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Vol. XII



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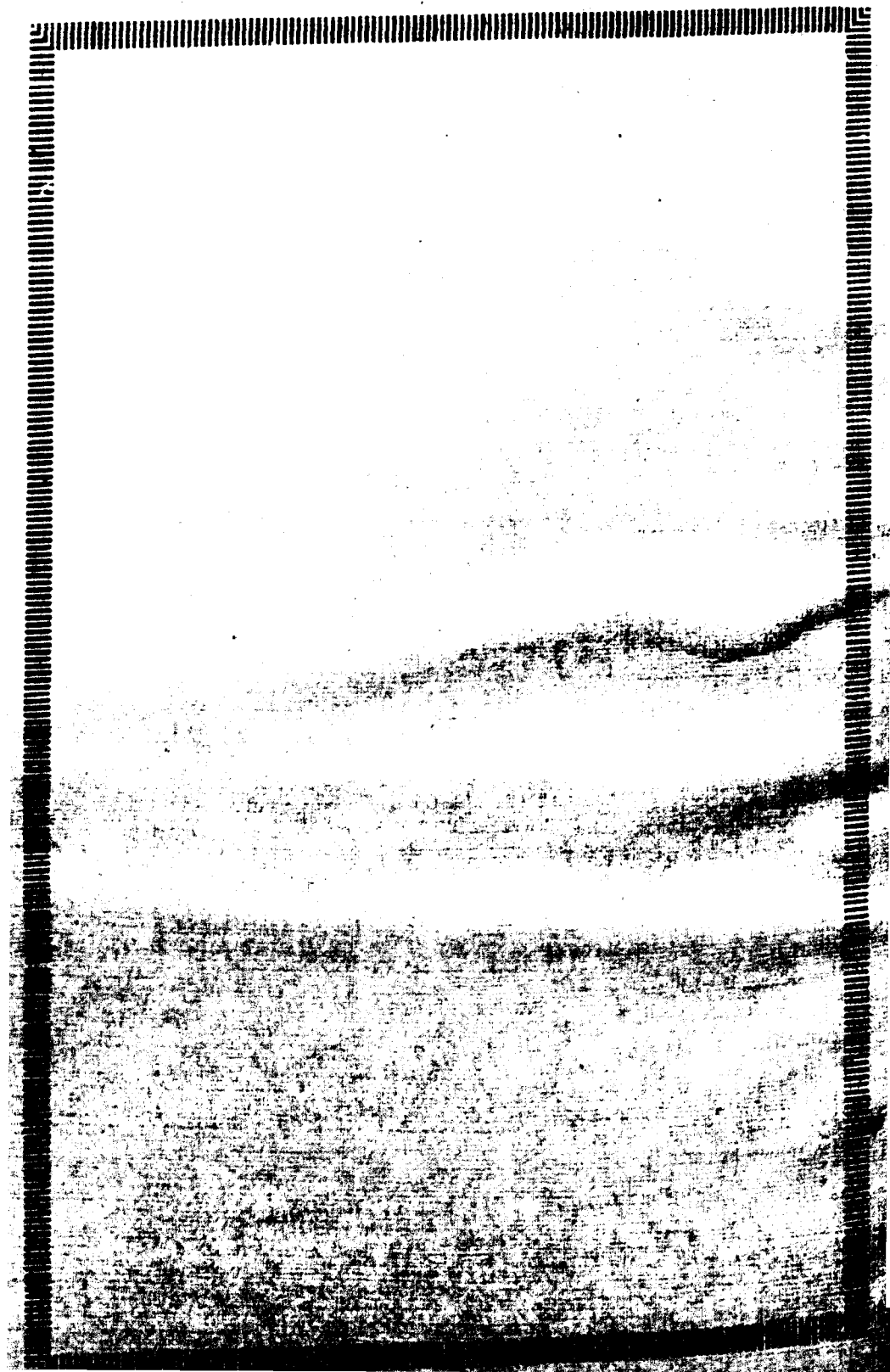
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Vol. XII, No. 4.

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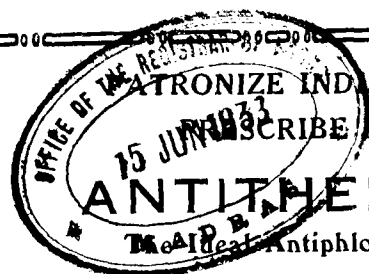
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Neither will I be prevailed upon by anyone to administer noxious medicines nor will I be the author of such advice myself. I shall never recommend means to procure abortion, but will live and practice chastely and religiously. I will not meddle with lithotomy, leaving that to operators of that art. Whatever house I am called upon to attend, I will aim at making the patient's good my chief aim, avoiding all injury, corruption and unchastity; and whatever I hear in the course of my practice relating to the affairs of life of my patients that ought to remain secret, nobody shall ever know of me.

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THE MADRAS

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MAY 1933

No. 4

Some Aspects of Thoracic Surgery.*

BY LT.-COL. K. G. PANDALAI, M.B., F.R.C.S. (ENG.), I.M.S.,

1st Surgeon and Prof. of Surgery, Govt. General Hospital, Madras.†

Lecture I.

History.—Until recent times very little was generally known about surgery of the chest in this country and much less was practised. The ordinary books on surgery do not dwell on the subject at length. The modern development of thoracic surgery began with the Great War of 1914, and one of the many things that the Great War has achieved for us is the development of thoracic surgery. Fragments of explosive shells penetrating the thorax and becoming lodged therein were some of the commonest injuries of war and Army Surgeon learnt by experience to deal with them in special ways.

