still under treatment (38.37%), six (6) were improving but left the treatment (6.98%) and twenty two (22) cases are maintaining status quo (25.58%). As regard cases of Ovarian cyst/Tubo - ovarian masses (Single and Multiple/Right and Left both) out of sixty two (62) cases forty (40) cases were cured (64.52%), eleven (11) are improving and still under treatment (17.74%), one (1) improved but left the treatment (1.61%) and ten (10) cases are maintaining status quo (16.13%). Better response was observed in cases of Ovarian cysts (64.52%) than in Uterine fibroids (29.07%).

Twenty one (21) homoeopathic drugs employed in the treatment of cases of Pelvic tumors are tabulated in the paper which weremainly anti-sycotic. The over all impact of this study is encouraging which should be further pursued by other colleaguesto open new vistas in converting this surgical problem into a medical one in considerable number of cases through judicious employment of already existing homoeopathic drugs.

INTRODUCTION

The incidence of pelvic hyperplasia is on increase in modern living due to too much biological intervention in normal reproductive life of a lady. Before the advent of different unnatural (artificial) measures of family planning like contraceptive pills, intra - uterine contraceptive devices

(IUCD), tubectomy and spermicidal creams etc the prevalence of such type of pelvic tumors/ growths was very very less as reported time and again by several scientists/journals/social workers. Emergence of diagnostic measures like Ultrasonography and C-T scan etc. has made the diagnosis easier as before their advent majority of cases remained undetected/undiagnosed.

The treatment of such tumors is chiefly surgical removal of the growth or complete removal of the uterus/ovaries depending upon the extent of the lesion. Many cases are deferred surgery owing to want of an issue, poor state of health, advanced age, presence of diabetes and/or hypertension and repeated laparotomy for other surgical procedures like cholecystectomy, partial hysterectomy or single/ multiple caesarian sections etc. otherwise surgery was the only choice in the cases fit for it in absence of suitable alternative. There are many drugs in the homoeopathic armamentorium which cover the signs and symptoms simulating pelvic tumors. There has been sporadic reporting in the homoeopathic journals about sucessful treatment of such problems in individual cases. Such cases were neither scientifically scrutinised by modern diagnostic parameters nor reproduced repeatedly to make them acceptable to modern medical scientist. Dr. N. Arora (1993), Dr. Nasreen Zainvi (1993) and Dr. S. Krishnan (1994) for the first time publisheed their positive results in Asian Homoeopathic Journal, however, they could not put forward a detailed statistical analysis of such cases to remove doubts from the physicians of other systems of medicine that these cures may be medical miracle, due to self recovery/physiological changes in the body and not due to homoeopathic drug.

Keeping above facts in view and to scientifically evaluate all kinds of cases of pelvic tumors with reproducible results and statistical analysis, this study was planned to convince any unbiased person, medical or non-medical, surgeon or physician any homoeopath or allopath. It has definitely given a sigh of relief to those for whom surgery was the only choice and also to those who had to otherwise undergo high risk surgery.

MATERIALS AND METHODS

1. Ultrasonography :

It was the main diagnostic parameter to assess the progress of cases and was precisely repeated after every three (3) months. In a few cases ultrasonologist and their machine remained the same and in other both were changed just to have a cross check and to remove any bias element in their reporting.

2. Patients :

A total of well - diagnosed four hundred and twenty seven (427) cases of Pelvic tumors comprising two hundred and forty six (246) of Uterine fibroids, one hundred and forty three (143) of Ovarian cysts and thirty eight (38) of Tubo - ovarian masses were taken up for the study. A total of one hundred and forty eight (148) cases of Pelvic tumors comprising eighty six (86) of Uterine fibroids, fifty four (54) of Ovarian cysts and eight (08) of Tubo-ovarian masses were properly followed - up by repeated ultrasonographic assesments. Out of which fifteen (15) patients were unmarried, one hundred and thirty three (133) were married, forty (40) were nullipara, eighteen (18) were primipara and ninty (90) were multiparous.

3. Drugs :

Twenty one (21) homoeopathic drugs employed in the study are given in the other table.

4. Computer and Software :

A P-II-166 computer and indigenous software specially developed for this study was employed. Slides were prepared by using Harward Graphics Software.

RESULTS AND DISCUSSION

Out of one hundred and forty eight (148) properly followed-up cases incidence of pelvic tumors was found to be more in married females (133) as compared to unmarried ones (15). Likewise multiparous women (90) were found to be more vulnerable (90) to Pelvic tumors than premipara (18) and nullipara (40). Out of one hundred and forty eight (148) properly followed - up cases of Pelvic tumors sixty five (65) were curred, forty four (44) are improving and still and treatment, seven (07) were improving but left treatment and thiry two (32) are maintaining status quo. Better response was seen in cases of Ovarian cysts (64.52% cured) as compared to Uterine fibroid (29.07% cured). In cases of single uterine fibroid better response was obtained (30.77% cured) as compared to multiple uterine fibroids (23.07% cured). Likewise

percent cured was better in cases of multiple ovarian cysts (66.67% cured) as compared to single ovarian cyst (64.15% cured).

The main drug employed in more or less every case was *Thuja occidentalis* in 1M to 50M potencies. It was prescribed as the best anti - sycotic drug because such tumors are the result of tissue proliferation which comes under sycotic miasm as propounded by Dr. Hahnemann. *Lachesis* and *Sepia* were given in high potencies as these drugs covered most of the symptoms at the age of menopause. *Calcarea carb* and *Pulsatilla* were given mostly on the basis of patient's constitution, the former being fair, fat, sweaty and chilly lady having long lasting menses whereas the letter being emotional and oversensitive lady having weeping disposition and scanty menses. The other drugs mentioned in the table were employed on the basis of their indications which is beyond the scope of this paper. *Aurum mur*, *natronatum* 3X was prescribed to all the cases. *Thlaspi B. P.* Q and *Millefolium* Q were used as anti - haemorrhagic drugs. *Hydrastis can*. Q was employed in cases of cervical erosions in addition to pelvic tumors.

The main emphasis was to select a drug on the basis of (1) signs and symptoms available, (2) underlying sycotic miasm and (3) to give intercurrent drugs to give relief in acute symptoms. Such type of approach may appear non classical or non homoeopathic but it has yielded results. If a potentised drug is working in the living system and giving palliative/ curative results it has to follow law of similars just like key and lock mechanism. Cure can achieved by prescribing anti - miasmatic drugs in a clearcut miasmatic conditon, as in cases of pelvic hyperplasia/tumors and that too in a rapid, gentle and permanent way. It is confirmed by the fact that their are no relapses after cure.

INFERENCE

The over all impact of this scientific study is encuraging and discloses that all sorts of cases of pelvic tumors, big or small, single or multiple, ovarian or uterine and with or without complications can be effectively dealt with suitable momoeopathic rermedies. These drugs are equally effective in cases who are otherwise fit for surgery botu want to avoid that and in cases where surgery is highly risky or can not be performed at all. Homoeopathic treatment can avoid the physical and mental trauma of a lady who underwent repeated laparotomies (LSCS and other abdominal surgeries) and doesn't want to be de-

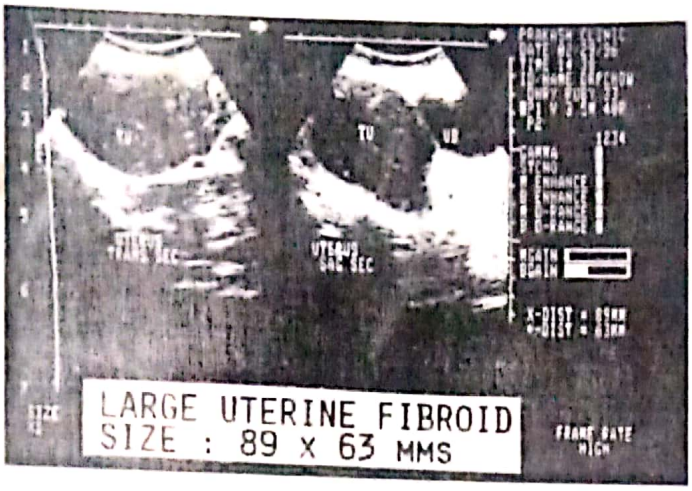


Fig. 1 : BEFIRE TREATMENT

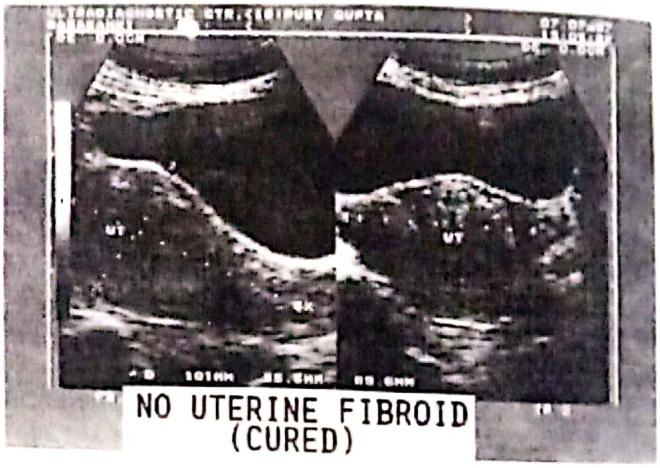


Fig. 2 : BEFIRE TREATMENT

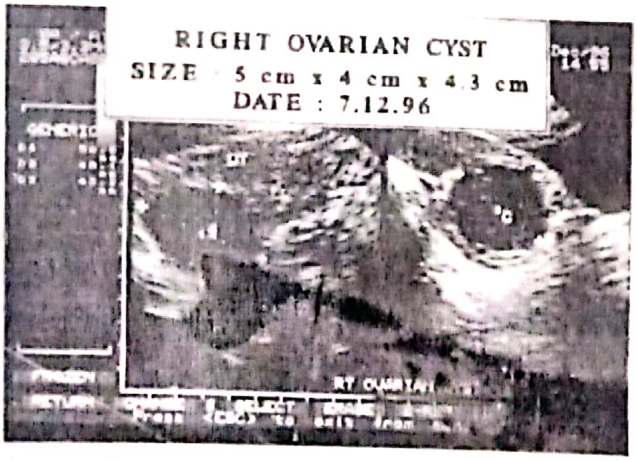


Fig. 3 : BEFIRE TREATMENT

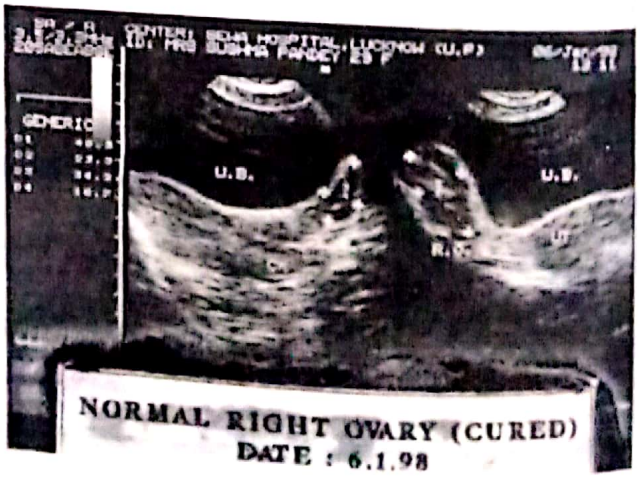
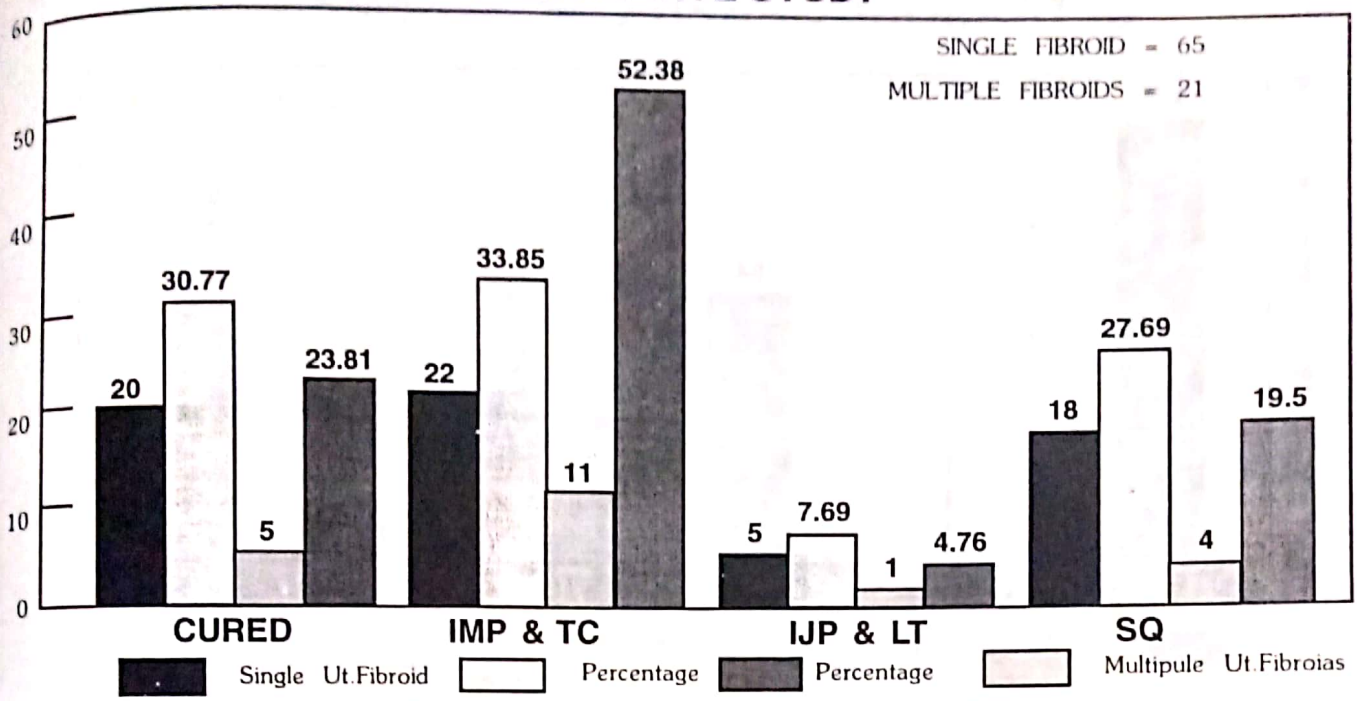


