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THE
SECRET OF HEALTH
A MONTHLY JOURNAL
FOR
PRESERVATION OF ONE'S HEALTH

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*"God made your Body and He made it Great
It has a guest of might and high Estate
Keep the Shrine noble, handsome, high and whole
For in it lives God's Guest, a kingly Soul."*

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AYURVEDA SIDDHASRAMAM

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1. The Dravida Ayurvedic Vaidya Sammelana Conference and Exhibition, Tiruvendipuram, South Arcot District, 1919.
2. The Tamil Vaidya Conference and Medical Exhibition, Tinnevely, 1921.
3. Industrial Exhibition, Bezvada, 1921.
4. The Bhagalpur Exhibition, Bhagalpur, 1922.
5. The Indian Industrial Exhibition, Karachi, 1922.
6. The Bellary Industrial and Agricultural Exhibition, Bellary, 1923.
7. The Second Tamil Vidya Conference and Medical Exhibition, Madras, 1923.
8. The Second Karnataka Provincial Conference and Exhibition, Bijapur, 1923.
9. The Baroda Exhibition, Baroda, 1923.
10. The Mangalore Industrial Exhibition, Mangalore, 1923.
11. The Jatiya Maha Mela Exhibition, Calcutta, 1923.
12. The Indian Industrial Exhibition, Poona, 1924.

THE SECRET OF HEALTH

A MONTHLY JOURNAL

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With a view to open a discussion on the following subjects in the aspect of Sidha Ayurvedic System confining the argument to definite boundaries, we hereunder extract certain premises from the expressed opinions of eminent modern diagnosticians of the west to start with.

From "X-Ray Diagnosis in Pulmonary Tuberculosis"
By R. S. E. Murray, B.A., M.D. in C. M. A.

The application of roentgenology to the study of tuberculosis of the lungs is widely accepted as one of the most important diagnostic aids by which both the individual sufferer and attending physician can be benefited. This paper is intended to present the modern roentgenological view point in an incisive manner, unencumbered with high technicality.

Lung Anatomy

The anatomy and histology of the lung is briefly as follows: The bronchial tree embraces the bronchi and ramifying bronchioles, each one supplied by branches of the pulmonary artery and vein and ramifying arterioles and venules respectively. The lymphatics are similarly distributed. In the lung periphery these associated blood

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vessels lymphatics and respiratory ductules constitute the lobules. These lobules are wedge-shaped with the point directed towards the lung root or hilus. In disease, all the tissue structures of one or a number of lobules take part in the pathological reaction, giving rise to the somewhat characteristic fan-like configuration, so frequently encountered in the upper thirds of both lungs.

Histologically, the pulmonary arterioles center in the lobules and give off final branches to all the alveoli. The delicate walls of these terminal air cells bear the capillary net-work which bridges the pulmonary arterial, carbon-dioxide-carrying vessels and the pulmonary venous, oxygen-carrying vessels. This is the pulmonary circulation. The function of the bronchial arterial circulation is purely nutritive.

In regard to the lymphatic system, it is important to realize that there are no lymphatics in the terminal alveoli. This lack of a lymphatic capillary system in the alveoli may reasonably explain the stasis of substances produced pathologically at that point. This may account for the characteristic mottling of an acute so called miliary process when examined radiographically. Subsequent healing leaves in its wake numerous small, headlike areas of calcification occurring at regular intervals along the lymphatic trunk ramifications. The distribution of parenchymatous lesions coincides with the lymphatic distribution.

A point of interest is the fact that the pleura is rich in valve-bearing lymphatics. These valves open towards the pleura, which gives us a valuable hint of the hydrostatic cause of the formation of serous effusions within the pleural cavity and other body cavities lined by serous membrane.

In regard to the formation of lymphnodes, it is well to recall that these develop at the bifurcations of the lymphatic tree, those glands nearest to the hilus being the largest. The study of this anatomical feature is thoroughly germane to the roentgenology of the chest, as outlying, active lung pathology is always subtended by an indurated

interwoven lymphatic distribution. Healing leaves these trunks expressed as harsh string-like shadows with well-beaded bifurcations.