The reasons why thoracic surgery was lagging behind were firstly the anatomical structure of the chest which made access to the cavity one of difficulty and attended with no little danger. The most vital organs of circulation and respiration are placed in this bony box as safely as the brain in the skull; secondly the intra-thoracic viscera are perpetually moving with rhythmic contractions and as such the manipulation within the cavity requires great delicacy; thirdly, the negative pressure inside the chest

* Being a Post graduate lecture delivered under the auspices of the University Extension Board, Madras.

† Reprint from the *Antiseptic* by the kind courtesy of the Editors.

proved to be a great handicap. Any interference must necessarily give rise to the establishment of communication with the external atmosphere and therefore alteration of the negative pressure, resulting in serious consequences. The beginnings of thoracic surgery were marked by heroic attempts at controlling this negative pressure, especially by continental surgeons. For this purpose, such operations were conducted in specially constructed air-tight chambers the pressure inside which, was kept below that of the atmosphere. The patient's chest, the surgeon and his assistant were inside this chamber, the Anaesthetist sitting outside, at the head of the patient, which was kept outside the chamber, shut off by a well-fitting collar round the neck of the patient. There was a telephonic arrangement between the helmet of the Surgeon and the Anaesthetist outside. Such arrangements were cumbersome and expensive and beyond the resources of the ordinary Surgeon.

Another attempt at overcoming the negative pressure within the chest was made by means of a positive pressure arrangement in which the intra-pulmonary pressure was kept above normal by administering the patient compressed air with his anaesthetic. This process was equally difficult and constituted a barrier against the generalised adoption of this method.

A third method was intra-tracheal insufflation of ether vapour. Under light anaesthesia, a gum-elastic tube was gently put in, past the vocal cords to the bifurcation of the trachea and ether vapour pumped in, the quantity being controlled by a mechanical regulator. The tube introduced was of comparatively small thickness so that the expired air could flow back between the tube and the trachea.

In these days the surgeon gets into the intra-pleural space with impunity. The air is let in slowly, so that the

lungs could accommodate themselves to the surrounding conditions. Expensive and cumbersome apparatus is entirely dispensed with.

INJURIES OF THE CHEST.

Thoracic injuries are not rare; they were especially common in the Great War. The contents of the chest are highly delicate and very sensitive to trauma; and hence, in spite of the strong osseous fortification chest wounds are highly dangerous. Such injuries are more frequently caused by a stab or a gun-shot. Stabs are common in civil life, while gun shots are specially common in warfare. The present day bullet is narrow, sharp and long, 2 to 3 inches in length, shaped like a lead pencil and travels with enormous speed. The present day bullet could pass through important organs and cause very little damage. It might pass through a hat on a person's head without hurting the head.

There was an interesting case of a man in the army who was shot at a close range of 6 feet. The bullet entered the right side of the chest, passed under the heart to the opposite side and then through the arm outside without causing serious damage. His wounds healed by first intention and he is alive to-day.

Another case was that of a man who was shot through the shoulder from a distance, the bullet passing through the chest and getting lodged in the spine. The only symptom he used to complain of was occasional pain in the back with seasonal variations. Such cases are best left alone as surgical interference may prove harmful.

There is a classical example of a man who was lying in the prone position during war. When he thrust his hand in the trousers pocket for his clay-pipe it was found broken and smeared with blood. Later on he fainted, and

on close examination it was found that he had been shot right through, the bullet passing above his clavicle through the chest and abdomen and emerging in the groin had shattered his clay-pipe.

Cases of bullets passing between the femoral artery and the vein resulting later in a varicose aneurysm are well known.

Bullets in the spongy tissue of the head of the humerus and the bodies of the spine are in most cases best left alone ; but the case is different in the soft spongy tissue of the lung especially when an irregular irritating metal piece is lodged within. Injury to the lung is generally followed by signs of severe shock. Haemoptysis may result or blood may trickle into the pleura causing haemothorax or air may get in from within the lung or outside the chest causing pneumothorax and sometimes surgical emphysema may supervene. In the latter case, air escapes into the subcutaneous tissues and may spread over the chest, neck, face and sometimes over the whole body giving the patient a hideous look, sometimes causing pressure symptoms on the trachea. Later on, reaction to trauma in the form of inflammation and pneumonia with rise of temperature and varying types of expectoration take place. The blood in the pleura may become infected and cause pyo-thorax.

Removal of foreign bodies in the lungs must be undertaken with great caution. One ought to think several times before making up one's mind. Each case must be judged on its own merits. Here is an example of a case where the bullet was lodged in the lower lobe of the right lung. The patient at the commencement had symptoms of severe injury which gradually passed off. As time passed he was subject to periodical attacks of paroxysmal cough and purulent sputum. The chest was X-rayed and the bullet localised. It moved with the position of the

patient. Lipiodol was injected into the bronchial tree and the X-ray showed a large cavity with a freely moving shadow and an aperture at the top through which periodical discharge of sputum occurred. On repeated requests by the patient, the chest was opened in the posterior axillary line and the lung was stitched to the costal pleura with a view to the formation of adhesions. The operation was followed by violent inflammation of the lung and he expired two days later. Perhaps he might have lived for years if he had been left alone.

Of the many methods of removing foreign bodies from the lungs, the closed method is the best one and is done in the X-ray room. A small incision is made in the skin under Novocaine, long specially constructed forceps are passed in under a fluorescent screen ; the bullet is grasped and is gently removed. Light general anaesthesia may be required to complete the operation.

The commonest complications in such cases are chronic fibrosis of the lung, bronchial dilatation and intra-thoracic suppuration.

SURGICAL DISEASES OF THE LUNGS.