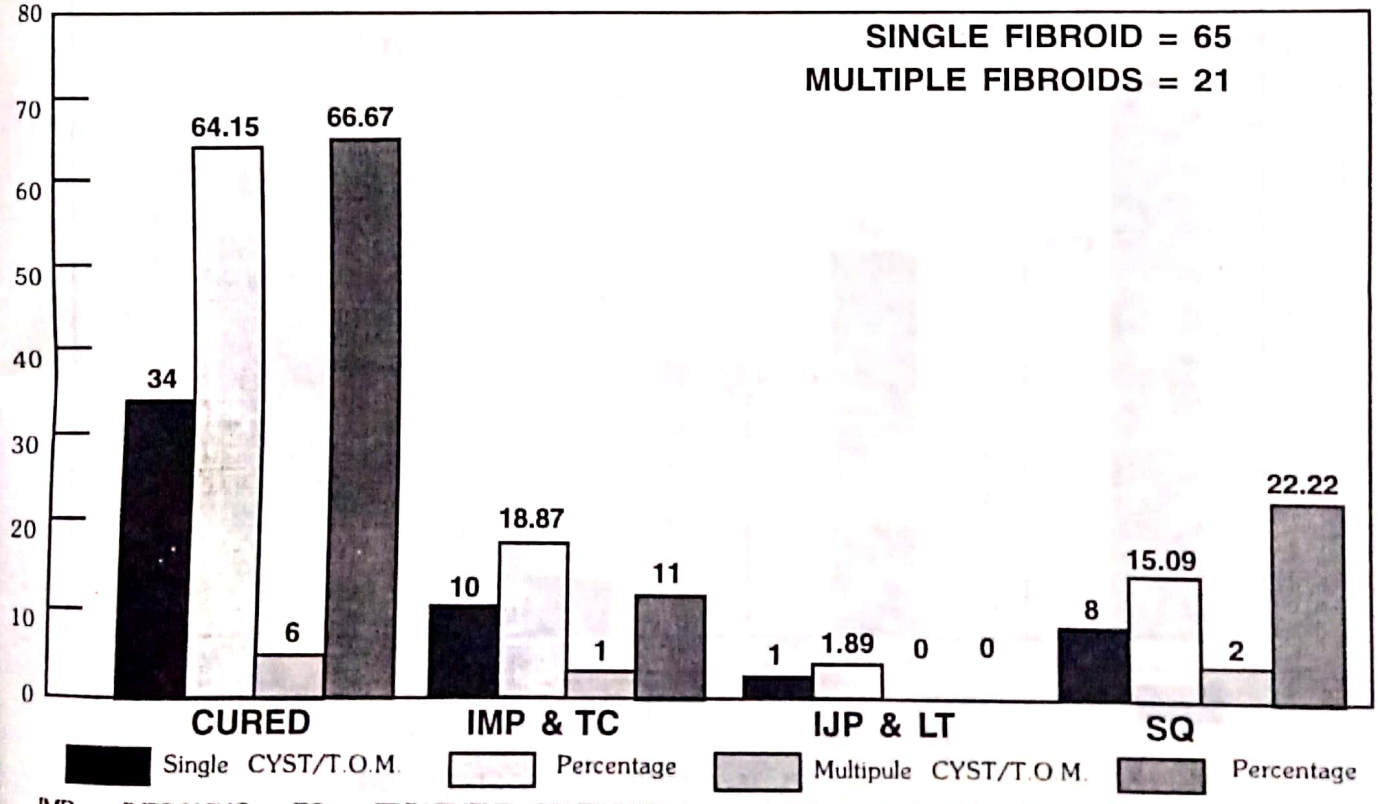
Fig. 4 : BEFIRE TREATMENT

CASES OF UTERINE FIBROIDS (SINGLE & MULTIPLE) : A COMPARATIVE SYUDY



IMP = IMPROVING ; TC = TREATMENT CONTINUED
LT = LEFT TREATMENT ; SQ = STATUS QUO

CASES OF OVARIAN CYSTS/T.O. MASSES (SINGLE & MULTIPLE) : A COMPARATIVE SYUDY



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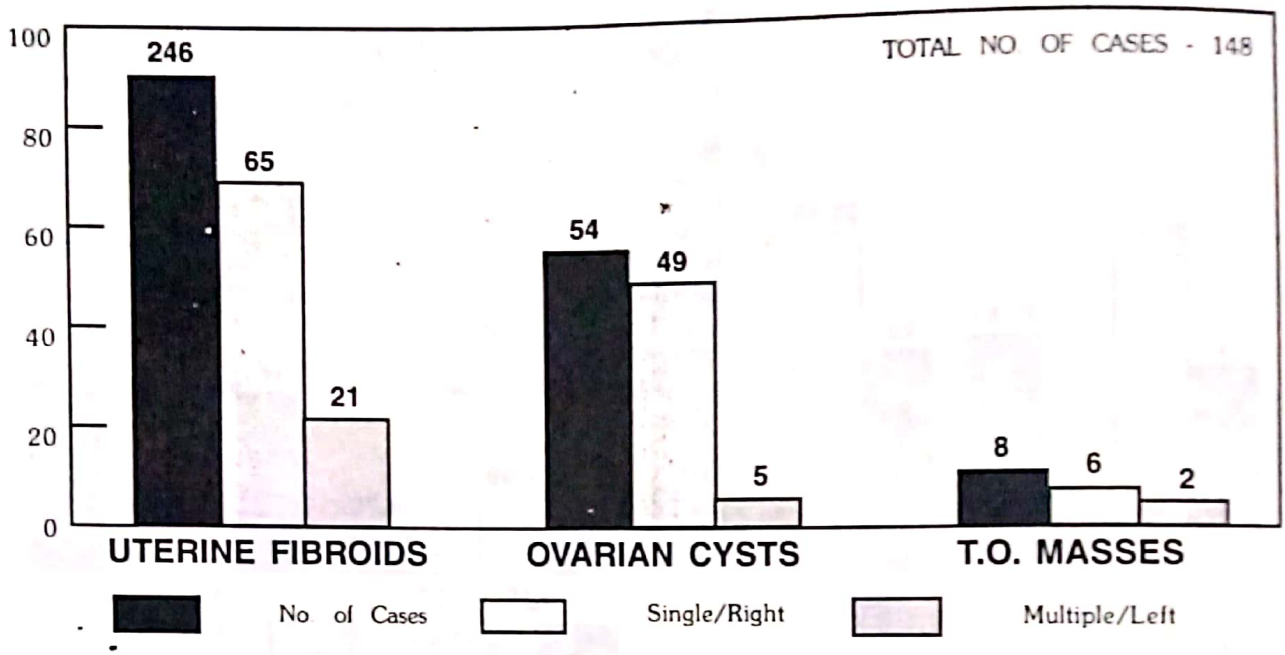
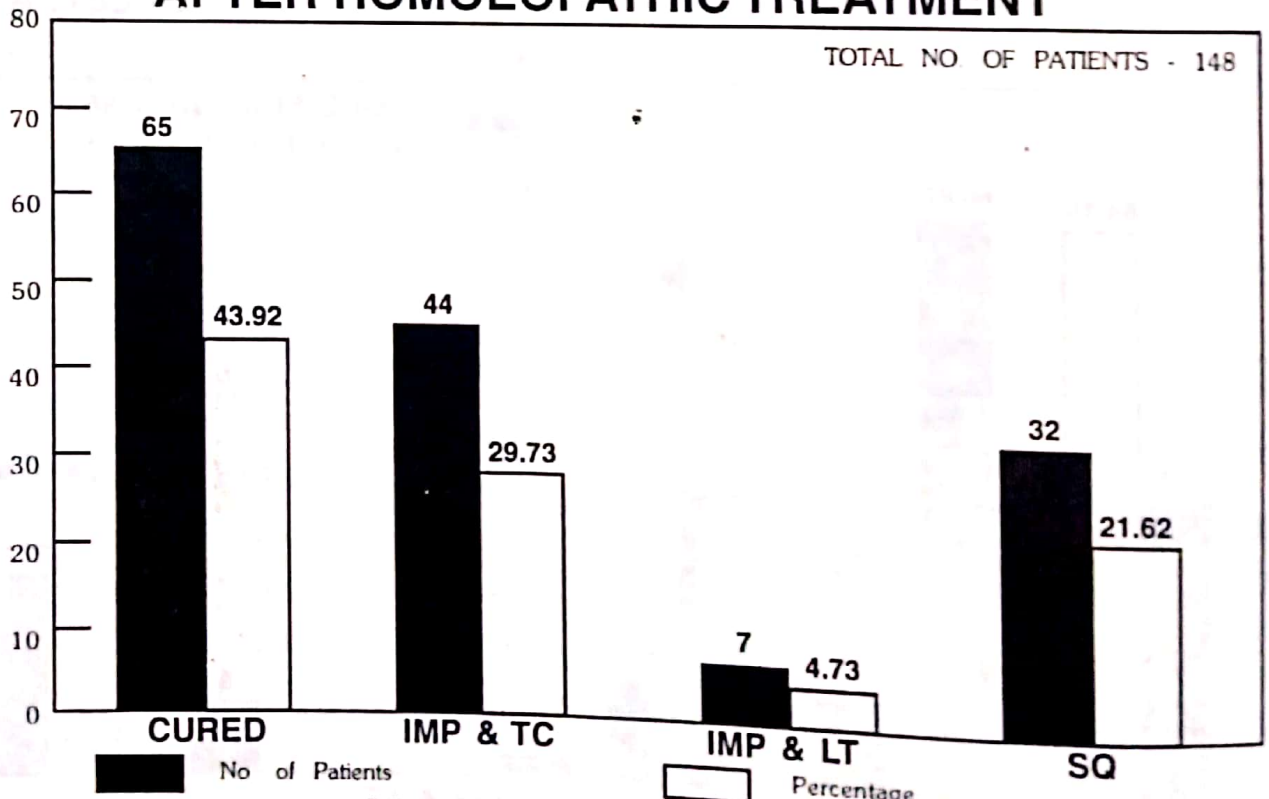
CASES OF PELVIC TUMORS FOLLOWED-UP BY ULTRASONOGRAPHIC ASSESSMENT



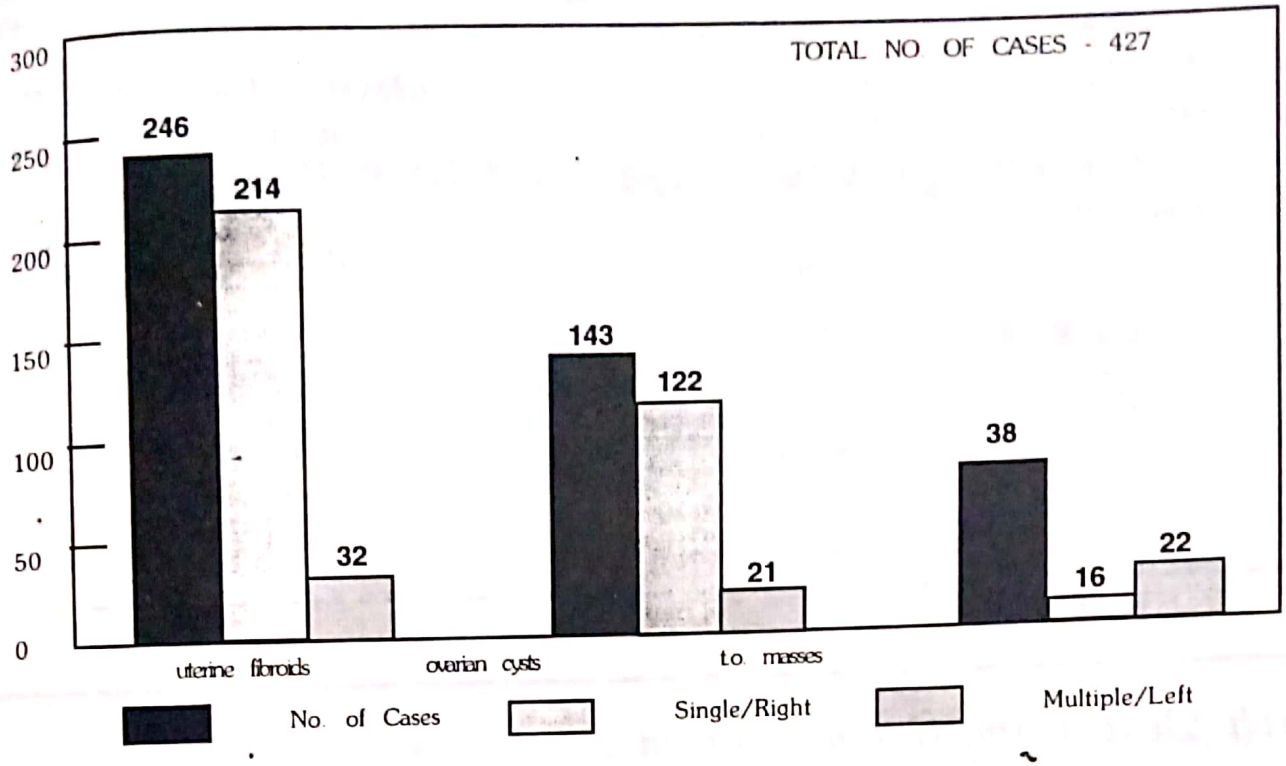
STATUS OF CASES OF PELVIC TUMORS AFTER HOMOEOPATHIC TREATMENT



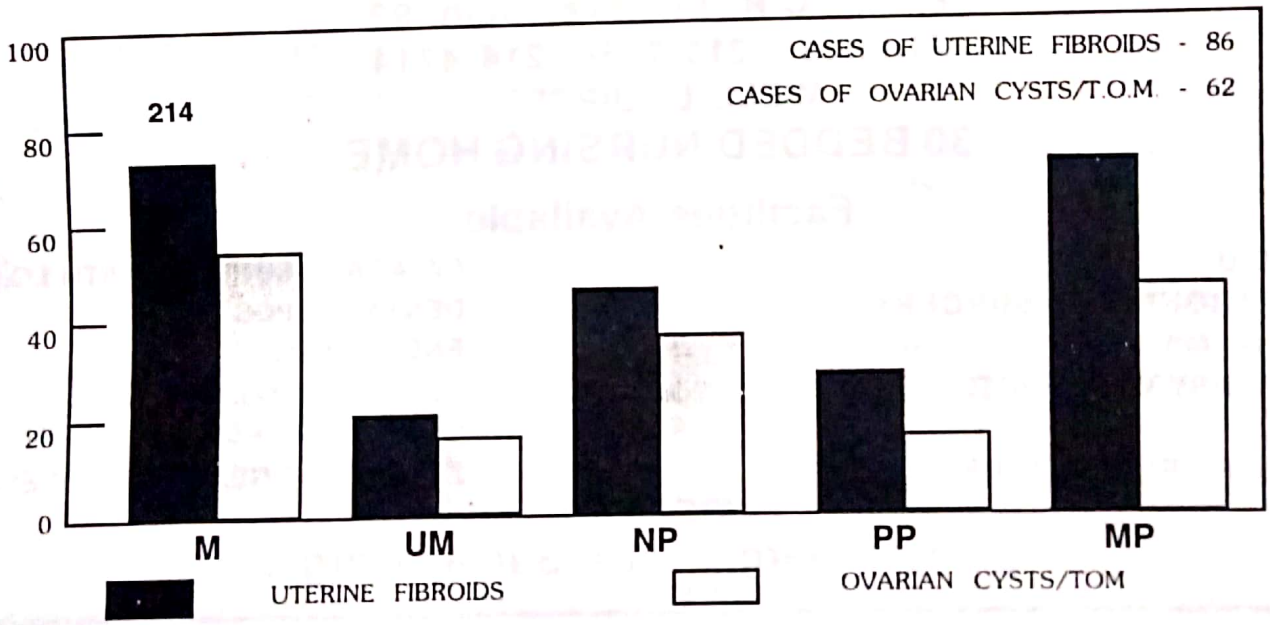
IMP = IMPROVING , TC = TREATMENT CONTINUED

LT = LEFT TREATMENT ; SQ = STATUS QUO

TOTAL NO. OF CASES OF PELVIC TUMORS SEEN DURING THE PERIOD 1988 - AUG. 1998



DIVISION OF CASES OF PELVIC TUMORS ACCORDING TO MARITAL STATUS AND PARITY



M - MARRIED, UM - UNMARRIED, NP - NULLIPARA

PP - PRIMIPARA; MP - MULTIPARA.

MAIN DRUGS USED IN PRESENT STUDY

CONSTITUTIONAL DRUGS	ORGANIC DRUGS	MOTHER TINCTURES
THUJA 1M, 10M, 50M	THYROIDINUM 30	THLASPI B.P. Q
LACHESIS 1M, 10M	SABINA 30	MILLEFOLIUM Q
SEPIA 1M, 10M	TRILLIUM 30	HYDRASTIS Q
CALCAREA CARB. 1M, 10M	CALCAREA IOD. 30	
PLUS AT, LLAIM, 10M	LILIUM TIG. 30	
	CIMICIFUGA 30	
	LAPIS ALBA 30	
	PALLADIUM 30	
	SECALE COR. 30	
	CONIUM MAC. 30	
	PHYTOLACCA 30	
	AURUM MUR NAT 3X	

HYPERTENSION CONCEPT OF HOMOEOPATHIC SYSTEM OF MEDICINE

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Principal Nehru Homoeopathic Medical College & Hospital

Hypertension is persistent elevation of blood pressure at which the morbidity & mortality rate is increased. In adults persistent systolic pressure of 140m.m of Hg or more or persistent diastolic pressure of 90 m.m. of Hg or more. It is just one symptoms of the malady which involves the entire constitution with specific attention to the symptom of congestion of circulatory system. The flow of blood through its vessels is deranged. About 20-30% adults in the urban area & 10-15% adults in rural area have hypertension in our country. Men & Women have the same risk of developing hypertension.

Concept of Health, Disease-Hypertension

A practitioner of modern system of medicine will subject to through clinical and laboratory investigations. The Chemical and structural components of physical body i.e. the physico-chemical hypothesis and its direct laboratory evidence is the basis of diagnosing any disease. According to them health is a condition of absence of any static morbid lesion detectable by their chemical examination or special investigations and disease is a condition where such static morbid lesions can be trace out. Health is the balanced state of body and mind of an individual. When we are healthy we enjoy normal sensations and functions because both body and mind work in a harmonious way, being controlled by immaterial life substance. Normally, the activities of the body and mind-Sensations, Functions, willing understanding, memory, thinking etc. are maintained but remarkable disharmonies like abnormal sensations, abnormal cravings and aversions, timodity, nervousness etc. are commonly neglected and are often not noticed but when the abnormality increase to the extent that one is not in a position to perform normal activities then only a physician is asked to intervene. Human being is not a chemical equation. It comprises multidimensional levels and slight disturbance at any level causes ripples of effects, to flow both ways.

The prevalent classification given in text book of medicine is not followed in Homoeopathy because:

(a) Disease gives its manifestations in sensations first and the pathological changes in the tissues and organs come at a later stage.]