The reticulum or connective tissue of the lung follows the general conformation of the bronchial tree. This anatomical structure must not be lost sight of, as some pulmonary affections cause chronic thickening of the connective tissue, which to the unwary interpreter may be mistaken for chronic induration of the pulmonary lymphatics of tuberculous etiology.

Physiology

The physiology of respiration concerns the nicely inter-related balance between the arterial and venous pulmonary blood flow, on the one hand, and the oxygen and carbon dioxide exchange on the other. Bearing this in mind, we must be prepared to interpret some of the changes in the appearance presented in the chest film of a pulmonary case, as manifestly due to a compensation, following changes in the physical or biochemical equipoise, or both a few examples will illuminate this. For instance, emphysematous distension of part of one lung may result from chronic loss of function in some other respiratory area. The barrel-shaped chest is the result of the lifting action of the upper extrinsic respiratory musculature, which is encouraged by lack of sufficient oxygen absorption over a long period of time. Deviation from the normal position of structures occupying the mediastinum is entirely a compensatory change of position due to various causes, prominent amongst which will be found those due to pleural effusions, spontaneous pneumothoraces, cicatricial contractions in fibrous tissues and spinal curvature. These matters will be more fully developed further on.

Pathology

The pathology of tuberculosis of lungs is best divided anatomically in three fields, namely that associated with the bronchial tree, that involving the pulmonary parenchyma and that affecting the investing pleura.

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AMRUTA RATNAKARAM

3

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B. H. D. W. PERERA Esq., Mooloya, Hewaheta, Ceylon, writes on 19—9—1925.

This is to inform you that the phial of Amruta Ratnakaram which I have got down last month from you has been used by a friend of mine and effected him like a charm than any other Nervine Tonic that he has used.

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Mr. R. S. VISWASAM, Kent Estate, Mahawella R.
O. Matale, Ceylon, Dated 10th August 1923.

Pathology involving the bronchial tree is characterized by infiltration or clouding and thickening of the hilus configuration. Dense shadows formed by a combination of enlarged glands, edematous lymphatic ducts and thickened air passages will be noted. The posterior mediastinal space will often appear clouded due to chronic adenitis of the mediastinal and peribronchial lymphatics, when the patient is examined by the maneuver of oblique fluoroscopy. Pathology of the parenchyma itself begins as all inflammatory processes begin, namely, as a diffuse hyperemia and swelling, which the combined cellular and chemical mechanism of the blood endeavour to localize. This rapidly by an obliterative process developed first within the alveoli and later within the lobules. Microscopically, the center of each tubercle is filled with caseous material, homogeneous in character. Towards the periphery of each tubercle, we find giant cells and large numbers of endothelial cells. Connective tissue infiltration with leucocytes surrounds the acteristic soft mottling of activity. In the more advanced cases, the caseation becomes confluent and, consequently, cottony in appearance. In rapidly caseating types the large area of consolidation have the appearance of infraction.

Where the disease affects the serous membranes, the same picture of clouding due to pathological thickening is to be found. Should the affected membrane become fibrotic, it will show permanent haziness on repeated X-ray examination. In active cases small subpleural tubercles may sometimes be observed. This will give a slightly mottled appearance to the pleura. This phase will be accompanied by effusion. In cases which develop inflammatory reaction in the visceral pleura, the homogeneous clouding is quite sharply demarked and corresponds to the position of a lobe. Thickening of the pleura is a very common feature of an advanced tuberculosis.

(To be continued).

Facts not fancy

It is not necessary you should believe every announcement you see. It is impossible. All announcements make so many statements, many of which are mere statements made by the person or firm announcing them, unsupported by reliable, independent evidence.

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Dr. R. N. SAXENA, Senior Medical Officer, Central Lunatic Asylum, Agra, *Dated 2nd October 1924.*

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Mr. B. KESAVAN CHETTY, 25 Wolfendhal St., Colombo, writes on 11-6-25.

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