I propose to deal with only a few of the important conditions and these are :—

1. Pulmonary Tuberculosis.
2. Empyema.
3. Bronchiectasis.

Bronchiectasis is in fact an end result of other conditions in the lungs. Until recently, tuberculosis affections of the lungs were placed purely under medical treatment. Local surgical treatment has now come into vogue and one of the commonest methods is artificial pneumothorax. The results are satisfactory if the lungs could be collapsed

completely. Contra-indications to this treatment are few in number. An A. P. could be done in one lung if disease on the other side is not advanced. The idea is to collapse the affected lung and to give it rest.

But this collapse therapy is futile in cases of pleural adhesions, which prevent the collapse of the lungs. For this purpose special instruments have been devised. A small opening is made in one of the inter-costal spaces and a Thoracoscope is introduced into the pleural cavity. Through another opening either in the same or in the next intercostal space is introduced an electric cautery by means of which the bands of adhesions are cauterised under direct vision through the thoracoscope. Adhesions are either cord-like or flat and ribbon-like. The cord-like ones are most easily handled and they snap without difficulty while the band like adhesions are more difficult to treat. Further the underlying tissue is likely to be injured by the cautery giving rise to great pain with escape of serum and blood into the pleura.

Other methods for collapsing the lung have been devised. Phrenicotomy or division of the phrenic nerve has done some good, though temporary and partial, and the collapse is mainly at the lower lobe. It has been extensively practised as a routine in early Tuberculosis of the lungs. An incision is made in the neck on the affected side at the outer border of the sterno-mastoid which is pulled apart exposing the scalenis anterior, on which lies the phrenic nerve. It is lifted up on a hook and divided. The distal segment is twisted up on a pair of forceps and pulled out of the thoracic cavity as much as possible. The failures are due to the development of collateral anastomosis or to the lower inter-costal nerves taking the function of the phrenic nerve.

Another operation done with a view to collapse the lungs is Thoracoplasty. It was not commonly practised

before, except in special clinics. Extra-pleural thoracoplasty consists in the removal of portions of one or more ribs in one or more stages according as the condition of the patient warranted. This can be done under local anaesthesia, if necessary, helped by a little gas and oxygen. Intervertebral injection of Novocaine is generally sufficient. The results are often very beneficial.

Empyema forms a large group of the surgical diseases of the chest. Those occurring in children are usually pneumococcal in origin. It begins as a cold in the chest with catarrh of the lung tissue and is of no serious import. But in run-down individuals it may take a grave turn, purulent effusion being poured into the pleural cavity. Most cases begin as simple effusion later on becoming purulent. For a long time the effusion appears to be non-purulent though full of pyogenic organisms as in the case of an inflamed hydrocele. In Severe infections as in streptococcal pleurisy the effusion is comparatively clear for a long time for the reaction is weak and the white blood corpuscles thrown into the effusion are few. Streptococcal infection is commoner in adults and is of rather grave import.

Small quantities of pus in the pleural cavity may be absorbed as in the peritoneal cavity giving rise to no further trouble. Adhesions are left behind in some cases, some others become chronic with thickening and fusion of the pleural surfaces.

With regard to diagnosis, in all cases of doubt, one must put in a needle to make sure of the nature of the pleural contents, stain on a slide with methylene blue and send a specimen for culture.

Treatment of the condition consists in the removal of the pus by the closed method for preference. The closed

method is adopted for the first few aspirations and is done by means of Potain's apparatus. This gives great relief and should be repeated before the open method is thought of.

The open method consists in emptying the pleural cavity after rib re-section. An incision is made in the course of a rib which is lifted off the periosteum and a length of about 2" is removed. The pleura is incised and drainage by the closed suction method is instituted. The wound closes readily when the underlying inflammation subsides.

The expansion of the lung is facilitated by the use of a Wolfe's bottle, the patient exercising his lungs by blowing air from one bottle to the other.

INJURIES OF THE HEART.

These are mostly of academic interest for, although the heart and pericardium are easily accessible through the bare area of the heart and come into view on removal of the anterior ends of the 2nd, 3rd and 4th ribs, yet, heart cases which require surgical help, are few, for, cases with serious injury to the heart immediately succumb and the few others which survive minor damage do not require any attention.

One of the commonest surgical emergencies of the heart is cardiac failure and anaesthesia necessitating immediate cardiac puncture, 2 c.c. of Adrenalin solution 1/1000 is injected into the left ventricle through the 3rd inter-costal space, immediately to the left of the sternum. About 2" of the needle must be inside the chest wall. The surgeon feels the needle first passing the muscle and then entering the cavity of the heart. Blood is drawn into the syringe and mixed with the adrenalin before the actual injection. The contractions of the heart are further



stimulated and assisted by intermittent pressure over the chest, (artificial respiration) or actual cardiac massage through the diaphragm if the abdomen has been opened already. The right hand is placed under the diaphragm and the left over the cardiac area and the heart is squeezed rhythmically between the hands from half to one minute. If the heart does not respond to this method within a minute, the patient is unlikely to recover.

Pericardial Effusions and Pyopericardium can be tapped in the above mentioned space or one space below, but drainage is best done at the lowest part at the xiphisternal notch near the termination of the 7th costal cartilage. Very recently operations have been done in special clinics in stenotic valvular diseases. After exposing the heart in its pericardium the left ventricle is punctured by means of specially made scissors and the mitral valve is cut in cases of mitral stenosis. Such operations are attended with great danger and are rarely performed.

THE ACUTE ABDOMEN.*

Lecture II.

"The Acute Abdomen" is an emergency usually tackled by the emergency or night staff of hospitals and has a high mortality.

These emergencies have been broadly classified as Surgical or Medical according as immediate surgical interference is necessary or not. But they are not brought in labelled as surgical or medical and it is for us to observe, analyse and classify. In most cases a good deal of difference of opinion may exist as to the nature of the condition and the steps to be taken for its relief. An accurate

*A Lecture delivered to Post-graduates under the auspices of the Madras University Extension Board.

diagnosis is one of the difficulties and for this reason the abdomen has been termed as the "Temple of Surprises."