(b) There is over emphasis of the significance of pathological changes in the tissues.

(c) The science of pathology and diagnosis is changing every day.

(d) There are diseases, which cannot be diagnosed because of paucity of data. Their treatment will be impossible if treatment is diagnosis based.

(e) They consider common symptoms as a specific tittle and start specific treatment. Homoeopathy Believes in individualization.

The practitioner of other school, restricts to the objective material aspects of disease with total indiference to subjective aspect. Concern is with common features of a particular form of disease and the total neglect of uncommon features of particular case The static material and results of dynamic life processes hardly takes into account the later processes which are manifested by various subjective phenomena.

Disease is dynamic derangement of the spiritual self acting, all pervading vital force and chronic diseases are caused by a predisposition of predisposing weakness of the defense mechanism of the body, which is termed as MIASM (morbific agent) and is responsible for the true constitutional pathology. Complete cure takes longer time as the prescriber systematically peels off layer upon layer of predisposing weakness by by carefully prescribuing each remedy based on the totality of symptoms. In broad classification, the disturbances can be of three types only.

(1) Deficiency or Hypofunctional physiology - PSORA MIASM.

(2) Excess or Hyperactive, anatomical Hyperplasia - SYCOSIS MIASM.

(3) Deviation or Dystrophies dysfunction and degeneration

- SYPHILTIC MIASM

Hypertension is caused by dynamic influence of any morbific agent (MIASM). It may be psoric, sycotic or of syphilitic dimension or a combination of two or three miasms. In psoric dimensions there is stress both at emotional and physical level- Excitement Anger, Anxiety, Worries, Tension, Shock due to financial loss, loss of dear ones etc. over a period of time when this factor settles down more likely, the elevated level of blood pressure may stettle down to normally. In sycotic dimension. this elevation could be due to metabolic changes following some systemic disorders like Diabetes Mellitus or prolinged use of contraceptive pills or Neoplastic growths causing pressure symptoms. Atherosclerosis; Renal Disorders, coaractations of Aorta or even spasms in the vascular system. In syphilitic dimension, there will be widespread destructive changes in the vital organs of the body such as hear, kidney, Retina etc.

TREATMENT

The aim of Homoeopathic physician is never to lower the blood pressure per se. but to permanently annihilate entire diseased condition of the individual as a whole as depicted by his totality of symptoms. The management of the patient rather than the disease is most important.

Homoeopathic physician identifies the stage at which the patient has presented him self before the treatment is instituted. Normally the folliwing group of patients, seek help for Homoeopathic treatment.

Group I - Who seek helf for altogether some other complaint having no apparent relation to hypertension but on exmination shows elevated blood pressure.

Group II - Patients who come with signs and symptoms of hypertension and want to be examined for those conditions.

Group III - Patients who are confirmed hypertensive and are on regular anti-hypertentive drugs or on diuretics and seek help to get over those drugs, which need to be taken life long and for their side effects.

Group I & II can be treated under Homoeopathic care by taking full history and fix him up at the appropriate stage of the disease. It is necessary to determine the cause of the onset of the disorder and whether the stage is functional or reversible structural or irreversible structural. For treating Group III, Significant points in the detailed history of the patient are very important. One should not normally discontinue the anti-hypertensive treatment that he is on at that time. Sudden withdrawal of the drugs may cause more harm than doing good to the patient. The physiological drugs may be gradually withdrawn keeping the vital paramenters in mind.

MEDICINAL TREATMENT : Drug often used in different groups are-

Psoric Dimensional Hypertension: Aconite; Ignatia; Coffea cruda; Belladonna; Glononine; Nux Vomica; Nat mur; Liliumm Tig, Spigelia; Passiflora incarnate; Staphysagria etc.

Sycotic Dimensional Hypertension :

Lycopodium; Spongia; Baryta mur; Calcaria carb; graphites; kali carb etc.

Syphilitic Dimensional Hypertension :

Aurum Met; Baryta Carb; Lachesis; Phosphorus; Silicea; Arnica Mont; Ars album; Aur Mur; Naja;Kalmia etc.

Palliation drugs : Like Adonis, Apocynum, Iberis, Laurocerasus, Lycopus, Strophanthus, Rouwolfia etc. are after given in the form of mother tincture on pathological basis, which may be needed when pathology is advanced and the condition is unresponsive.

Remedy will depend on the characteristic individualizing features of the case.

A specific remedy for the particular case in hand is to be found out. Homoeopathic treatment based on finding the similimum to match the essence of totality of the case forms the basis of therapeutic endeavor in cardiac problems.

ACCESSORY MEASURES :

MODERATION in all things should be the guiding principle.

EXERCISE for those who lead sedementary life style. Long brisk walk produces a feeling of well being Skin becomes more flexible and the face looks alive. It builds self esteem. It is an excellent way to work off tension. It results in better mental attitude and frame of mind thus resulting in improved thinking. It promotes feeling of Euphoria, Tranquillity and Relaxation.

Weight reduction- Should be about 2 kg per month as rapid weight loss is difficult to sustain.

Diet- Vegetarian or high fibre diet is recommended.

Stress- is contribution factor to most

of the cases of hypertension. There are 2 ways to over come stress.

(a) ***Eliminating the stressors*** - which may not be possible.

(b) ***Reducing the reaction to stressors***- Work done with relaxed mind and without meeting dead line does not lead to stress in the creation of mind Struggle, Responsibility & Ambition can be avoided by Rest, Recreation & Relaxation.

Learning to adopt. Developing a new philosophy of life and changing one's attitude towards the world and life situations in general is the essence.

HOMOEOPATHIC MEDICINES HAS POWER TO CURE GALLSTONES

Dr. Pankaj Bhatnagar DHMS (Delhi)
Ex. Member Central Council of Homeopathy
Ministry of health & Family Welfare
(Govt. of India)

WHAT IS A GALLBLADDER?

It is a pear shaped organ situated in a fossa, on inferior surface of liver.

WHAT IS ITS WORK?

It act as a reservoir of bile, and releases it into the duodenum, when required.

It also absorbs water & concentrate bile.

WHAT IS A GALL STONE?

When stones are present inside the gallbladder, it is known as gallstones or Cholelithiasis.

WHAT IS A GALLSTONE MADE UP OF?

75% of stones are made up of cholesterol and other calcium salts like calcium Bilinubinate, calcium phosphate, calcium carbonate, calcium palmitates. Rest of 25% of stones are made up of pigments especially calcium Bilinubinate only. (more common in developing countries)

HOW ARE GALLSTONES FORMED?

The normal gallbladder also absorb small amounts of a loose bile salt cholestrol compound. When gall bladder is inflamed, the concentration function becomes abnormal & bile salts alone are absorbed, leaving cholestrol behind. Cholestrol is transported in form of micelle & vesicle, gall stone formation requires a nucleus to initiate the precipitation of cholesterol crystal known as nucleation step, followed by aggregation of crystals into macroscopically visible stone known as aggregation step.

In short,

MICELLE + VESICLE
└ CHOLESTEROL ┘
SUPERSATURATION
|
NUCLEATION
|
CHOLESTEROL CRYSTALLIZATION
|
AGGREGATION
|
STONE

WHAT ARE RISK FACTORS FOR GALL STONES FORMATION?

Racial, increased age, female sex, obesity, increased parity, diabetes mellitus, parenteral nutrition, High caloric diet, lack of dietary fibres, Estrogen and oral contraceptive use, rapid weight loss etc.

In short,

Fat, Fertile, Flatulent Female, above forty - fifty age gp.

WHAT ARE SYMPTOMS, PATIENTS COMPLAINS OF?

If a gall stone become acutely inpacted in the cystic ductt, the patient will experience Pain, of sudder onset & sustained for about 2 hours. Pain is felt in epigastrium in 70% of patient. Rest of 30% felts pain in right upper quadrant. The term Biliary colic is misnomer because pain does not rhythmically increase & decreases in intensity as in colic of rental and intestinal disease.

However, 80-90% of gallstones are Asymptomatic. This means, without any symptom.

WHAT INVESTIGATIONS ARE DONE TO RULE OUT GALLSTONES?

1. In 20% of patient, plain abdominal radiograph will demonstrate calcified gall stone
2. Rest of 80% patient, usually require Ultrasonography.
3. Also oral cholecystography can be used
4. Also computed tomography can be used.

WHAT ARE COMPLICATIONS OF GALL STONES, IF LEFT UNTSEATED?

In gallbladder, stones can lead to, Inflammation of gall bladder - acut echolecystitis, chronic cholecystitis, hydrops of gallbladder, mucocele, porcelain gallbladder & also later on carcinoma gallbladder.

WHAT IS ROLE OF HOMOEOPATHY IN GALL STONES?

Homoeopathy is a system of therepeutics developed by Dr. Samuel Hahnemann based on natural law of healing which means that likes are cured by likes.

Homoeopathic medicines before being given to the patients, are proved upon healthy human beings, via Drug proving.

We prescribe only those medicines, whose medicinal properties, are known through drug proving.

1. A female patient, named Deepika, Age 25, with the diagnosis.

Us done on 4-5-98 : Gallbladder have at least 40-50 Echogenic calculi 4-12mm in size, are seen freely floating in GB lumen.

(After taking treatment) (for 2 months) Us done on 7-7-98 : Gall bladder shows fine Echogenic sand like calculi No mass seen.

2. A female patient, Mrs. Angoori devi, 55 yrs. of age reported, with pain in abdomen & with diagnosis of choleti thiasis.

Us done on 19-05-97 : Gallbladder is Contracted & its lumen reveals (60-70), echogenic calculi 3-5 mm in size is seen.

(After taking treatment for 6 months) Us done on 16-01-98 : Gall bladder is Contracted. Echogenic fine pin point shadows presenting sand like calculi are seen in its lumen mseperable from eachother.

(3) Smt. Sumitra, Age 65, reported with pain & heaviness in Abdomen.

Us done on, 23-05-97 : Says at least 18-20 Echogenic calculi 5-6mm insize are seen, freely floating in its lumen.

After taking treatment for 3 months.

Us done on, 16-08-97 : Approx, 15-18 Echogonic calculi 2-4 mm in size are seen freely floating in its lumen.

Us done on, 1-12-97 : Gall bladder shows fine echogenic sand like calculi inseperable from each other.

(4) Another Lady Mrs. Sunita, was treated successfully.

Us done on 09-04-97 : At least 25-30 Echogenic calculi are seen in its lumen 3-10 mm size. After taking treatment, for 3 months.

Us done on 01-07-97 : Gall bladder shows 15-20 calculi, 2-5 mm in size seen in its lumen.

Us done on 05-11-97 : Numerous echogenic sand like calculi are seen, inseperable from each other.

Us done on 26-03-98 : Echogenic focri, pinpoint in size, inseperable from each other seen. No mass.

(5) Mr. Tejinder, 40 yr of age, was treated for his gall stones.

Us done on 17-08-96 : Gallbladder shows multiple approx 4mm calculi, at least 40-50 are seen fvealy floating in its lumen.

(After treatment for 6 months) Us done on 6-2-97 : Gall bladdes shows multiple pinpoint, sand like particles, 1-2 mm size, seen in its lumen.

(6) Mrs. Nirdesh, Age 31, was cured of Her stones.

Us done on 19-05-97 : Gall bladder shows, numerous echogenic calculii 3-5 mm size, densly packed to gether.

(After treatment for 2 months) Us done on 30-07-97 : Numerous 2-5 mm Echogeinc calculii are seen densely packed in its lumen.

Us done on 29-09-97 : Its lumen reveals numerous calculi 2-4 mm size, packed together densely.

Us done on 23-03-98 : Its lumen reveals fine echogenic sand like calculi, inseperable from each other. No mass seen.

(7) Another female pt. Mrs. Rajni, 36 yr. of Age is under treatment for her gallstones.

Us done on 12-05-98 : Gall bladder showsl multiple 40-50 Echogenic calculi, 3 mm size of wall, seen.

(After treatment for 2 months) Us done on 30-07-98 :

At least 18-20 eclrogenic calculi are seen in its lumen.

She is under treatment till today

(8) Mr. Rampal, 65 yr. of Age, was Sucessfully treated for his gallsontes.

Us done on 19-03-98 : Gall bladder shows numerous at least 50-60 echogenic calculii seen in its lumen, ranging from pinpoint to 15 mm in size.

After taking treatment, just for 3 moths.

Us done on 20-06-98 : Gall bladder lumen reveals numerous echogenic sand like calculii inseperable from each other.

(9) Ms. Chanchal, 55 yr. old female, was treated successfully.

Us done on 14-04-95 : Gall bladder distended & multiple hyperechoic shadows suggestive of cholethiasis After taking treatment for 1 Yr.

Us dond on 15-03-96 : Gall bladder shows no mass or no calculus in lumen.

(10) Mrs. Sudesh Roday, 42 Yr. old female was also cured sucessfully

Us done on 21-11-97 : Gall bladder distended, with multiple micro calculii 2 mm. thin sludge formation

After taking treatment, for 2 months.

Us done on 17-01-98 : Gall bladder lumen shows a soft tissue mass, not moving with change of position further.

Us done on 08-04-98 : Gall bladder has normal shape. No mass or calculus seen in its lumen.

(11) Mrs. Samina Khatoon, a muslim female came to for her gall stone.

Us done on 05-02-98 : Gall bladder shows at least 50-60 echogenic calculii 4-8 mm in size are seen.

After taking treatment for 6 months.

Us done on 18-08-98 : Gall bladder showes numerous sand like echogenic calculii 2-3 mm size seen.

(12) Mr. Shareef Ali, Age 70 Yr. A Muslim Male, came to for her gallstones.

Us done on 22-06-95 Gall bladder large in size and a hyperecloic seesile shadon is seen, attached to posterior wall.

After treatment for 5 months.

Us done on 08-11-95 gall bladder have no mass or calculus seen in its lumen.

(13) Mr. Mahender 28 Yr. old, Pt. was cured of his gallstones.

Us done on 29-12-95 gall bladder shows multiple luminal calculi as echogenic lesion suggestive of cholelithiasis.

After taking treatment for 5 months.

Us done on 29-05-96 : Gall bladder lumen shows multiple calculi 3-4 mm in size in its lumen.

After further treatment, for next 6 month.

Us done on 08-11-96 : Gall bladder shows numerous fine pin point echoes in its fossa.

A combination of following medicines are given to all patients i.e. corduns MQ, Cheld Q Puls Q, Lyco Q Berb Vul Q Apis 6 cale flour 6 mix all medicines in equals parts/15 drops to be taken four times a day for 3 months review ultra sound suggested decrease in number any infection of gall bladder and size of stones.

This prescription may look absured to many but try to give a proper try in your practise in cases which you are going to refer to a surgeon.

Request to I.S.M.&H. Physicians to Join A.I.I.M.G.A.

अपील

डॉ० डी० आर० दीक्षित *(चैयरमैन भूदान कमेटी)*

सदा की भान्ति इस वर्ष भी ऑल इण्डिया इण्डियन मैडिसिन ग्रेजुएट्स एसोसियशन द्वारा भगवान धन्वन्तरी जयन्ती समारोह बडे हर्षोल्लास से आयोजित किया जा रहा है। यह प्रसन्नता का विषय है कि केवल धन्वन्तरी दिवस ही नहीं, इस संस्था द्वारा वर्ष में अन्य अनेक अवसरों पर भी उत्सवों का आयेाजन किया जाता है। जिसमें भारतीय चिकित्सा पद्धति के बढावा देने, इस क्षेत्र में सलग्न महानुभावों को सम्मानित करने आदि को विशेष महत्व दिया जाता है, और ये सभी समारोह सफलता पूर्वक सम्पन्न होते रहे हैं।

परन्तु अखिल भारतीय स्तर की इस रजिस्टर्ड संस्था के द्वारा आयोजित होने वाले हर समारोह के अवसर पर एक विशेष कठिनाई का सामना करना पड़ता है। वह है इस संस्था का अपना निजी कोई भवन न होना, जिसके कारण हर बार किराये का स्थान ढूंढना पड़ता है, जिसमें अनेक कठिनाईयों का सामना करना पड़ता है। और धन का भी अपव्यय होता है। अतः संस्था का अपना एक भवन होना नितान्त आवश्यक है।

संस्था के अपने भवन के निर्माण–हेतु सर्वप्रथम भूमि की आवश्यकता होती है। जिसके लिये सरकार / डी. डी. ए. उचित मूल्य पर भू–खण्ड उपलब्ध करा सकती है, परन्तु भू–खण्ड का मूल्य चुकाने एवं भवन निर्माण के लिये सर्वाधिक आवश्यकता है आर्थिक सहयोग की। जिसके लिये समस्त सहयोगी, इस, संस्था के संरक्षक एवं हितचिन्तकों से विशेष अपेक्षा रहेगी। उनके द्वारा दिया गया पैसा 80जी के अन्तर्गत कर मुक्त होगा।

यद्यपि इस ओर कुछ महानुभावों ने दस – दस हजार रुपये देने का वचन दिया है और कुछ एक ने अपना योगदान देने में पहल करके इस शुभ कार्य का श्री गणेश करते हुए हमारा मनोबल बढ़ाया है, यद्यपि हम सब को इस अत्यन्त आवश्यक एवं पुनीत कार्य की पूर्ति के लिये जी जान से जुट जाना होगा।

एक कवि के अनुसार,

'रूकने से पहले जरा ओर चल लें, अभी पॉव टूटे नही हैं थकन से'।

आदरणीय सदस्य/पाठक गण

मुझे वर्ष 1997 एवं वर्ष 1998 की स्मारिकाओं का सम्पादन करने का अवसर प्राप्त हुआ। मैंने स्मारिकाओं को उत्तम बनाने का हर संभव प्रयास किया इस प्रयास मे मैं और मेरे सभी साथी सम्पादक कितने सफल हुए, भविष्य में अधिक उत्तम कैसे बनाया जा सकता है कृपया अपनी राय एवं सुझाव अवश्य भेजें। हमें इंतजार रहेगा।

डॉ० अब्दुल हसीब *मुख्य सम्पादक*

श्रद्धांजली

भारतीय चिकित्सा पद्धति के चिकित्सक एवं लम्बे समय तक चिकित्सक के रूप में मानवता की सेवा में संलग्नहकीम अब्दुल हफीज, कविराज वेदव्रत शर्मा एवं डा० नरेन्द्र कुमार आहूजा का इस वर्ष स्वर्गवास हो गया है। यह विधि का विधान है कि रोगियों को स्वस्थ लाभ पहूंचाते हुए स्वयं चिकित्सक भी ऐसे स्थान पर आ जाते हैं जहां अन्ततः इस नशवर शरीर का परित्याग करना पडता है। इस समय प्रत्येक मनुष्य इतना विवश हो जाता है कि कुछ कर नहीं पाता। परिवार के एक सदस्य का हमेशा के लिये बिछड़ जाना कितना दुखदाई होता है इस दुख: भरे समय में एमगा के सभी सदस्य संवेदना व्यक्त करते हैं एवं ईश्वर से प्रार्थना करते हैं शोकाकुल परिवार के सभी सदस्यों को इस दुख को सहने की शक्ति प्रदान करे एवं महान आत्मा को शांति प्रदान करें

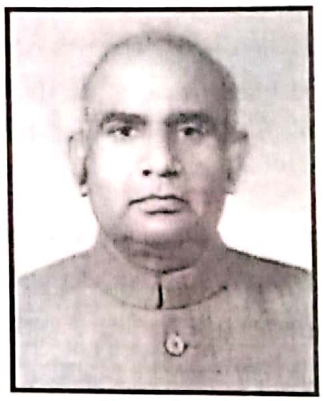
जाने वाले की रह जाती हैं यादें एवं महान कार्य जो अपने-अपने जीवन में किये हैं। एमगा की और से श्रद्धा सुमन अर्पित करता हूँ।

अध्यक्ष डॉ० जे० एस० पंवार

स्व० हकीम अब्दुल हफीज
(- (1998)

जीवन परिचय

नजीबाबाद, जिला बिजनौर, (यू० पी०) में जन्म हुआ। पिता स्व० हकीम अब्दुल हकीम एक विख्यात चिकित्सक थे। उनके पूर्वज भी चिकित्सक थे। तिब्बिया कॉलिज लखनऊ से उपाधि ग्रहण करने के पश्चात् चिकित्सा कार्य आरम्भ किया। मदरसा (स्कूल) फारूक-उल-उलूम के संस्थापक एवं मैनेजर थे। विभिन्न संस्थाओं में मानद पदों पर रहे, हमदर्द दवाखाना आसिफ अली रोड़ दिल्ली में वरिष्ठ चिकित्सक के रूप में भी चिकित्सा कार्य किया। 27 मार्च 1998 को स्वर्गवास हो गया। परिवार में धर्म पत्नी, तीन बेटे, पाँच बेटिया हैं। सबसे बड़े बेटे डॉ० अब्दुल हसीब एमगा के सक्रिय सदस्य हैं।



स्व० कविराज वेदव्रत शर्मा
(1938-1998)

जीवन परिचय

1 जुलाई 1938 में ग्राम मौहम्मद पुर-रायसिंह जिला मुजफ्फर नगर (यू० पी०) में जन्म हुआ। पिता स्व० वेद जगदीश प्रसाद शर्मा विश्व विख्यात चिकित्सक थे। 1961 में आयुर्वेद एण्ड यूनानी तिब्बिया कॉलिज करोल बाग दिल्ली से बी० आई० एम० एस० की उपाधि ग्रहण कर चिकित्सा कार्य आरम्भ किया। राष्ट्रपति के मानद चिकित्सक थे। अहिंसा आयुर्वेदिक कॉलिज के संस्थापक प्राचार्य, कई संस्थाओं में प्राध्यापक थे। विभिन्न संस्थाओं में अध्यक्ष, महासचिव, सलाहकार, निदेशक एवं सदस्य थे। अनेक विदेशों में आयुर्वेद प्रचारार्थ यात्रा की 24 मई 1998 को देहान्त हो गया। उनके परिवार में धर्म पत्नी, पाँच बेटे एवं एक बेटी है सबसे बड़े बेटे वेद अरविन्द शर्मा जी हैं।

स्व० डॉ० नरेन्द्र कुमार आहूजा
(1956-1998)

जीवन परिचय

5 फरवरी 1956 को हरियाणा के एक ग्राम में जन्म हुआ। 1981 में आयुर्वेद एण्ड यूनानी तिब्बिया कॉलिज करोल बाग दिल्ली से बी० ए० एम० एस० की उपाधि ग्रहण कर हरियाणा में चिकित्सक का कार्य आरम्भ किया। एमगा के सक्रिय कार्यकर्ता थे। 2 सितम्बर 1998 में स्वर्गवास हो गया। परिवार में धर्मपत्नी एक बेटी एक बेटा है।

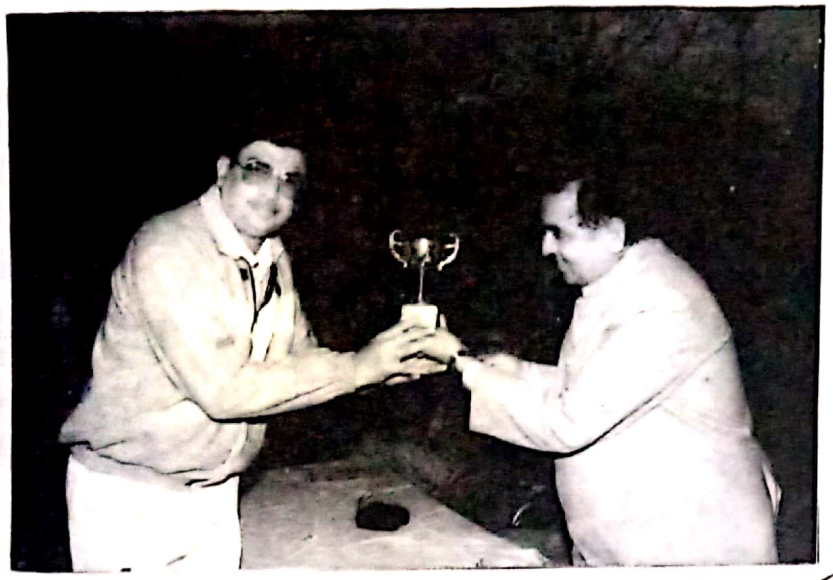
Hon'ble Deputy Mayer of Delhi, Shri Mahandra Singh
Opening the Sports Tournament-1998.

Sports
A.I.I.M.G.A.

Hon'ble Deputy Mayer of Delhi, Shri Mahandra Singh
and Dr. J.S. Panwar, (President)

A View of Tournament

A View of Tournament

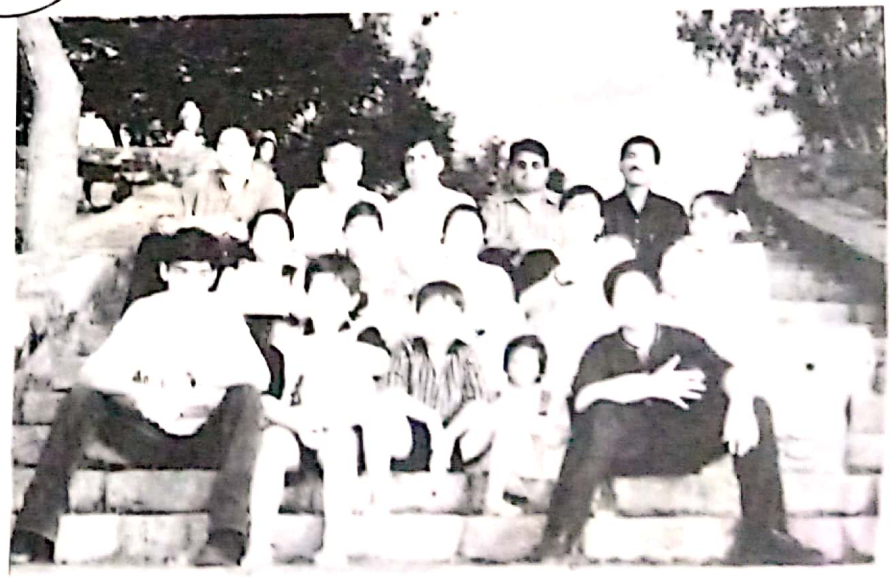


Dr. Mahesh Goar is receiving Troffy from
Mr. Madan Lal Gaba (M.L.A)

Sports
A.I.I.M.G.A.

A View of Tournament

Closing Ceremony of Tournament by Mr. Madan Lal Gada (M.L.A),
Dr. O.P. Vashisth, Dr. J.S. Panwar, Dr. R.P. Panchal



A Picnic Organisted by East-II Zone at Suraj Kund

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यूनानी चिकित्सा प्रणाली बोर्ड का चुनाव कराने की मांग

सहारा समाचार

नयी दिल्ली, 23 जून। भारतीय चिकित्सा पद्धति के चिकित्सकों की संस्था आल इंडिया इंडियन मेडिसिन ग्रेजुएट्स एसोसिएशन ने प्रदेश के स्वास्थ्य मंत्री को पत्र लिखकर अपनी समस्याओं से उन्हें अवगत कराया है। संस्था के अध्यक्ष डा. आर.पी. पांचाल ने यह जानकारी दी है।

स्वास्थ्य मंत्री को लिखे पत्र में आयुर्वेदिक एवं यूनानी चिकित्सा प्रणाली बोर्ड के पुनः चुनाव कराने की मांग प्रमुखता से की गयी है। स्वास्थ्य मंत्री को बताया गया कि सन् 1987 के बाद से इस बोर्ड का चुनाव नहीं हो सका है, जबकि नियमानुसार यह पांच वर्षों के अन्तराल पर होते रहना चाहिए।

पत्र में गत वर्ष दिल्ली नगर निगम की डिस्पेंसरियों में अनुबंध आधार पर डाक्टरों की भर्ती के लिए मांगे गये आवेदनों का मुद्दा उठाते हुए शिकायत की गयी है कि भारतीय चिकित्सा पद्धति के किसी चिकित्सक को नहीं बुलाया गया।

एक ओर स्थिति यह है कि निगम की डिस्पेंसरियों में चिकित्सकों के 30 पद रिक्त हैं वहीं इन पदों के लिए आवेदन कर चुके युवा चिकित्सक अभी तक बेरोजगारी की मार झेल रहे हैं। खास बात यह है कि इन आवेदकों को दो बार प्रदेश सरकार के प्रधान सचिव (स्वास्थ्य) कार्यालय से साक्षात्कार के लिए बुलावा आया, मगर हर बार साक्षात्कार का कार्यक्रम ऐन मौके पर रद्द कर दिया गया। संस्था ने स्वास्थ्य मंत्री से इस ओर ध्यान देने तथा भारतीय चिकित्सा पद्धति के चिकित्सकों की समस्याओं के निवारण की मांग की है।

राष्ट्रीय सहारा

सस्थागत प्रशिक्षित डाक्टर प्रधानमंत्री से मिले

सहारा समाचार

नयी दिल्ली, 8 अप्रैल। आल इंडिया इंडियन मेडिसन ग्रेजुएट्स एसोसिएशन (एमगा) के एक प्रतिनिधिमंडल ने प्रधानमंत्री अटल बिहारी वाजपेयी से उनके निवास पर मुलाकात कर उन्हें भारतीय चिकित्सा पद्धति के संस्थागत प्रशिक्षित चिकित्सकों की परेशानियों से अवगत कराया। एमगा के दिल्ली प्रदेशाध्यक्ष डा. आरपी पांचाल की अगुआई में गये प्रतिनिधिमंडल ने प्रधानमंत्री को एक ज्ञापन भी दिया। एमगा अध्यक्ष द्वारा आज यहां जारी विज्ञप्ति के [illegible] कि भारतीय चिकित्सा पद्धति के संस्थागत चिकित्सकों को ड्रग एंड कास्मेटिक एक्ट-1995 में संशोधन के जरिये रजिस्टर्ड मेडिकल प्रेक्टिशनर श्रेणी में शामिल कर लिया गया था। तब इसका आधार उनकी पढ़ाई के दौरान आधुनिक दवाइयों की शिक्षा व प्रशिक्षण पाठ्यक्रम में शामिल पाया जाना माना गया था।

डा. पांचाल के अनुसार भारतीय चिकित्सा पद्धति के चिकित्सकों के लिए भारत सरकार ने 1970 में अलग से भारतीय चिकित्सा केन्द्रीय परिषद का गठन किया था। अब इन चिकित्सकों की समस्या यह है कि इनके द्वारा आधुनिक पद्धतियों की दवाइयों के प्रयोग को नाजायज कहकर इस पर रोक लगायी जा रही है।

राष्ट्रीय सहारा 8-4-98

पंजाब केसरी

आयुर्वेदिक एवं यूनानी चिकित्सा प्रणाली बोर्ड की उपेक्षा का आरोप

नई दिल्ली, 23 जून (नि.स.)। भारतीय चिकित्सा पद्धति से जुड़े चिकित्सकों की प्रतिनिधि संस्था आल इंडिया मेडिसन ग्रेजुएट्स एसोसिएशन (एमगा) के अध्यक्ष डा. आर.पी. पांचाल ने दिल्ली सरकार पर आयुर्वेदिक एवं यूनानी चिकित्सा प्रणाली बोर्ड के प्रबन्ध की उपेक्षा करने तथा पिछले चार वर्षों से बोर्ड के चुनाव टालने का आरोप लगाया है। उन्होंने कहा कि देशी चिकित्सा प्रणाली बोर्ड के मरणासन्न हो जाने से देशी चिकित्सा पद्धति से जुड़े नए चिकित्सकों की उपेक्षा की जा रही है।

दिल्ली सरकार के स्वास्थ्य मंत्री डा. हर्षवर्धन को लिखे पत्र में डा. पांचाल ने कहा है कि जो आयुर्वेद व यूनानी चिकित्सा पद्धति के दवाखाने दिल्ली नगर निगम के पहले से ही चल रहे हैं उनमें भी चिकित्सक उपलब्ध नहीं हैं। दिल्ली नगर निगम का चुनाव 1997 में हुआ। इससे पहले दिल्ली नगर निगम का कार्यभार भी दिल्ली सरकार ही देख रही थी। आयुर्वेदिक चिकित्सकों की उपेक्षा करने का आरोप लगाते हुए उन्होंने कहा है कि दिल्ली सरकार ने फरवरी 1997 में प्रधान सचिव (स्वास्थ्य) श्री रमेश चन्द्र के आफिस में दो बार कान्ट्रैक्ट आधार पर चिकित्सा अधिकारी (आयुर्वेद) कुल वेतन 6000 रुपए मासिक आधार पर साक्षात्कार के लिए भारतीय चिकित्सा पद्धति के स्नातक चिकित्सकों के साक्षात्कार के लिए आवेदन मांगे थे। लेकिन इन पदों को भरने के लिए साक्षात्कार की तिथि हर बार आगे बढ़ा दी जाती है।

दिल्ली नगर निगम में भी भारतीय चिकित्सा पद्धति के रिक्त पड़े चिकित्सक पदों के लिए आवेदन पत्र जमा करवाए गए हैं लेकिन एक वर्ष से यह नियुक्तियां नहीं हो पाई हैं।