Three questions have to be answered in cases brought in with symptoms of Acute abdominal trouble. Firstly, is there an emergency? Secondly, if so, is it surgical or medical? If surgical, what form of interference is the best? A close scrutiny of the case is essential in solving such problems. A clear history of the case is of great value and a systematic examination from head to toe must be made in all cases.

A history of recent trauma in or about the abdomen or a history of pre-existing abdominal diseases goes a great way in locating the lesion. Trauma may result from a fall, a stab, a shot or involvement in a motor crash, and may produce anything from a shake-up to severe crushing injuries of the liver and spleen, often through an unbroken skin.

Long-standing cases of abdominal pain simulating a gastric or a duodenal ulcer, chronic appendicitis or cholecystitis when followed by an acute exacerbation ending in an abdominal emergency may give us a clue as to the nature of the catastrophe that has supervened.

The characteristic symptoms of the acute abdomen are pain, vomiting, abdominal distension, constipation or diarrhoea. These can be easily elicited. All of them may not be present in every case and therefore this complete symptom complex is not essential for the diagnosis of every case of acute abdomen.

PAIN may start with dramatic suddenness or may only be an acute exacerbation of a pre-existing chronic pain. It is nearly always the dominating symptom for which the patient seeks admission.

TENDERNESS is an objective symptom of which the patient never complains and therefore the Surgeon has to

elicit the same by gentle pressure over the abdominal wall. It has been found by experience that certain areas of tenderness correspond to certain diseased viscera and this fact goes a great way in the diagnosis of the causative condition.

VOMITING may or may not be preceded by nausea. It may be of the projectile variety. The vomit may contain bile, blood or faeces occasionally mixed with frothy material. In long standing cases of obstruction, stercoraceous matter is vomited but actual faecal matter is found only in cases of gastro-colic fistula.

Inspection of the abdomen shows the presence or otherwise of *distension*. The swelling is mainly in the upper abdomen in cases of distension of the stomach. In cases of intestinal distension with the ladder type of abdomen, the swelling is general but mainly round the umbilicus. Distended colon can be diagnosed from both these swellings by the position and direction of the swelling. To gauge the extent of distension, the Surgeon must have an idea of the size of the patient's normal abdomen. Distension is comparatively a late symptom and cannot, therefore, be relied on in the early stages.

In doubtful cases of abdominal pain, changes in the rate, volume and tension of the *patient's pulse* are of diagnostic importance. The pulse may be deceptive especially in young people and in early stages of the condition. In all suspected cases the pulse should be recorded half-hourly and a steady increase in the rate must be taken as a positive sign.

RESPIRATION is usually rapid and is of the thoracic type. The rigidity of the abdomen interferes with the respiratory excursions of the diaphragm. Hence the rate and type of breathing will help the diagnosis.

The most important of all the signs of acute abdomen is *rigidity* of the abdominal muscles. Rigidity is a reflex phenomenon, the muscles standing on guard to protect the diseased viscera within. The apparent rigidity of the abdominal muscles, often seen in neurotic patients can be made to disappear by distracting the attention of the patient. The common causes of acute abdominal pain can be classified into colics, obstruction, perforation, and haemorrhages.

Colic is characterised by the typical pain. The patient may roll, wriggle about in his bed and doubles upon himself. His pulse is fairly steady and expression one of pain. Rigidity is absent and pressure relieves the pain.

The proximity of the abdomen to the chest above and the pelvis below makes the diagnosis of abdominal pains a matter of difficulty. Diaphragmatic pleurisy usually starts as an acute pain referred to the upper abdomen with reflex rigidity, thoracic respiration and rise of temperature. It may be easily mistaken for an abdominal emergency in the absence of a pleuritic rub. This reminds me of the case of a young man, some years ago, who was brought into hospital for fracture of the left femur. He developed acute pain in the right iliac fossa. The appendix was suspected and removed. The temperature persisted and pneumonia of the right base was evident by the next day. Here is an example of the absence of a clear line of demarcation between medical and surgical causes of acute abdominal pain.

A few years ago, a young man was admitted into my wards with a typical history of duodenal ulcer. He had a bluish look about the face and puffiness of the ankles which put me on guard. Routine examination showed myocardial deficiency.

A British officer was admitted for intense pain in the epigastrium with repeated vomiting, in the early hours of the morning. He had a similar attack a week previous. Rest in bed and a carminative mixture were ordered. The pains settled down and he was discharged after ten days. The Physician, who was called in, diagnosed it as angina Pectoris. The diagnosis was confirmed by an electrocardiogram.

Occasionally, Malaria, especially the Malignant tertian infection, has been the cause of confusion. Hepatitis and peri-hepatitis have been mistaken for cholecystitis and acute attacks of colitis for perforation of the intestines. Such errors in diagnosis are well-known and even the most experienced surgeon may make such mistakes.

Three things have to be avoided in cases of acute abdominal pain. They are purgatives, morphia, and delay. Purgatives may cause perforation or rupture in the diseased part of the intestine. Morphia masks the symptoms and thus interferes with diagnosis. Delay has been the cause of numberless deaths. Most patients taking ill at night wait for the morning to be taken to the hospital when perhaps it is too late. To operate by the clock under normal circumstances is bad, but in abdominal emergencies it is a virtue, for every minute that is saved is in favour of the patient's recovery. The patient is already in a condition of shock. And therefore, the quicker the operation the better for him.

The success of the operation depends a great deal on the art of the surgeon. Manipulations of the viscera must be done with the utmost gentleness. Respect for the tissues reduces the shock of the operation.

The problem of drainage in such cases is one of some importance.

The points to be remembered in connection with drainage are

1. When to drain?
2. How to drain? e.g. suction, swabbing, etc.
3. Where to drain?
4. And with what material to drain.

The abdominal wall is best drained by a small piece of corrugated rubber sheet (Rubber dam). The cavity is best drained by a cigarette drain. This is made by rolling up into a tube a piece of corrugated rubber sheet within which a wick of gauze is stitched.

Stitching of the abdominal wall may be done in layers if the condition of the patient would allow it. Otherwise through and through stitches could be employed thus saving time and minimising shock.

In olden days, after opening the abdomen in a case of generalised peritonitis lavage of the peritoneum and its contents was frequently employed with a view to the removal of the septic or foreign matter from within. The intestines were brought out of the wound, bathed in hot saline, the septic matter removed and the intestines put back into the abdominal cavity. This process of lavage has now been abandoned and cannot be too severely condemned. The peritoneum is a very resistant structure and does not require so much antiseptic care as the wound in the abdominal wall itself.

The importance of drainage is clear from the following example. I was asked by a Physician to see a case of abdominal emergency on the medical side of the hospital. On examination, the patient was found to have general peritonitis with all the signs and symptoms of septic intoxication. I opened the abdomen more to explore than with

a clear diagnosis. The peritoneal cavity was full of pus which was removed. The pouch of Douglas was drained by a large sized tube and the abdomen closed as usual. His condition was so bad that a search for the cause was not made. To my great surprise, the patient survived. To this day I do not exactly know what he suffered from.

When to drain and when not to drain is a difficult question to decide. Drainage must be avoided as far as possible. But when in doubt it is safer to drain.

Swabbing out the septic contents has been long practised and is even now being done. This causes peritoneal trauma and therefore increases the shock. This method is being superseded by the process of mechanical suction which is quick and neat and eliminates shock.

The best place for drainage is the site of the lesion if it could be shut off from the general peritoneal cavity. Otherwise the lowest part is always chosen, depending on the principle of gravitation, *e.g.*, Douglas pouch in Fowler's position; the loins in the lateral position and the upper abdomen in Trendelenberg position. Upper abdomen is as good a place as the Pouch of Douglas for purposes of drainage.

Surgery of the Genito-Urinary Tract*

By DR. N. MANGESHA RAO, M.B.C.M., F.R.C.S., D.L.O.,

3rd Surgeon, Govt. General Hospital, Madras.†

Lecture I.

INVESTIGATION OF SURGICAL LESIONS OF URINARY TRACT.

I shall deal only of non-traumatic lesions of the urinary tract.

Practically a patient comes to one, complaining of slight or severe haematuria or pyuria with or without pain and with or without frequency of micturition.

After noting his symptoms one must see him passing the urine. It is advisable to do the four-glasses test at this time.

After cleaning the glans and meatus, the anterior urethra is washed with sterile normal saline and washing kept in glass I. Now he is instructed to pass about an ounce or two of urine into glass II. Next he passes most of his urine into glass III and the last ounce into glass IV. Discolouration of glass I, the rest of glasses being clear indicates that lesion is in the anterior urethra. If the last three glasses are uniformly discoloured the lesion is in the kidney and ureter. If the last glass contains pure blood "terminal haematuria" lesion would be in the bladder. Below is a classification of this :

Site of lesion.	Glass I.	II.	III.	IV.	Remarks.
Ant. Urethra	+	—	—	—	
Post. Urethra	—	+	—	+	
Prostate and Neck of bladder	—	+	—	++	{ Terminal hæmaturia.
Bladder	—	+	+	++	
Kidneys	—	+	+	+	

* Being a post graduate lecture delivered under the auspices of the University Extension Board, Madras.

† Reprint from the Antiseptic by the kind courtesy of the Editors.

Surgery of the Genito-Urinary Tract

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Urine should be sent now for analysis and deposits should be examined under the microscope. A specimen of urine under aseptic precautions is obtained and sent for cultural purposes.

At the same time points of pain and tenderness and referred or radiating pains and their directions are noted. Next a general examination of patient is done and presence of tumour and its consistency, etc., are noted. A rectal examination should invariably be done, of prostate, seminal vesicles and ureters, etc. Below is a rough scheme of renal lesions with their prominent signs and symptoms. A plain roentgenogram is done.

Renal lesion.	Pain.	R.B.C.	Pyuria.	Cystitis.	Tumour.	X-rays.	Remarks.
Calculus	+	+	+	—	—	+	
Tubercle	+	+	+	+	—	+?	{ calcified areas.
Aseptic Hydro-nephrosis	+	—	—	—	+	—	
Septic hydro-nephrosis	+	+?	+	+?	+	—	
Tumour malignant	+	++	rarely	—	+	+?	
Essential hæmaturia or tumour	—	++	—	—	—	—	

Further examination for localization of lesion is done by the Cystoscope. This instrument is to the Urinary Surgeon what the Ophthalmoscope is to the Eye-surgeon. Even children can be examined by a small sized cystoscope.

In adults one can use the catheterising cystoscope of size 23 F. Cystoscopy can be done under local, sacral or spinal anaesthesia. Local is enough for simple examination and pyelography, sacral anaesthesia is useful in nervous people or for fulguration and minor operations through cystoscope. Spinal may be used as an alternative, but care should be taken not to over-distend the bladder. A general anaesthetic is required for children or for prolonged cystoscopic operations. It is always advisable to pass in a gum-elastic bougie, size 23 or 24

F, to see that urethra is not obstructed by stricture, etc. After the cystoscope is passed in, the bladder is washed with boric lotion till the return is clear. Sometimes the blood flow may not have stopped and if 15 minims of adrenaline 1/1000 be injected it may control vesical bleeding enough, to give a clear vision. Otherwise cystoscopy is postponed till haematuria has stopped.