'तमक श्वांस' पर वैज्ञानिक संगोष्ठी आज

सहारा समाचार

नयी दिल्ली, 22 अगस्त। आल इंडिया इंडियन मेडिसन ग्रेजुएट्स एसोसिएशन (एमगा) की दिल्ली प्रदेश इकाई के तत्वावधान में तमक श्वास (ब्रोंकीयल अस्थमा) पर एक वैज्ञानिक संगोष्ठी का आयोजन किया जा रहा है। संगोष्ठी 23 अगस्त को इंडियन मेडिकल एसोसिएशन (आईएमए) हाल में की जायेगी। एमगा के अध्यक्ष डा. आरपी पांचाल ने यह जानकारी देते हुए बताया है कि तमक श्वास रोग राजधानी में व्याप्त वायु प्रदूषण के कारण बढ़ रहा है।

एमगा अध्यक्ष के अनुसार तमक श्वास रोग में आयुर्वेद व अन्य भारतीय चिकित्सा पद्धतियों के इलाज अत्यंत कारगर सिद्ध होते हैं। इस संगोष्ठी में इन्हीं सब तथ्यों पर विचार-विमर्श किया जायेगा। संगोष्ठी में भारतीय चिकित्सा पद्धतियों के अनेक चिकित्सा विशेषज्ञ भाग लेंगे।

पंजीकृत चिकित्सक विवाद में हरियाणा सरकार की याचिका रद्द

पानीपत, 4 अगस्त (सो.अ.)। बिहार से पंजीकृत चिकित्सक के हरियाणा में प्रैक्टिस करने के विवाद में सर्वोच्च न्यायालय ने हरियाणा सरकार की याचिका रद्द कर दी है।

हरियाणा आयुर्वेदिक मैडिसन एसोसिएशन के प्रधान मोहम्मद आजम ने उक्त जानकारी देते हुए बताया कि यह निर्णय सर्वोच्च न्यायालय के मुख्य न्यायाधीश एम.एम. पुंछी, न्यायमूर्ति टी थामस और न्यायमूर्ति सईद शाह कादरी की खंड पीठ ने सुनाया। उल्लेखनीय है कि यह वाद करनाल जिला के गांवपुरा में प्रैक्टिस कर रहे फूल सिंह के खिलाफ 10.6.82 को उस क्षेत्र के ड्रग इंस्पैक्टर द्वारा की गई कार्यवाही को लेकर प्रारम्भ हुआ था। इस वाद में 31.8.84 को सी.जे.एम. अदालत ने फूल सिंह को एक वर्ष के कारावास और 300 रुपए जुर्माना सुनाया था। इस निर्णय को जिला एवं सत्र न्यायालय ने बहाल रखा जबकि 20.9.85 को पंजाब-हरियाणा हाई कोर्ट ने उक्त निर्णय रद्द करते हुए फूल सिंह को जुर्माना की राशि भी वापस करा दी। हरियाणा सरकार ने वर्ष 85 में ही इस निर्णय को लेकर सर्वोच्च न्यायालय में याचिका दायर की जो कि 29.7.98 को रद्द कर दी गई।

हरियाणा आयुर्वेदिक मैडिसन एसोसिएशन ने इस निर्णय का स्वागत किया है। श्री आजम ने बताया कि 23 अगस्त को सोनीपत में होने वाली पंजीकृत वैद्यों की रैली में भी प्रैक्टिस के अधिकार की मांग को सरकार के सामने रखा जाएगा।

एमगा
समाचार दर्पण

हम सब ही प्रतिदिन एक या दो समाचार पत्र ही पढ़ पाते हैं। सभी प्रकाशित समाचार पत्र पढ़ पाना यदि असम्भव नहीं है तो कठिन अवश्य है। कभी आवश्यकता पड़ने पर समाचार पत्रों को लाईब्रेरी में भी खोज पाना कठिन कार्य है।

विभिन्न समाचार पत्रों में प्रकाशित उन सभी समाचार की कटिंग दी जा रही है जो एमगा से या भारतीय चिकित्सा पद्धति से सम्बन्धित है ताकि सभी सदस्य एवं पाठक प्रकाशित सभी समाचार का अवलोकन कर सकें यह पन्ने हमारी मिनी लाईब्रेरी के समान है जो वर्षों तक आवश्यकता होने पर उस की पूर्ति करते रहेंगे।

पूर्ण वर्ष तक, सभी समाचार पत्रों से, सम्बन्धित समाचार की कटिंग करना एवं इन सभी को अहतियात से रखने में हमारे सदस्य मुख्यतः डॉ० आर० पी० पाँचाल का योगदान है।

मुख्य सम्पादक :- डॉ अब्दुल हसीब

विज्ञान [illegible]
का अ[illegible]

- नवभारत टाइम्स 13-6-98

आयुर्वेदिक अस्पतालों का होना नहीं होने के बराब[र]

अनु जैन

नई दिल्ली। एक तरफ तो दिल्ली सरकार का स्वास्थ्य विभाग आयुर्वेदिक चिकित्सा प्रणाली को बढ़ावा देने के लिए बड़े बड़े दावे कर रहा है तथा हर अस्पताल में आयुर्वेदिक औषधालय खोलने की बात चल रही है वहीं दूसरी तरफ उसी के राज में दिल्ली नगर निगम द्वारा चलाए जाने वाले लगभग हर आयुर्वेदिक औषधालय का बुरा हाल है। इन औषधालयों में प्राथमिक चिकित्सा देने संबंधी सामान उपलब्ध नहीं है। आजकल गर्मियों के कारण राजधानी का लगभग हर व्यक्ति बुखार, दस्त, पेट के रोगों से परेशान है लेकिन इन औषधालयों में इन रोगों के उपचार [illegible] के लिए दवाइयां उपलब्ध नहीं हैं। कई औषधालयों का तो इतना बुरा हाल है कि कभी भी आसपास की दीवार गिर सकती है। यही नहीं, यहां डाक्टरों का भी अभाव है।

निगम की ओर से इस समय राजधानी में 95 आयुर्वेदिक औषधालय चलाए जा रहे हैं। लेकिन इनका होना या न होना बराबर ही है क्योंकि इनमें मरीजों के उपचार के लिए दवा तथा डाक्टर तक नहीं है। इस संवाददाता ने राजधानी में चल रहे कुछेक आयुर्वेदिक औषधालयों का बाकायदा मरीज बनकर दौरा किया, इनमें दरियागंज, सब्जी मंडी, मालवीयपुर, गीता कालोनी के औषधालय प्रमुख हैं। इन औषधालयों में रुई, पट्टी, प्लास्टर अथवा कोई एंटीबायोटिक दवा उपलब्ध नहीं है अगर हो भी तो गरीब मरीजों को नहीं मिल रही है।

गर्मी के कारण हर जगह दस्त, बुखार, पेट रोग के मरीज बढ़ रहे हैं लेकिन इन औषधालयों में दस्त की बीमारी में देने के लिए गंगाधर चूर्ण, गरपुर रस, बिलवादी चूर्ण तथा बुखार में देने के गोदंती भस्म, महासुदर्शन चूर्ण, आनंद भैरव रस, त्रिभुवन कीर्ति रस है ही नहीं। बेचारे मरीज आते हैं और उन्हें दवाई खरीदने के लिए बाहर का रास्ता दिखा दिया जाता है। बहुत से औषधालयों में तालीसादी चूर्ण और सीतोप्लादी चूर्ण भी नहीं है। उदर विकारों के लिए मुख्यतः मरीजों को लवण भास्कर चूर्ण, त्रिफला चूर्ण, हिंगवास्तक चूर्ण दिया जाता है लेकिन ये भी ज्यादातर औषधालयों से गायब रहता है। इसी प्रकार मूत्र विकार के लिए चंद्र प्रभावटी, पेट के कीड़ों के लिए कीमी कुठार रस भी मरीजों को नहीं मिल पा रहा है।

बहुत से औषधालयों की हालत भी बहुत खस्ता है। इनमें सब्जी मंडी, मालवीयपुर, अंधा मुगल, बख्तावर पुर के औषधालयों का नाम ले सकते हैं। गंदगी और घुटन के माहौल में मरीज अपने साथ और बीमारियां लेकर वापस आता है। निगम अधिकारी किसी भी समय जाकर देख सकते हैं। निगम के 35 औषधालय किराए की जगहों पर चल रहे हैं उनके रखरखाव की कोई भी पुख्ता व्यवस्था नहीं है। यहां मकान-मालिक को अपने किराए से मतलब है और निगम को औषधालय चलाने की खानापूर्ति से, कोई भी इमारत के रखरखाव, वहां फैली गंदगी को दूर करने के लिए पहल नहीं कर रहा है।

सूत्रों से पता चला है कि इस समय निगम में लगभग 30 डाक्टरों की कमी है। [illegible] दो औषधालयों में [illegible] पड़ती है। यह भी पता च[illegible] लोग हैं जिन्हें पदोन्नत [illegible] जा सकता है लेकिन यह [illegible] आधार पर बाहर से डाक्[टर] [illegible] रहा है। हालांकि चिकित्[सा] [illegible] समिति और नियुक्तियां [illegible] संबद्ध विषय समिति ने [illegible] है कि विभागीय कर्मचारि[यों] [illegible] बनाए जाएं। लेकिन अभी [illegible] है। इसके पीछे किसका [illegible] कोई वाकिफ है? इस बा[त] [illegible] पूछने के लिए निगम के [illegible] के दफ्तरों में कई बा[र] [illegible] लेकिन हर बार यही जवाब [illegible] है।

डा. पांचाल ने बताया कि वर्ष 1959 में लोकसभा एवं राज्यसभा में [illegible] में संशोधन करने के पश्चात ही भारतीय चिकित्सा पद्धति के संस्थागत चिकित्सकों को सम्मिलित किया गया था। उन्हें सम्मिलित करने का आधार भारतीय चिकित्सा पद्धति के संस्थागत चिकित्सकों को उनकी पढ़ाई के दौरान आधुनिक दवाइयों की शिक्षा एवं ट्रेनिंग उनके पाठ्यक्रमों के आधार पर ही सम्मिलित किया गया था। लेकिन यह आधार [illegible] के कारण उसका फल आज भारतीय चिकित्सा पद्धति के चिकित्सकों को भुगतना पड़ रहा है। एसोसिएशन का कहना है कि भारतीय चिकित्सा पद्धति के चिकित्सकों को आधुनिक दवाइयों को इस्तेमाल करने का अधिकार मिलना चाहिए।

दिल्ली भारतीय चि[कित्सा] परिषद बिल का वि[रोध]

राष्ट्रीय सहारा 6-10-98

नयी दिल्ली, 5 अक्तूबर। आल इंडिया इंडियन मेडिसन ग्रेजुएट एसोसि[एशन] [illegible] प्रदेश अध्यक्ष डा. आरपी पांचाल ने हाल ही में दिल्ली विधानसभा में पारित हु[ए] [illegible] परिषद 1998 विधेयक में खामियां बताते हुए इसका विरोध किया है। डा. पांचा[ल] [illegible] को विधानसभा में पेश किये जाने से पूर्व भारतीय चिकित्सा पद्धतियों से जुड़ी [illegible] किया जाना चाहिए था जो नहीं किया गया।

डा. पांचाल ने इसके नाम को भ्रामक बताते हुए इस पर आपत्ति की है। [illegible] भारतीय चिकित्सा परिषद में कुल 21 सदस्यों में से 11 को मनोनीत किये जाने [illegible] पांचाल का कहना है कि किसी भी संस्था में एक तिहाई से अधिक सदस्य [illegible] अलोकतांत्रिक है, जबकि इस विधेयक के द्वारा परिषद में आधे से अधिक सदस्[य] [illegible] किया गया है। एमगा ने विधेयक द्वारा चिकित्सकों को हर पांचवें साल रजिस्[ट्रेशन] [illegible]

बाद में
का रद

एमगा
समाचार दर्पण

हम सब ही प्रतिदिन एक या दो समाचार पत्र ही पढ़ पाते हैं। सभी प्रकाशित समाचार पत्र पढ़ पाना यदि असम्भव नहीं है तो कठिन अवश्य है। कभी आवश्यकता पड़ने पर समाचार पत्रों को लाईब्रेरी में भी खोज पाना कठिन कार्य है।

विभिन्न समाचार पत्रों में प्रकाशित उन सभी समाचार की कटिंग दी जा रही है जो एमगा से या भारतीय चिकित्सा पद्धति से सम्बन्धित है ताकि सभी सदस्य एवं पाठक प्रकाशित सभी समाचार का अवलोकन कर सकें यह पन्ने हमारी मिनी लाईब्रेरी के समान है जो वर्षों तक आवश्यकता होने पर उस की पूर्ति करते रहेंगे।

पूर्ण वर्ष तक, सभी समाचार पत्रों से, सम्बन्धित समाचार की कटिंग करना एवं इन सभी को अहतियात से रखने में हमारे सदस्य मुख्यतः डॉ० आर० पी० पांचाल का योगदान है।

मुख्य सम्पादक :- डॉ अब्दुल हसीब

विज्ञान पर किसी क्षेत्र विशेष का अधिकार नहीं : जोशी

नई दिल्ली, 20 मई (वार्ता)। विज्ञान और प्रौद्योगिकी मंत्री डा. मुरली मनोहर जोशी ने कहा कि विज्ञान पर किसी क्षेत्र विशेष का एकाधिकार नहीं है इस क्षेत्र में भारत अपने मानक स्वयं तय करेगा।

डा. जोशी यहां आयुर्वेद चिकित्सा पद्धति पर आधारित पुस्तक वनौषधि सार संग्रह का विमोचन कर रहे थे। आयुर्वेद चिकित्सा पद्धति के लिए संदर्भ पुस्तक का काम करने वाली इस पुस्तक का संपादन केंद्रीय वैज्ञानिक और औद्योगिक अनुसंधान परिषद के वैज्ञानिक डा. देवेंद्र शर्मा ने किया है।

डा. जोशी ने कहा कि मोहन जोदड़ो की सभ्यता के समय से ही हमारे देश के अपने मानक हैं। हमारे वैज्ञानिकों को देश की उपलब्धियों का विश्लेषण और परीक्षण करना चाहिए। उन्होंने कहा कि वनौषधियों के गुणों को समग्रता से देखे जाने की आवश्यकता है। डा. जोशी ने कहा हमें किसी का अनुकरण नहीं करना चाहिए। उन्होंने वैज्ञानिकों और चिकित्सकों से आग्रह किया वे आयुर्वेद चिकित्सा पद्धति पर काम कर रहे वैद्य समाज के साथ मिलकर काम करें।

इस अवसर पर संसद सदस्य स्वामी चिन्मयानंद, स्वास्थ्य मंत्रालय में सचिव सुश्री शांता शास्त्री, उत्तर प्रदेश के चिकित्सा शिक्षामंत्री प्रो शिवकांत ओझा, सी एस आई आर के महानिदेशक डा. रघुनाथ अनंत माशेलकर, आईसीएमआर के महानिदेशक डा. एन के गांगुली और कविराज बृहस्पतिदेव त्रिगुण भी उपस्थित थे।

नवभारत टाइम्स 13-6-98

आयुर्वेद चिकित्सा पद्धति को बचाना जरूरी: उपराष्ट्रपति

विशेष संवाददाता

नई दिल्ली। उपराष्ट्रपति कृष्णकांत ने कहा है कि आयुर्वेद हमारी राष्ट्रीयता का प्रतीक है पर अफसोस कि इस दिशा में वह काम नहीं हो रहा है जो होना चाहिए। ज्ञान बहुत है किन्तु उसका संकलन नहीं किया जा सका है। वक्त के अनुकूल आयुर्वेद का आधुनिकीकरण किए बगैर सिर्फ अतीत की दुहाई देने भर से काम नहीं चलने वाला।

श्री कृष्णकांत ने ये विचार सोमवार को कायामाया आयुर्वेदिक अस्पताल एवं अनुसंधान केंद्र द्वारा रसशास्त्र पर आयोजित एक कार्यशाला का उद्घाटन करते हुए व्यक्त किए। इसमें देश भर से इकट्ठे नामी वैद्यों को संबोधित करते हुए उपराष्ट्रपति ने कुछ बातें बिना किसी लाग-लपेट के रखीं। उन्होंने कहा कि हम भगवान धनवन्तरि, चरक और सुश्रुत जैसे ऋषियों का नाम सुनते सुनते ऊब गए हैं। पुरानी विरासत का नाम लेने भर से कुछ नहीं होने वाला। इस देशी चिकित्सा पद्धति को चीन की तरह नई जिंदगी देने के लिए उसमें जान फूंकनी होगी, अन्यथा आयुर्वेद जैसी विधाएँ समाप्त हो जाएँगी। आज खतरा उसके समाप्त होने का ज्यादा है, क्योंकि नए वैद्य आयुर्वेद से इलाज की बजाए इंजेक्शन लगाने का काम कर रहे हैं।

श्री कृष्णकांत ने कहा कि नए चरक और नए सुश्रुत पैदा हुए बगैर आयुर्वेद का नामलेवा नहीं बचेगा, क्योंकि आज के पुराने वैद्यों की पीढ़ी भी तेजी से खत्म होती जा रही है। उसे अपने ज्ञान का विस्तार नीचे तक करना होगा। पर आज हालत है कि कोई नामी वैद्य अपना नुस्खा दूसरों को बताने को तैयार नहीं है। जानकारी को छिपाने से काम नहीं चलने वाला। इसका फैलाव करना होगा। आयुर्वेद तभी पनप सकेगा।

महामहिम ने कहा कि खुशी की बात है कि कायामाया के कविराज नानकचंद शर्मा ने यह चुनौती स्वीकारी है। रसशास्त्र पर [illegible] के लिए उन्होंने देश भर के नामी वैद्यों को एक मंच पर इकट्ठा कर दिया है। उम्मीद है कि दो दिन की यह कार्यशाला आयुर्वेद में प्राण फूंकने का काम करेगी। एक और अच्छी बात है कि यहां देश का वैद्य समाज और सरकार दोनों जमा हुए हैं। इससे तालमेल में मदद मिलेगी।

उन्होंने कहा कि आजादी के बाद सोचा बहुत कुछ था। सोचा था कि डाक्टरों को शिक्षा आयुर्वेद और एलोपैथी को मिलाकर देंगे। इससे नए पुराने के मेल से चमत्कार हो जाएगा, पर ऐसा नहीं हो सका। दुखद तो यह कि आयुर्वेद वाला आज भी गर्व का अनुभव नहीं करता। अपने को दोयम दर्जे का मान कर चलता है। दबा-दबा रहता है। हीनता की इस ग्रंथि को हर हाल में खत्म करना होगा। आयुर्वेद सहित देशी पद्धतियों का उद्धार तभी हो सकेगा।

केंद्रीय पेट्रोलियम व गैसमंत्री जनेश्वर मिश्र ने भी अपनी बात बेहद बेबाकी से रखी। उनका कहना था कि भारत ने मानव सभ्यता को जो दिया, उसमें आयुर्वेद का नाम सबसे ऊपर है। मगर आज चिकित्सा की यह देशी पद्धति बहुराष्ट्रीय कंपनियों की साजिश की शिकार है। हल्दी, तुलसी और अब बासमती चावल तक दूसरों ने पेटेंट करा लिए हैं। इसलिए आयुर्वेद को हर हाल में बचाना होगा।

इसके पहले वैद्य त्रिगुणा सहित अनेक वक्ताओं ने कार्यशाला में मौजूद केंद्र सरकार की सचिव (भारतीय चिकित्सा पद्धति) श्रीमती शांता शास्त्री से माँग की कि रसशास्त्र पर एक राष्ट्रीय संस्थान की स्थापना की जानी चाहिए। इससे आयुर्वेद को बचाने में मदद मिलेगी। वैद्य अमित शर्मा ने उपराष्ट्रपति सहित सभी अतिथियों का आभार व्यक्त किया। कार्यशाला तीन व चार मार्च को भी जारी रहेगी।

नवभारत टाइम्स 3-3-98

[...]दिक अस्पतालों का होना नहीं होने के बराबर

होना या न होना बराबर ही है क्योंकि इसमें मरीजों के उपचार के लिए दवा तथा डाक्टर तक नहीं है। इस संवाददाता ने राजधानी में चल रहे कुछेक आयुर्वेदिक औषधालयों का बाकायदा मरीज बनकर दौरा किया। इसमें दरियागंज, सब्जी मंडी, मोतनगर, गीता कालोनी के औषधालय प्रमुख हैं। इन औषधालयों में रुई, पट्टी, प्लास्टर अथवा कोई एंटीबायोटिक दवा उपलब्ध नहीं है अगर हो भी तो गरीब मरीजों को नहीं मिल रही है।

गर्मी के कारण हर जगह दस्त, बुखार, पेट रोग के मरीज बढ़ रहे हैं लेकिन इन औषधालयों में दस्त की बीमारी में देने के लिए गंगाधर चूर्ण, गरपूर रस, बिल्वादी चूर्ण तथा बुखार में देने के गोदंती भस्म, महासुदर्शन चूर्ण, आनंद भैरव रस, त्रिभुवन कीर्ति रस है ही नहीं। बेचारे मरीज आते हैं और उन्हें दवाई खरीदने के लिए बाहर का रास्ता दिखा दिया जाता है। बहुत से औषधालयों में तालीसादि चूर्ण और सीतोपलादी चूर्ण भी नहीं है। उदर विकारों के लिए मुख्यतः मरीजों को लवण भास्कर चूर्ण, त्रिफला चूर्ण, हिंगवास्तक चूर्ण दिया जाता है लेकिन ये भी ज्यादातर औषधालयों से गायब रहता है। इसी प्रकार मूत्र विकार के लिए चंद्रप्रभावटी, पेट के कीड़ों के लिए कोमी कुठार रस भी मरीजों को नहीं मिल पा रहा है।

बहुत से औषधालयों की हालत भी बहुत खस्ता है। इसमें सब्जी मंडी, मोतनगर, अंधा मुगल, बख्तावर पुर के औषधालयों का नाम ले सकते हैं। गंदगी और घुटन के माहौल में मरीज अपने साथ और बीमारियां लेकर वापस आता है। निगम अधिकारी किसी भी समय जाकर देख सकते हैं। निगम के 35 औषधालय किराए की जगहों पर चल रहे हैं उनके रखरखाव की कोई भी पुख्ता व्यवस्था नहीं है। यहां मकान मालिक को अपने किराए से मतलब है और निगम को औषधालय चलाने की खानापूर्ति से, कोई भी इमारत के रखरखाव, वहां फैली गंदगी को दूर करने के लिए पहल नहीं कर रहा है।

सूत्रों से पता चला है कि इस समय निगम में लगभग 30 डाक्टरों की कमी है। जिसके कारण एक डाक्टर को दो औषधालयों में जाकर बारी-बारी से ड्यूटी करनी पड़ती है। यह भी पता चला है कि निगम में बहुत से ऐसे लोग हैं जिन्हें पदोन्नत करके डाक्टरों के पदों पर लगाया जा सकता है लेकिन यह न करके निगम द्वारा अनुबंध के आधार पर बाहर से डाक्टरों की नियुक्ति की बात की जा रही है। हालांकि चिकित्सा सहायता एवं जन स्वास्थ्य समिति और नियुक्तियां, पदोन्नति, अनुशासनात्मक एवं संबद्ध विषय समिति ने भी निगम अधिकारियों को कहा है कि विभागीय कर्मचारियों को ही पदोन्नत करके डाक्टर बनाए जाएं। लेकिन अधिकारी अपनी बात पर अड़े हुए हैं। इसके पीछे किसको, क्या फायदा है इस बात से हर कोई वाकिफ है? इस बात के बारे में जानकारी प्राप्त करने के लिए निगम के मुख्य स्वास्थ्य अधिकारी डा. के. एन. तिवारी से कई बार बात करने की कोशिश की लेकिन हर बार यही जवाब मिला कि वह बैठक में व्यस्त हैं।

डा. पंचाल ने बताया कि वर्ष 1959 में लोकसभा एवं राज्यसभा में [illegible] में संशोधन करने के [illegible] भारतीय चिकित्सा पद्धति के संस्थागत चिकित्सकों को सम्मिलित किया गया था। उन्हें सम्मिलित करने का आधार भारतीय चिकित्सा पद्धति के संस्थागत चिकित्सकों को उनकी पढ़ाई के दौरान आधुनिक दवाइयों की शिक्षा एवं ट्रेनिंग उनके पाठ्यक्रमों के आधार पर ही सम्मिलित किया गया था। लेकिन यह [illegible] के कारण उसका फल [illegible] भारतीय चिकित्सा पद्धति के चिकित्सकों को उठाना पड़ रहा है। एसोसिएशन का कहना है कि भारतीय चिकित्सा पद्धति के चिकित्सकों को आधुनिक दवाइयों को इस्तेमाल करने का अधिकार मिलना चाहिए।

दिल्ली भारतीय चिकित्सा परिषद बिल का विरोध

राष्ट्रीय सहारा 6-10-98

नयी दिल्ली, 5 अक्तूबर। आल इंडिया इंडियन मेडिसन ग्रेजुएट एसोसिएशन (एमगा) के दिल्ली प्रदेश अध्यक्ष डा. आरपी पांचाल ने हाल ही में दिल्ली विधानसभा में पारित हुए 'दिल्ली भारतीय चिकित्सा परिषद 1998' विधेयक में खामियां बताते हुए इसका विरोध किया है। डा. पांचाल के अनुसार इस विधेयक को विधानसभा में पेश किये जाने से पूर्व भारतीय चिकित्सा पद्धतियों से जुड़ी संस्थाओं से विचार-विमर्श किया जाना चाहिए था जो नहीं किया गया।

डा. पांचाल ने इसके नाम को भ्रामक बताते हुए इस पर आपत्ति की है। दूसरे विधेयक द्वारा दिल्ली भारतीय चिकित्सा परिषद में कुल 21 सदस्यों में से 11 को मनोनीत किये जाने पर आपत्ति की गयी है। डा. पांचाल का कहना है कि किसी भी संस्था में एक तिहाई से अधिक सदस्यों के मनोयन का प्रावधान अलोकतांत्रिक है, जबकि इस विधेयक के द्वारा परिषद में आधे से अधिक सदस्यों के मनोयन का प्रावधान किया गया है। एमगा ने विधेयक द्वारा चिकित्सकों को हर पांचवें साल पंजीकरण कराने के प्रावधान को इंस्पेक्टर राज को बढ़ावा देने वाला तथा चिकित्सकों का शोषण करने का माध्यम करार दिया है।

एमगा की सरकार से माग

कार्यालय संवाददाता

नई दिल्ली, 12 अप्रैल। आल इंडिया इंडियन मेडिसन ग्रेजुएटस एसोसिएशन (एमगा) ने केंद्र सरकार से अनुरोध किया कि भारतीय चिकित्सा पद्धति के छह वर्षों के पाठ्यक्रम के बाद डिग्री पाने वाले डाक्टरों द्वारा एलोपैथी की दवाओं के प्रयोग को गैर कानूनी नहीं माना जाना चाहिए।

प्रदेश एमगा अध्यक्ष डा. आर. पी. पांचाल के नेतृत्व में एक प्रतिनिधिमंडल ने इस सम्बंध में प्रधानमंत्री श्री अटल बिहारी वाजपेयी से भेंट कर उन्हें एक ज्ञापन दिया।

हिन्दुस्तान 13-4-98

PUBLIC NOTICES

PUBLIC NOTICE

CENTRAL Council of Indian Medicine notify that the practitioners of Indian Medicine possessing qualifications included in Schedules of Indian Medicine Central Council Act 1970 and registered with statutory boards/councils of different States and UTs enjoy all rights of practice mentioned in the respective acts and notifications issued by the State Govt./Central Govt. from time to time.

Notifications issued by any other Council can not in any way affect the right of practitioners of Indian Systems of Medicine. Many State Acts and Govt. orders make these practitioners entitled to practice modern medicine also in addition to Indian Medicine. This previlage conferred on them is protected under Clause (b) of Sub Section 3 of Section 17 of the IMCC Act 1970.

This is for information of the General Public and all concerned.

33479-G

हिन्दुस्तान 10-2-98

एमगा खेल

आल इंडिया इंडियन मेडिसन ग्रेजुएट एसोसिएशन (एमगा) की स्पोर्ट्स कमेटी ने तीन दिन की क्रिकेट, बेडमिंटन, टेबल टेनिस आदि खेलों की प्रतियोगिता का आयोजन पूर्वी दिल्ली स्पोर्ट्स काम्पलेक्स दिल्ली में किया।

क्रिकेट फाइनल में एमगा पश्चिम क्षेत्र ने एमगा मध्य जोन के कुल रन 117 के जवाब में अपने 3 विकेट खोकर मैच 7 विकेट से जीत लिया। इस प्रकार एमगा पश्चिम क्षेत्र ने इस साल की एमगा क्रिकेट ट्राफी जीत ली। टेबल टेनिस प्रतियोगिता डा. मुकेश विजयी रहे।

आयुर्वेद व यूनानी के छात्र दुर्दशा झेल रहे हैं

कार्यालय संवाददाता

नई दिल्ली, 23 जून। भारतीय चिकित्सा पद्धति के प्रति दिल्ली सरकार के उपेक्षापूर्ण रवैये के कारण इस पद्धति में आयुर्वेद एवं यूनानी चिकित्सा के हजारों स्नातक बेरोजगारी के कारण दुर्दशा झेल रहे हैं। आयुर्वेदिक एवं यूनानी चिकित्सा प्रणाली बोर्ड में 6 हजार से अधिक स्नातक पंजीकृत हैं लेकिन इनमें से केवल 10 प्रतिशत को ही रोजगार उपलब्ध हुआ है। दिल्ली सरकार द्वारा इनके प्रति उपेक्षापूर्ण व्यवहार होने के कारण देशीय चिकित्सा पद्धति के अनेक औषधालयों चिकित्सकों के स्थान रिक्त पड़े हुए हैं।

अखिल भारतीय, देशीय चिकित्सा पद्धति स्नातक संगठन के अध्यक्ष आर. पी. पंचाल के अनुसार दिल्ली नगर निगम और दिल्ली सरकार के अंतर्गत चलने वाली आयुर्वेदिक एवं यूनानी डिस्पेंसरियों में चिकित्सक न होने के कारण एक ही चिकित्सक दो-दो डिस्पेंसरियों का कार्यभार संभाले हुए हैं।

दिल्ली सरकार ने फरवरी 1997 में प्रधान सचिव (स्वास्थ्य) के कार्यालय में दो बार कंट्रेक्ट के आधार पर चिकित्सा अधिकारी (आयुर्वेद) की नियुक्ति के लिए साक्षात्कार के लिए बुलाया गया था। इनको नियुक्ति पर 6 हजार रुपया प्रति माह वेतन दिया जाना था। लेकिन खेद की बात यह है कि दोनों बार इन चिकित्सकों को यह कह कर बाग वापिस लौटा दिया गया कि साक्षात्कार रद्द कर दिया गया है।

इसके बाद दिल्ली नगर निगम में भी समाचार पत्रों के माध्यम से नगर निगम की आयुर्वेदिक डिस्पेंसरियों में भी ठेके के आधार पर प्रतिमाह 6 हजार रुपए वेतन पर देशीय चिकित्सा पद्धति के चिकित्सकों की नियुक्ति के लिए आवेदन-पत्र मांगे गए थे। लेकिन आवेदन-पत्र भेजे हुए एक वर्ष से अधिक का समय हो गया है। अभी तक न तो किसी का साक्षात्कार के लिए बुलाया गया और न ही किसी की नियुक्ति की गई है। हजारों बेरोजगार चिकित्सकों के आवेदन-पत्र फाइलों में पड़े धूल चाट रहे हैं। लगभग 30 आयुर्वेदिक औषधालय बिना चिकित्सकों के चल रहे हैं।

यही नहीं चालू वर्ष में भी दिल्ली सरकार के भारतीय चिकित्सा पद्धति एवं होम्योपैथिक विभाग ने भी देशीय चिकित्सा पद्धति के स्नातकों से मजाक किया। विभाग ने 22 आयुर्वेद चिकित्सकों को रोजगार कार्यालय के माध्यम से 30 मई, 1998 को साक्षात्कार के लिए प्रधान सचिव (स्वास्थ्य) के कार्यालय में बुलाया। इन्हें भी 6000 रुपए प्रतिमाह वेतन पर नियुक्ति की जानी थी लेकिन साक्षात्कार के बाद भी आज तक इन्हें नियुक्ति नहीं दी गई।

डॉ. पांचाल ने बताया कि आयुर्वेदिक एवं यूनानी चिकित्सा प्रणाली बोर्ड का अंतिम चुनाव 1987 में हुआ था। 5 वर्ष बाद बोर्ड के चुनाव हो जाने चाहिए लेकिन बोर्ड के चुनाव आज 11 वर्ष बाद भी नहीं हुए हैं। उन्होंने इस संबंध में दिल्ली सरकार के स्वास्थ्यमंत्री डॉ. हर्ष वर्धन को पत्र लिख कर भारतीय चिकित्सा पद्धति के स्नातकों के साथ न्याय करने तथा दिल्ली की जनता को भारतीय चिकित्सा पद्धति के लाभ से वंचित न रखे जाने का अनुरोध किया है।