When the washing is clear 8 ounces of fluid are left and examination of bladder is done:—first the fundus, then the lateral walls, then the trigone and ureteral openings and their surroundings. Most of the lesions are found on the trigone or round the ureteral openings.

The trigone is an equilateral triangle bounded by three ridges. On the lateral sides are the two Bell's muscles meeting towards the vesical outlet, distally they diverge to meet the Inter-ureteric bar of Mercier. On the prominence formed by this junction on each side of base of trigone will be found the ureteric openings. If this place is watched a little dimple or slit may be noticed which every few seconds (5 to 10) opens out to discharge urine. This is called the "efflux". Before the discharge occurs a vermicular movement may be noticed in this part of ureter. These vermicular movements, the frequency and colour of efflux from each ureter, should be noted. Then the surrounding mucosa is carefully examined. The changes that are seen will be mentioned later under different diseases. If the lesion be of the kidneys it is advisable to pass up the ureteral catheters and collect urine from each kidney for biochemical, bacteriological and microscopic examinations. The catheters should be passed right up to renal pelvis *i.e.*, at least 9 inches of it should go up the ureters. Now the cystoscope is withdrawn leaving the catheters in the ureters. The following tests may conveniently be carried out now.

Phenol-sulphone phthalein test.—Patient is given a drink of 10 ounces of water and an intravenous injection of 1 cc. solution

of 6 mgms of the dye in sterile distilled water. Urine from each catheter is received in test tubes containing a couple of drops of 25 per cent NaOH solution. The time-interval between the injection and the appearance of pink colour in the test tubes is noted. First hour's and second hour's collections are now made from each ureteral catheter and tested quantitatively for the dye. Normally 60-65 per cent in the first hour and 20-25 per cent in the second hour should be secreted by both kidneys jointly. A relative count will show which is damaged and to what extent and also indicate whether the unaffected kidney is adequate enough to excrete all the waste products. Normally each kidney should show the pink colour in the test tubes in 24 minutes.

Indigo carmine test.—As an alternative this test may be used but it is not as definite as the previous one. 7 ccs of 0.4 per cent solution indigo carmine is given intravenously and the time-interval for the appearance of the blue and depth of colour are noted. A reference to the following table will show if any damage is present.

	Time of appearance.	Depth of colour.
Normal	4 to 5 minutes.	quickly deepens in two effluxes.
Very slight damage	Delay to 7 minutes	quickly deepens.
	5 minutes	slowly „
Slight damage	Delay 7 minutes	colour poor.
More damage	Delay to 7-15 minutes	„ „
Great damage	Delay beyond 15 „	„ „

Next we proceed to do retrograde pyelograms. The solution commonly used is a sterile 15 per cent solution of Sodium Iodide in distilled water or 15-20 per cent solution of either Abrodil or Uroselectan B, can be used. The normal capacity of renal pelvis is 5-7 ccs. The pelvis should be emptied by gentle suction with a syringe and 5-7 ccs. slowly injected by gravity method. As soon as patient complains of pain injection should be stopped. It indicates distension of renal pelvis. If

hydronephrosis is suspected it is better to use a 30 per cent abrodil solution as it will get diluted but at the same time give a shadow. Roentgenograms are taken now. After emptying the fluid another roentgenogram should be taken where calculi are suspected. In hydronephrosis the intravenous method is better and safer. It is also useful in children where retrograde method may not be possible.

Intravenous method.—Either Abrodil or Uroselectan B is used. Both contain a little over 50 per cent iodine inseparably combined and both are excreted as such by the kidneys. Adult dose is 20 grams in 80 ccs. of redistilled water given intravenously. Pictures are taken 14, 45, 75 minutes after injection. A Bucky diaphragm should be used and bladder should be emptied and an air-cushion pressed over the bladder area to bring out the ureters also. Delayed pictures may be required in cases of hydronephrosis to give time for enough concentration of the drug in the renal pelvis. The only contra-indications for it are latent or manifest uraemia, acute pyelitis, pyelonephritis and acute infections of urinary tract.

Diagrammatic appearance of left renal pelvis.—Usually

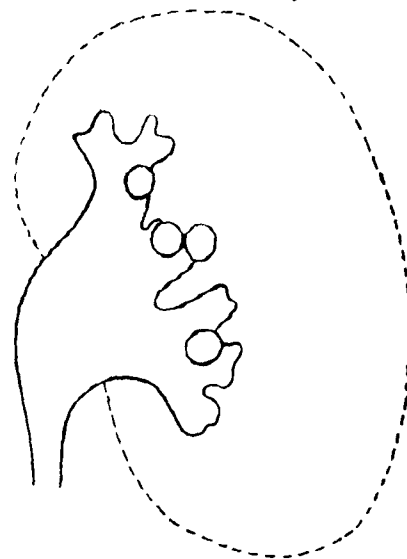


Diagram of Renal Pelvis.

three major calyces, rarely two, are present. Minor calyces are 8 to 12.

In a normal pyelogram the upper border of renal pelvis forms an α -shaped curve with the medial border of upper calyx. The contours are in even curves.

Hydronephrosis.—The minor calyces become convex towards renal substance and appear as knobs. A flattening of the curved interior border of renal pelvis and an inward bulging of pelviureteral junction are noticed. Later the pelvis and calyces all look enlarged.

New growths.—In the early stages some minor calyces appear elongated and later groups of calyces are blotted out especially the upper ones, and pelvic contour is encroached upon.