हिन्दुस्तान

आयुर्वेदिक यूनानी चिकित्सा बोर्ड के काम ठप पड़े हैं

अनु जैन

नई दिल्ली। आयुर्वेदिक एवं यूनानी चिकित्सा पद्धति बोर्ड को वर्ष 1997-98 के लिए अभी तक वित्तीय सहायता न मिलने के कारण यहां के सारे कार्य ठप पड़े हुए हैं। बोर्ड कर्मचारियों को महीनों से वेतन नहीं मिला है। यही नहीं यूनानी एवं आयुर्वेदिक पद्धति के लगभग 400 चिकित्सक अपनी चिकित्सा शुरू करने के लिए महीनों से यहां पंजीकृत होने की इंतजार में बैठे हैं। बोर्ड को वित्तीय सहायता न मिलने सबसे ज्यादा प्रतिकूल असर नीम हकीम विरोधी अभियान पर पड़ा है। रुपए न होने के कारण बोर्ड इन चिकित्सकों की जांच पड़ताल करने में पूरी तरह असमर्थ हो गया है जो दिल्ली में अपनी प्रैक्टिस कर रहे हैं और स्वास्थ्य विभाग के सतर्कता विभाग के शक के घेरे में हैं। उनके नामों की लिस्ट जांच के लिए बोर्ड में पड़ी सड़ रही है और दिल्ली में झोला छाप डाक्टरों का सफाया करने का नारा देने वाला स्वास्थ्य विभाग मूक दर्शक बना बैठा है।

बोर्ड को अप्रैल माह से कोई भी वित्तीय सहायता नहीं मिली है। पहले बोर्ड को स्वास्थ्य सेवा निदेशक विभाग से अनुदान दिया जाता था। लेकिन दो वर्ष पूर्व भारतीय चिकित्सा पद्धति एवं होम्योपैथिक निदेशालय के गठन के बाद बोर्ड को अनुदान राशि यहां से मिलनी शुरू हो गई। लेकिन इस निदेशालय में व्याप्त अनियमितताओं के कारण बोर्ड को वर्ष 1997-98 के लिए अभी तक अनुदान की राशि नहीं मिली है। बोर्ड में कार्यरत कर्मचारियों को अप्रैल माह से वेतन नहीं मिला है जोकि लगभग सवा दो लाख के करीब बैठता है। यही नहीं यहां पर कागज, स्टेशनरी तथा हर अन्य वस्तुओं का अभाव बना हुआ जिसके कारण बोर्ड न तो अपने रोजमर्रा के काम कर पा रहा है और न ही विशेष तथा महत्वपूर्ण कार्य।

बोर्ड को इस समय लगभग 400 चिकित्सकों की उनकी डिग्री संबंधी जांच रिपोर्ट पूरी करके उन्हें पंजीकृत करना है। लेकिन बोर्ड की खस्ता हालत का परिणाम इन चिकित्सकों को भुगतना पड़ रहा है जोकि आयुर्वेदिक एवं यूनानी चिकित्सा पद्धति की डिग्री लेने के बाद भी अपनी चिकित्सा शुरू नहीं कर पा रहे हैं। इनमें से बिहार, केरल, हिमाचल के सबसे ज्यादा चिकित्सक हैं।

दिल्ली स्वास्थ्य विभाग के सतर्कता विभाग द्वारा राजधानी में सक्रिय झोला छाप डाक्टरों के विरुद्ध चलाए जाने वाले अभियान के तहत बोर्ड के पास लगभग 200 चिकित्सकों के नाम जांच के लिए भेजे हुए हैं। विभाग को शक है कि उनके पास जाली अथवा गलत पंजीकृत प्रमाणपत्र है।

नवभारत टाइम्स 23-12-97

देशी पद्धति के चिकित्सकों के साथ अन्याय के खिलाफ प्रदर्शन

सहारा समाचार

नयी दिल्ली, 19 जनवरी। आल इंडिया इंडियन मेडिसिन ग्रेजुएट्स एसोसिएशन ने आज जनकपुरी स्थित भारतीय चिकित्सा केंद्रीय परिषद कार्यालय पर प्रदर्शन किया और परिषद के अध्यक्ष वैद्य श्रीराम को मांग पत्र दिया। मांग पत्र में कहा गया है कि आज पूरे देश में भारतीय चिकित्सा पद्धति के संस्थागत चिकित्सकों के साथ ज्यादती हो रही है। एलोपैथी पद्धति के चिकित्सकों एवं भारतीय चिकित्सा परिषद द्वारा उनके अधिकारों का हनन जारी है। एसोसिएशन के सचिव डा. आर.पी. पांचाल ने केंद्रीय परिषद से भारतीय चिकित्सा पद्धति के चिकित्सकों के अधिकारों की रक्षा करने व समस्याओं के समाधान की मांग की है।

डाक्टरों की मांग

ऑल इंडिया डॉक्टर्स एसोसिएशन ऑफ आई.एस.एम. व दिल्ली मेडिकल एसोसिएशन के एक प्रतिनिधिमंडल ने मुख्यमंत्री श्री साहिब सिंह वर्मा से भेंटकर मांग की कि नीम हकीमी निषेध अधिनियम को विधानसभा के आगामी सत्र में पास कराना सुनिश्चित करें। प्रतिनिधिमंडल में विभिन्न स्वयंसेवी संस्थाओं के सदस्य भी शामिल थे। उल्लेखनीय है कि नीम हकीमी निषेध अधिनियम को पिछले वर्ष विधानसभा में प्रस्तुत करने के बाद इसे प्रवर समिति को सौंप दिया गया था।

नवभारत टाइम्स 18-1-98

देसी चिकित्सा पद्धतियों को ठिकाने लगाने की

कलायत (नस): हरियाणा व पंजाब सरकार के आयुर्वेदिक (भारतीय चिकित्सा पद्धति) को आधुनिक चिकित्सा पद्धति से समन्वित करने की मांग के प्रति उपेक्षित रवैया अपनाने को लेकर इन राज्यों के हजारों आयुर्वेदिक स्नातकों के सड़क पर आने की घोषणा से स्थिति विकट हो गई है।

हरियाणा राज्य में आयुर्वेदिक स्नातकों (बी.ए.एम.एस., बी.एस.एम.एस.) के असंतोष का मुख्य कारण डा. पी.एल. जिंदल, निदेशक स्वास्थ्य विभाग हरियाणा के वे आकस्मिक आदेश हैं जो विगत 19 दिसम्बर, 1997 को राज्य के मुख्य जिला चिकित्सा अधिकारियों को पत्र क्रमांक 2-7/229-3 दो 11/9/7687-7705 द्वारा भेजे गए थे। जहां एक ओर इन आदेशों में बिना पंजीकरण के प्रैक्टिस करने वालों के विरुद्ध कार्रवाई करने के आदेश हैं वहीं दूसरी ओर यह निर्देश भी है कि इंडियन मेडिकल कौंसिल एक्ट 1956 की धारा 15 (2) व 15 (3) के तहत जो चिकित्सक पंजीकृत नहीं हैं, वे अंग्रेजी (एलोपैथिक) दवाइयों के प्रयोग की सलाह नहीं दे सकते।

प्राप्त जानकारी के अनुसार गत माह इसी तरह के आदेश निदेशक स्वास्थ्य विभाग पंजाब चंडीगढ़ में 6 नवम्बर 1997 को पत्र क्रमांक पी बी 97/16650-60 में पंजाब सरकार ने सभी जिला सिविल सर्जनों को भी दिए थे। इस सारे मामले में मैडिसन (सी सी आई एम) ने विगत 18 अक्तूबर, 1996 को राज्यों के स्वास्थ्य सचिव को भेजे पत्र क्रमांक एफ 5/96 ए वाई (AY) में ये स्पष्ट निर्देश दिए थे कि भारतीय चिकित्सा पद्धति में आयुर्वेद यूनानी तथा सिद्धा के जो स्नातक भारतीय चिकित्सा अधिनियम 1970 के अंतर्गत आते हैं, वे एलोपैथी दवाओं की सलाह देने का प्रयोग के पात्र हैं।

गौरतलब है कि चिकित्सा पद्धति की शिक्षा आयुर्वेद चिकित्सा के साथ-साथ एलोपैथी की शिक्षा अनुपातिक रूप में देशभर के विभिन्न आयुर्वेदिक संस्थानों में आयुर्वेदिक स्नातकों को दी जाती है। इन संस्थाओं से प्रति वर्ष करीब पांच हजार छात्र शिक्षा प्राप्त करके निकलते हैं। विडम्बना है कि इनमें से दस प्रतिशत से भी कम को सरकारी अस्पतालों तथा ग्रामीण अंचलों में स्थित डिस्पेंसरियों में नौकरी मिलती है, जबकि अन्यों को निजी क्लिनिक खोल प्रैक्टिस करनी पड़ती है। राज्य सरकारों द्वारा नागरिकों को स्वास्थ्य सुविधाएं मुहैया कराने की योजना को पूर्ण रूप देने में लगे ये आयुर्वेद स्नातक महानगरों की गलियों, बस्तियों से लेकर कस्बों तथा दूरस्थ ग्रामीण क्षेत्रों में लोगों को उनके घरों के निकट अब तक चिकित्सा सुविधाएं उपलब्ध करवा रहे हैं।

इसी के दृष्टिगत वर्ष 1960 में भारतीय संसद ने ड्रग तथा कॉस्मेटिक्स एक्ट 1940 में एक विशेष धारा नियम 2 (ईई) (111) जोड़कर भिन्न चिकित्सा पद्धति वाले स्नातक डाक्टरों को एलोपैथी दवाइयों को रखने व उनके उपयोग का अधिकार दिया था, परंतु राज्य सरकार की दुविधा नीति के चलते अधिकांश...

मैडिसन ग्रेजुएट शिष्टमंडल की प्रधानमंत्री से भेंट

नई दिल्ली, 8 अप्रैल (उमेश)। आल इंडिया इंडियन मैडिसन ग्रेजुएट एसोसिएशन (एमगा) के एक प्रतिनिधिमंडल ने आज प्रधानमंत्री श्री अटल बिहारी वाजपेयी से भेंट की और उन्हें एक ज्ञापन दिया। ज्ञापन में प्रधानमंत्री से भारतीय चिकित्सा पद्धति के चिकित्सकों के प्रति भेदभाव की नीति अपनाने का कड़ा विरोध किया गया था। प्रधानमंत्री ने इस संबंध में स्वास्थ्य मंत्री से मंत्रणा करने का आश्वासन दिया।

एमगा की दिल्ली प्रदेश इकाई के अध्यक्ष डा. आर.पी. पांचाल ने बताया कि भारतीय चिकित्सा पद्धति के संस्थागत चिकित्सकों को ड्रग एण्ड कास्मेटिक एक्ट 1945 में रजिस्टर्ड मेडिकल प्रैक्टीशनर की परिभाषा में 1959 में संसद में फार्मेसी एक्ट में संशोधन करने के उपरांत ही भारतीय चिकित्सा पद्धति के संस्थागत चिकित्सकों को सम्मिलित किया गया था।

डा. आर.पी. पांचाल ने प्रधानमंत्री को यह भी बताया कि भारतीय चिकित्सा पद्धति के संस्थागत चिकित्सकों के लिए भारत सरकार ने सन् 1970 में अलग से भारतीय चिकित्सा केन्द्रीय परिषद (सी.सी.आई.एम.) का गठन किया था। आई.एम.सी.सी. एक्ट 1970 में भी ड्रग एण्ड कास्मेटिक एक्ट 1945 की समीक्षा किया गया तथा इन चिकित्सकों के अधिकारों को सम्मिलित किया हुआ है।

इसी संदर्भ में आज एक प्रतिनिधिमंडल केन्द्र सरकार के स्वास्थ्य सचिव से मिला। इस प्रतिनिधिमंडल में अखिल भारतीय आयुर्वेद महासम्मेलन के वैद्य श्री देवेन्द्र त्रिगुणा, डा. एस.के. मिश्र, भूतपूर्व आयुर्वेद सलाहकार भारत सरकार, वैद्य गौरी लाल वाजपेयी, एमगा दिल्ली अध्यक्ष डा. आर.पी. पांचाल, डा. ओ.पी. वशिष्ठ, सदस्य भारतीय चिकित्सा केन्द्रीय परिषद, डा. ओ.पी. जग्गी, डा. राजेन्द्र छाबड़ा आदि ने भाग लिया।

एमगा ने भारतीय चिकित्सा विधेयक की आलोचना की

नई दिल्ली, 2 अक्तूबर (उमेश)। आल इण्डिया इण्डियन मैडीसन ग्रेजुएट्स एसोसिएशन (एमगा) की दिल्ली इकाई के अध्यक्ष डा. आर.पी. पांचाल ने दिल्ली विधानसभा में हाल ही में पारित ''दिल्ली भारतीय चिकित्सा परिषद विधेयक 1998'' में रह गई कुछ कमियों का कड़ा विरोध करते हुए कहा है कि यह बिल पेश करने से पहले भारतीय चिकित्सा पद्धति से जुड़ी संस्थाओं के प्रतिनिधियों से विचार-विमर्श नहीं किया गया है।

डा. पांचाल ने इस सम्बन्ध में जारी बयान में कहा है कि इस विधेयक में यह प्रावधान है कि ''दिल्ली भारतीय चिकित्सा परिषद'' में कुल 21 होंगे तथा इन सदस्यों में 11 मनोनीत व 10 निर्वाचित होंगे। यह एक अलोकतांत्रिक तरीका है क्योंकि हिन्दुस्तान में किसी भी संस्था, परिषद व विधान परिषद में कहीं भी मनोनीत सदस्यों की संख्या 53 प्रतिशत से अधिक नहीं है। इस तरह मनोनीत सदस्यों की संख्या इस परिषद में 7 से अधिक नहीं होनी चाहिए थी।

उन्होंने कहा कि विधेयक में ऐसा प्रावधान किया गया कि एक चिकित्सक को अपना पंजीकरण हर पांच साल बाद कराना अनिवार्य है जबकि दिल्ली राज्य में पहले से आयुर्वेद व यूनानी चिकित्सा पद्धति का बोर्ड है लेकिन उसमें ऐसा प्रावधान नहीं था।

उन्होंने कहा है कि इस विधेयक में ऐसा प्रावधान किया है कि 'भारतीय चिकित्सा केन्द्रीय परिषद' 1970 की अनुसूची 1, 2 व 3 में जो डिग्रियां हैं वे सभी मान्य होंगी जबकि 'भारतीय चिकित्सा केन्द्रीय परिषद 1970 में अनुसूची 2, 3 व 4 में डिग्रियां हैं अनुसूची 1 में डिग्रियां नहीं हैं। इस प्रावधान से अनुसूची 4 की डिग्रियों के चिकित्सक इसमें पंजीकृत नहीं हो सकेंगे, जो एक बहुत बड़ी भूल है।

अगली सदी ... पद्धतियों ...

पद्धतियों को ठिकाने लगाने की कोशिश पर रोष

ए वाई (AY) में वे स्पष्ट निर्देश दिए थे कि न चिकित्सा पद्धति में आयुर्वेद यूनानी तथा सिद्धा स्नातक भारतीय चिकित्सा अधिनियम 1970 के त आते हैं वे ऐलोपैथी दवाओं की सलाह देने का के पात्र हैं।

रितलब है कि मिश्रित चिकित्सा पद्धति की शिक्षा द चिकित्सा के साथ (साथ ऐलोपैथी की शिक्षा त्मक रूप से देशभर में स्थित आयुर्वेदिक ों में आयुर्वेदिक स्नातकों को दी जाती है। इन ओं से प्रति वर्ष करीब पांच हजार छात्र, छात्राएं प्राप्त करके निकलते हैं। विडम्बना है कि इनमें से तिशत से भी कम को सरकारी अस्पतालों तथा अंचलों में स्थित डिस्पेंसरियों में नौकरी मिलती कि अन्यों को निजी क्लीनिक खोल प्रैक्टिस पड़ती है। राज्य सरकारें द्वारा नागरिकों को न सुविधाएं मुहैया कराने की योजना को पूर्ण रूप लगे ये आयुर्वेद स्नातक महानगरों की गरीब ों से लेकर कस्बों तथा दूरस्थ ग्रामीण क्षेत्रों में को उनके घरों के निकट अब तक चिकित्सा ए उपलब्ध करवा रहे हैं।

ो के दृष्टिगत वर्ष 1960 में भारतीय संसद ने था कॉस्मेटिक्स एक्ट 1940 में एक विशेष धारा 2 (ईई) (111) जोड़कर मिश्रित चिकित्सा वाले स्नातक डाक्टरों को ऐलोपैथी दवाइयों को ा उनके उपयोग का अधिकार दिया था, परंतु रकार की द्विभदी नीति के चलते अधिकांश शिक्षा प्राप्त करने वाले बी.ए.एम.एस. स्नातकों को एम.बी.बी.एस. स्नातकों को कम श्रेणी का आंका जाता है। हालांकि दोनों का चयन समान शैक्षिक योग्यता के आधार पर सी.पी.एम.टी. द्वारा ही [illegible] है। जहां तुलनात्मक रूप से एम.बी.बी.एस. के छात्र को 5 वर्ष का पाठ्यक्रम तथा 1 वर्ष की इंटर्नशिप करनी होती है। वहीं बी.ए.एम.एस. के छात्र को साढ़े पांच वर्ष की निश्चित अवधि का पाठ्यक्रम तथा 1 वर्ष की इंटर्नशिप में आठ मास का आयुर्वेदिक तथा चार माह का ऐलोपैथिक चिकित्सा प्रणाली में यह पाठ्यक्रम पूरा करना होता है।

एलोपैथिक दवाओं को प्रयुक्त न करने के राज्य के स्वास्थ्य विभाग के आला अधिकारियों की इस एक पक्षीय कार्रवाई के आदेशों का विरोध कर रहे प्रदेश भोपाल आयुर्वेद संघ के प्रधान डा. मनमोहन शर्मा तथा कलायत इंटिग्रेटिड मैडिकल एसोसिएशन के प्रधान डा. बाबूराम यादव तथा महामंत्री डा. सुरेश तथा संयुक्त रजिस्टर्ड डाक्टर एसोसिएशन के प्रवक्ता डा. बलवंत सिंह श्योकंद का आरोप है कि हरियाणा तथा पंजाब के स्वास्थ्य मंत्रालय पर ऐलोपैथिक लॉबी के कुछ लोग दबाव डाल रहे हैं कि मिश्रित चिकित्सा पद्धति के डाक्टरों पर इस प्रकार के प्रतिबंध लगा कर उन्हें एम.बी.बी.एस. डाक्टरों के साथ प्रतियोगिता में ही बाहर कर दिया जाए। इनका कहना है कि इस लॉबी की प्राथमिक निष्ठा 'इंडियन मैडिकल एसोसिएशन' के प्रति है। वे इस सारी कार्रवाई को आयुर्वेदिक स्नातकों को हाशिये पर खिसकाने तथा सार्थक समन्वय न होने देने का षड्यंत्र बताते हैं।

न जाने किन कारणों से राज्य सरकारों का स्वास्थ्य मंत्रालय भी संसद द्वारा पारित केन्द्रीय भारतीय चिकित्सा अधिनियम 1970 की भावना तथा उसके प्रावधानों के साथ साथ 1983 की राष्ट्रीय स्वास्थ्य नीति एवं 8वीं पंचवर्षीय योजना (1992-97) लक्ष्यों का भी उल्लंघन कर रहा है, क्योंकि इसमें देशज तथा पाश्चात्य चिकित्सा के शनैः शनैः समन्वय हेतु क्रमिक कदम उठाने का वादा किया गया था, लेकिन हरियाणा तथा पंजाब में स्वास्थ्य विभाग की अफसरशाही के चलते स्वास्थ्य नीति को ठंडे बस्ते में डालने के प्रयास जारी है।

इन आरोपों को लेकर निदेशक हरियाणा स्वास्थ्य विभाग का कहना है कि पंजाब हरियाणा 1997 को पूर्व एक व्यक्ति द्वारा डाली गई याचिका पर दिए गए फैसले की अनुपालना हेतु ये आदेश उन्होंने पारित किए हैं, जबकि दूसरी ओर निदेशक स्वास्थ्य एवं परिवार कल्याण पंजाब ने पत्र क्रमांक हुग्स (आई) पांबा 97/20216-32 में पंजाब राज्य के जिला चिकित्सा अधिकारियों को 12 नवम्बर, 1997 को पुनः निर्देश दिए हैं कि मान्यता प्राप्त कौंसिल बोर्ड से पंजीकृत आयुर्वेद तथा यूनानी व होम्योपैथी स्नातक (जी.ए.एम.एस., बी.ए.एम.एस., डी.एच.एम.एस.) पूर्व आदेशों की परिधि से बाहर है। –

नवभारत 1-7-98

पार्टियां चुनाव घोषणा पत्र में आयुर्वेद के विकास के नारे को शामिल करें

नभाटा समाचार

नई दिल्ली: ऑल इंडिया मेडिसन ग्रेजुएट्स एसोसिएशन ने विभिन्न पार्टियों से मांग की है कि अपने चुनाव घोषणा पत्र में जन स्वास्थ्य एवं आयुर्वेद के विकास के नारे को शामिल करें। एसोसिएशन का कहना है कि देश में भारतीय चिकित्सा पद्धति से जुड़े चिकित्सक ही गांव गांव पहुंचकर गरीबों का इलाज कर रहे हैं। लेकिन सरकार द्वारा इन्हीं पद्धतियों की लगातार उपेक्षा की जा रही है।

एसोसिएशन ने एक कार्ययोजना तैयार करके उसे पार्टियों को अपने चुनाव घोषणा पत्र में शामिल करने के लिए दिया है। इसमें कुछ प्रमुख मांगे हैं भोर समिति और चोपड़ा समिति के आधार पर लिए गए केंद्रीय मंत्रिमंडल के उस फैसले को पलटा जाए कि भविष्य में स्वास्थ्य ढांचे का आधार एलोपैथी ही रहे। भविष्य में आयुर्वेदिक चिकित्सा को इसका आधार बनाया जाए। एलोपैथी के मुकाबले आयुर्वेदिक चिकित्सा पद्धति के विकास के लिए समान अवसर उपलब्ध करवाए जाएं। शुरूआत के तौर पर इसके लिए स्वास्थ्य बजट 30 प्रतिशत निर्धारित किया जाए। जन स्वास्थ्य पर भी शिक्षा की भांति कुल राष्ट्रीय आय का छह प्रतिशत व्यय किया जाए जिससे गरीबों को मलेरिया, टी.बी., जैसी पुरानी बीमारियों तथा एड्स, एवं कैंसर जैसी नई बीमारियों से बचाया जा सके।

एसोसिएशन की यह भी मांग है कि सरकारी स्वास्थ्य सेवाओं में एलोपैथी, होम्योपैथिक, आयुर्वेदिक तथा अन्य चिकित्सा पद्धति के विभाजन को समाप्त किया जाए और विभिन्न पद्धतियों द्वारा समन्वित सेवा प्रदान की जाए। राष्ट्रीय स्वास्थ्य कानून बनाया जाए तथा स्वास्थ्य के विषय को संविधान की राज्य अनुसूचि से निकाल कर समवर्ती सूची में डाला जाए। एसोसिएशन के सचिव डा. आर. पी. पंचाल के अनुसार यदि कोई भी पार्टी उनकी इस कार्ययोजना को मानती है तो वे उसका पूर्ण रूप से समर्थन करेंगे।

भारतीय चिकित्सा पद्धति के चिकित्सकों को तंग करने का विरोध एसोसिएशन ने भारतीय चिकित्सा केंद्रीय परिषद को एक पत्र लिखकर मांग की है कि उन्हें कुछ ऐसी नीतियां बनानी चाहिए जिससे अन्य परिषद भारतीय चिकित्सा पद्धति के चिकित्सकों पर अपने आदेश न थोपें। एसोसिएशन का कहना है कि कई राज्यों में भारतीय चिकित्सा पद्धति से जुड़े डाक्टरों को तंग किया जा रहा है। परिषद को उनके हित के लिए कुछ ठोस कदम उठाने चाहिए।

नवभारत टाइम्स 19-1-98

गा ने भारतीय चिकित्सा यक की आलोचना की

दिल्ली, 2 अक्तूबर (उमेश): आल इण्डिया न मैडीसन ग्रेजुएट्स एसोसिएशन (एमगा) की इकाई के अध्यक्ष डा. आर.पी. पांचाल ने विधानसभा में हाल ही में पारित "दिल्ली चिकित्सा परिषद विधेयक 1998" में कुछ कमियों का कड़ा विरोध करते हुए कि यह बिल पेश करने से पहले भारतीय सा पद्धति से जुड़ी संस्थाओं के प्रतिनिधियों र-विमर्श नहीं किया गया है।

पांचाल ने इस सम्बन्ध में जारी बयान में कि इस विधेयक में यह प्रावधान है कि भारतीय चिकित्सा परिषद" में कुल 21 था इन सदस्यों में 11 मनोनीत व 10 त होंगे। यह एक अलोकतांत्रिक तरीका है हिन्दुस्तान में किसी भी संस्था, परिषद व परिषद में कहीं भी मनोनीत सदस्यों की 53 प्रतिशत से अधिक नहीं है। इस तरह न सदस्यों की संख्या इस परिषद में 7 से नहीं होनी चाहिए थी।

होंने कहा कि विधेयक में ऐसा प्रावधान या कि एक चिकित्सक को अपना पंजीकरण व साल बाद कराना अनिवार्य है जबकि राज्य में पहले से आयुर्वेद व यूनानी सा पद्धति का बोर्ड है लेकिन उसमें ऐसा नहीं था।

होंने कहा है कि इस विधेयक में ऐसा किया है कि 'भारतीय चिकित्सा केन्द्रीय 1970 की अनुसूची 1, 2 व 3 में जो हैं वे सभी मान्य होंगी जबकि 'भारतीय ा केन्द्रीय परिषद 1970 में अनुसूची 2, 3 डिग्रियां हैं अनुसूची 1 में डिग्रियां नहीं हैं। धान से अनुसूची 4 की डिग्रियों के क इसमें पंजीकृत नहीं हो सकेंगे, जो एक ी भूल है।

अगली 'सदी भारतीय चिकित्सा पद्धतियों की ही होगी'

सहारा समाचार

नयी दिल्ली, 24 अक्टूबर। आयुर्वेद केवल चिकित्सा प्रणाली नहीं अपितु जीवन पद्धति है। आयुर्वेद के मामले में हम अपने आपको पहचानने में भूल कर रहे है।

यह उद्गार भाजपा नेता सांसद डा. मुरली मनोहर जोशी ने व्यक्त किये। उन्होंने कहा कि अगली सदी भारतीय चिकित्सा पद्धतियों की ही होगी। प्रगति मैदान स्थित प्रगति भवन में 'स्वास्थ्य प्रबंध में वैकल्पिक चिकित्सा पद्धतियों की भूमिका' विषय पर दिल्ली सरकार, विश्व स्वास्थ्य संगठन, भारत निर्माण एवं व्यापार मेला प्राधिकरण द्वारा संयुक्त रूप से आयोजित दो दिवसीय कार्यशाला में उद्घाटन भाषण देते हुए डा. जोशी ने कहा कि आयुर्वेद एक पुरातन चिकित्सा पद्धति है अतः यदि कोई इसको अन्य चिकित्सा पद्धति का विकल्प बताने की चेष्टा करता है तो यह उसकी दासतापूर्ण सोच है। उन्होंने कहा कि हम आयुर्वेद के मामले में अपने आप को पहचानने में भूल कर रहे है। चूंकि मानव मात्र शरीर ही नहीं, बल्कि मन, बुद्धि, आत्मा तथा शरीर का समुच्चय है अतः उसके लिए समग्र चिकित्सा पद्धति जरूरी है जो आयुर्वेद में निहित है।

डा. जोशी ने कहा कि तनाव कैसर, मधुमेह, हृदय रोग आदि अनेक रोगों का जनक है। जब तक इच्छायें व प्रतिस्पर्धाएं रहेंगी तब तक तनाव तो रहेगा ही। लेकिन इस जीवन में त्यागपूर्ण योग का सिद्धांत अपनाकर तनाव पर काबू पाया जा सकता है।

समारोह की अध्यक्षता प्रदेश के स्वास्थ्य मंत्री डा. हर्षवर्धन ने की। उन्होंने अपने वक्तव्य में इस बात के प्रति चिंता जतायी कि आयुर्वेद के वैद्य अन्य चिकित्सा पद्धतियों का सहारा ले रहे हैं।

डा. हर्षवर्धन ने कहा कि आधुनिक चिकित्सा पद्धति में ज्यो-ज्यो प्रगति हो रही है, इसका इलाज दिनों-दिन महगा होता जा रहा है। वे दिन भी शायद दूर नहीं जब आधुनिक चिकित्सा पद्धति से आम आदमी का इलाज करा पाना दूभर हो जाएगा। लेकिन हमारे देश की जो चिकित्सा पद्धति है वह सर्वसुलभ और सहज भी है लिहाजा यह निःसंदेह कहा जा सकता है कि 21वीं सदी भारतीय चिकित्सा पद्धतियों की शताब्दी होगी।

आयुर्वेद एवं अन्य भारतीय चिकित्सा पद्धतियों के उत्थान के प्रति दिल्ली सरकार की प्रतिबद्धता को दोहराते हुए डा. हर्षवर्धन ने कहा कि भविष्य में जो भी आधुनिक चिकित्सा के अस्पताल खोले जाएंगे उनमें 10 प्रतिशत बिस्तर भारतीय चिकित्सा पद्धति के होंगे।

शीघ्र ही नजफगढ़ के पास सौ एकड़ भूमि पर उत्तर भारत में अपने किस्म का पहला संस्थान स्थापित किया जाएगा जिसमें आयुर्वेद एवं प्राकृतिक चिकित्सा के अस्पताल एवं कालेज तथा अन्य औषधिरहित चिकित्सा पद्धतियों की व्यवस्था रहेगी।

लोकसभा के उपाध्यक्ष सूरजभान, दिल्ली सरकार के प्रधान स्वास्थ्य सचिव रमेश चंद्र, एच.सी. भंडारी, वैद्य देवेन्द्र त्रिगुणा, डा. कुरूप, डा. नंद किशोर तथा बड़ी संख्या मे आयुर्वेद एवं होम्योपैथी के चिकित्सक इस अवसर पर उपस्थित थे। कार्यशाला में तनाव मुक्ति पर भी कार्यशाला होगी।

दवा भारतीयों ने बनाई, पेटेंट अमेरिकी कम्पनी ने कराई

नई दिल्ली (भाषा) : हल्दी और बासमती चावल के बाद भारत अब एक दुर्लभ बूटी (कुटकी) से बनी अपनी दवा 'पिक्रोलिव' की चोरी से भी निपटने की तैयारी कर रहा है।

वैज्ञानिक और औद्योगिक अनुसंधान परिषद के व्यापार विकास विभाग के प्रमुख एच.आर. भोजवानी के अनुसार, भारत द्वारा विकसित इस दवा को अमेरिका में पेटेंट करा लिया गया है। उन्होंने कहा कि यह हद दर्जे की चोरी है। लखनऊ की हमारी एक प्रयोगशाला में करोड़ों रुपए खर्च करके तैयार की गई इस दवा का 'नेचर्स हर्ब' नामक अमेरिकी कम्पनी निर्माण और विपणन भी कर रही है। उन्होंने बताया कि इस मामले में परिषद अमेरिकी अदालत में मुकदमा दायर करेगी।

केन्द्रीय औषधि अनुसंधान संस्थान, लखनऊ ने सिर्फ उत्तर-पश्चिमी हिमालय में पाई जाने वाली बूटी कुटकी (पिक्रोराइजा कुरोआ) की जड़ों से 'पिक्रोलिव' नामक यह औषधि तैयार की है। पीलिया के विषाणु के प्रकोप से जिगर (लीवर) में होने वाली बीमारियों के निदान के लिए 'पिक्रोलिव' को वैज्ञानिकों ने बहुत उपयोगी पाया है।

श्री भोजवानी ने बताया कि अनेक वर्षों के अनुसंधान के बाद तैयार की गई इस दवा का इस समय मानवीय परीक्षण किया जा रहा है। केन्द्रीय औषधि अनुसंधान संस्थान की प्रयोगशाला के निदेशक सी.एम. गुप्ता ने बताया कि इस दवा को अगले दो वर्षों में बाजार में लाने की योजना थी।

अमेरिकी कम्पनी ने दवा के साथ दिए विवरण में के तहत 'पिक्रोलिव' उपलब्ध कराई जा रही है, जबकि अहमदाबाद की कैडिला लैबोरेटरीज को संस्थान ने इस दवा का लाइसेंस दिया है।

इसके अलावा प्राप्त जानकारी के अनुसार अन्य अमेरिकी कम्पनियों ने भी भारतीय औषधि अनुसंधान से जुड़े बहुत से तथ्य चुराए हैं।

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