Renal pelvis tumours.—Filling defects in the pyelogram or even effacement of pelvis may occur. A papilloma may show as a mottling in the filling defect.

Calculi of urates and uric acid may show as negative shadows and appear as ringed shadows after emptying of the pelvis.

Renal haematuria.—Painless haematuria in the absence of palpable tumour should not always be considered as essential haematuria. Haemophilia and blood diseases as purpura haemorrhagica, etc., may give rise to haematuria. But these conditions can be excluded by a careful general examination. Infarcts of kidney may cause haematuria. They are of sudden onset with pain in the kidney area and usually patient shows signs of endo-carditis. Arteriosclerosis may give rise to haematuria and this can usually be made out.

But in adults silent haematuria is often caused by malignant disease of kidney. It is essential to diagnose this as early as possible before a palpable tumour becomes evident. The earlier it is diagnosed the better the prognosis after nephrectomy. On

cystoscopy one could see blood flowing down the ureter of affected side. A retrograde pyelogram is useful for diagnosis. If in doubt, the kidney should be explored. Nephrectomy should be done when malignant tumour is diagnosed. Nephrectomy is also indicated in papilloma of pelvis with removal of ureter. Sometimes angioma or aneurysm of a branch of renal artery may give rise to hæmaturia. These conditions also require nephrectomy. It is always essential to find out if the opposite kidney is present and whether functionally good to meet the extra demand. In children the commonest malignant tumour is an embryoma and palpable tumour is present before any urinary symptoms appear.

Renal and ureteric calculi.—Generally hæmaturia is mixed with pus cells and pain either in the kidney region or as renal colic is present. Roentgenograms will give useful information. 2 per cent. of renal calculi are however transparent to X-rays, mostly uric acid and urate ones. Sometimes it becomes necessary to find out whether a shadow in the line of ureter or in the renal area is a stone. Here an opaque catheter passed up the ureter and a pyelogram is useful for settling the diagnosis.

Most renal calculi can be removed by pyelotomy, but occasionally a stone in the calyx may require nephrotomy for its removal. The important point is to have a roentgenogram taken on the morning of the operation. It is not unknown that a stone had slipped down the ureter during the course of the night after a roentgenogram had been done. Another point is that one should make certain that all stones are removed. In the Mayo Clinic they use a special table and screen arrangement by which they are able to view the kidney for any shadows before closing the wound.

Stones in the ureter are best delivered by dilating the ureter and injecting glycerine. They can be left in to travel down. Only occasionally is it necessary to perform an operation for their removal. Stones near bladder end of ureter are

best removed by cystoscopic methods. One could slit the ureteral mouth or dilate it for removing the stone. In cases where kidney is damaged beyond recovery, by calculous pyonephrosis, it would be advisable to do nephrectomy if the opposite kidney is healthy.

Calculus-anuria—If suppression of urine occurs by impacted calculi in the ureter, an attempt should be made to dilate the ureters and pass catheters up to the renal pelvis, and leave the catheters in. The stone may travel down and the patient recover. If this fails, kidney should be exposed decapsulated and a pyelotomy or nephrostomy done and a catheter drain left in. The side to be exposed is the one where pain was complained of just previous to anuria. If the kidney is atrophied here the opposite kidney should be exposed and similarly dealt with. This is a life-saving operation and if not performed death takes place in 6 to 8 days from uraemia.

Hydronephrosis:—It is easily made out by intravenous pyelography which also indicates the presence and condition of opposite kidney. Unilateral hydronephrosis is due to kinks or obstruction in the ureter or at pelvi-ureteral junction. Kinks are due to movable kidney or low placed kidney. Sometimes it is due to ball-valve action of a renal stone or an aberrant artery pressing on the ureter or pressure by tumours, etc. Bilateral hydronephrosis is usually due to obstruction at the bladder outlet or in the urethra. The ureters are also found dilated. In children and young adults this may be caused by congenital valves in the prostatic urethra. But in grown up adults it is often a septic hydronephrosis and then may be the result of obstruction at vesicle outlet and posterior urethra in males, and retroverted uterus or tumours in the pelvis in women.

For early cases of hydronephrosis due to movable kidney, fixation of the kidney and a plastic operation on the renal pelvis is enough. In cases due to stones 'ball-valve' action of a small stone the operative treatment is pyelo-lithotomy and drainage of

pelvis for some days. For aberrant vessels the ureter must be cut at its junction with renal pelvis and reimplanted into the pelvis so as to avoid pressure of the vessel. In no case can one ligature the vessel as this procedure will cut off blood to a portion of lower pole of kidney. Where hydronephrosis is so large that there is no kidney substance left, one should ascertain of the existence of a healthy kidney on the opposite side and if satisfied do nephrectomy of the affected one.

Pyelitis mild or severe is accompanied by pyuria and hæmaturia. The urine is usually acid if *B. Coli* or *B. Tubercle* are the organisms. Frequency of micturition is present in both. If urine is reported as sterile the infection is likely to be tubercle. In the case of *B. Coli* the urine has a fishy odour. Sometimes it may be due to pyococci. Culture will indicate the infection. In acute cases of *B. Coli* there is fever some times with rigors.

Treatment.—For *B. Coli* infection give potassium citrate dr. i every four hours in a draught of water till urine is alkaline and keep it so till fever and other symptoms disappear and then reconvert urine into acid by giving acid sodium phosphate. In pyococcal infection hexamine should be given and vaccines. If the condition persists a few lavages of renal pelvis by indwelling ureteral catheters will clear up the condition quickly. 1% silver nitrate or one of the protein salts of silver may be used for this.

Bilateral pyonephrosis is the so called surgical kidneys from obstruction and ascending infection. This either results from pressure on both ureters simultaneously as in women from gravid or retroverted uterus or pelvic tumours. In men it is due to obstruction at vesical outlet or in the urethra as stricture or enlarged prostate. It is important in these cases to know the total capacity of the kidneys to excrete waste products.

(1) *Elimination tests*—*Phenolsulphonephthalein, test*:—Patient is given 10 ounces of water to drink followed by intramuscular injection of 1 cc solution containing 6 mgs of phenol-

sulphonephthalein. A catheter is left in the bladder and urine is allowed to drop into a glass containing a small amount of 25% Na OH. As soon as a faint pink appears in the glass the catheter is clipped. The first hour and second hour urine are collected separately and tested for the dye. Normally first specimen contains 60-65% and second hour 20-25% of the dye. A total that is below 45% for two hours indicates renal insufficiency.

(2) *Calvert's test*.—Patient's last two meals should be meat-free. After 12 noon fluids are restricted. At 9 p.m. 15 grams of urea and 4 ozs. water are given. Bladder is emptied at 10 p.m. Urine passed from 10 p.m. till 7 a.m. is collected as specimen A. He is now given 30 ozs. of water to drink and urine from 7 to 9 a.m. is collected as specimen B. Urea in both is estimated in percent.

Urea Range is the difference between the percentages in A and B. Urea Index expressed in percentage = $\frac{\text{Urea Range}}{\text{Maximum or Percent in A.}}$
If index is above 25% elimination is good though delayed, but if below 12% it shows damage in kidneys with retention of urea. A small white kidney will give a low urea index. If urea index is below 25% operations on bladder or urethra should be delayed till the index is raised by treatment.

Tuberculosis of kidney.—Here we are concerned only with unilateral infection in otherwise healthy young adults. These patients usually complain of frequency of micturition especially nocturnal and not relieved by rest. There may be some burning sensation. A small amount of hæmaturia with pus cells may be found. In the early stages urine may be sterile but is acid. There may be no bacilli seen in the deposit. Guinea pig inoculation should be done. There are characteristic changes seen in the bladder on the homolateral side of ureter. These will be described later. Specimen of urine from each ureter should be taken and examined bacteriologically and microscopically.

There is sometimes a closed type of renal infection where ureter may be blocked or it may be sub-cortical infection not opening into the pelvis. In such cases a radiogram may show calcification. When diagnosis has been made and one is satisfied that the opposite kidney is healthy and adequate, a nephrectomy of affected kidney is done. The usual sanatorium treatment is carried out and patient rapidly improves. Tuberculin treatment is useful in this condition.

Congenital cystic kidney.—This is bilateral and though present from birth it gives rise to symptoms only in adult life. Frequency of micturition from polyurea and presence of R.B.Cs. in urine is the chief trouble. Later palpable tumours become evident. A bilateral pyelogram shows similar conditions on both sides. The calyces are drawn out into elongated curves with curved filling defects in the renal pelvis. These kidneys suffer from arteriosclerosis. No operation should ever be done on these. The patients die of uræmia.

Chyluria :—In filarial infection one occasionally comes across this condition. The chyle is not from the bladder directly but from one of the kidneys. The underlying pathology is that from obstruction in the thoracic duct the renal lymphatics become varicose and some time later give way, when chyle with a little blood flows down. The flow of chyle is intermittent depending on the rupture of the lymphatics in the renal pelvis when engorged, some time after a meal rich in fat. In examining these cases cystoscopically it is advisable to give them a drink of milk three hours before cystoscopy. The right kidney is more often affected as the lymphatics of this are shorter. At present there is no known treatment.*

II

VESICAL CALCULI

Formation of stones :—Though 2 to 4 grams of urinary salts are passed by an adult per day, urine shows no tendency for

* This lecture was illustrated with pyelograms and cystoscopic pictures.

crystallization of these salts into calculi in healthy people. Urine is a supersaturated solution of these salts. This is brought about by the presence of minute quantities of some reversible colloids apparently secreted by the kidneys. Only two of them have been indentified, *viz.* urochrome and mucin. Only certain salts have a tendency for calculus formation. These are uric acid, urates, oxalates and calcium phosphates and rarely cystine and xanthine. Though crystals may be precipitated, usually they show no tendency for conglomeration into calculi.

Keyser puts forth the theory that some qualitative or quantitative change or both occurring in the reversible colloids is responsible for formation of stone. McCarrison has experimentally produced calculi in rats. He says that deficiency of vitamin A with an imbalance in the blood calcium and phosphorus, the former being higher and the latter lower than normal may cause formation of stones. In addition something in the germs of cereals stimulates stone formation. This is present in wheat but not in rice. It is possible that stone-forming colloids are specific and caused by specific organisms. Rosenow considers that a specific organism causes it.

Once a nucleus is formed its growth into a calculus is favoured by stasis in the urine and also by alkaline or other changes in the urine. Vesical calculi may be divided into : Primary and Secondary.

Primary calculi are the result of small calculi that have travelled down to the bladder from the kidneys. These often escape per urethra but sometimes may be held up in pockets formed during contraction of the bladder. A favourite place is the 'bas fond' or retroureteric space. These grow in size gradually. Primary calculi are usually single. In the earlier stages their growth is slow but if urine become alkaline they quickly increase in size by deposit of triple phosphates.

Signs and symptoms.— They are more common in men than women. When small they may give rise to stammering of the

stream, sudden stoppage of the stream which is relieved by change of posture or even acute retention from impaction in the vesical outlet. When they are large they generally lie on the trigone and give rise to frequency of micturition. Urine will contain pus cells and red blood corpuscles and crystals. The stone lying on trigone or in the bas fond is liable to set up also terminal hæmaturia especially if it is made of calcium oxalate. Frequency of micturition is relieved by rest to a certain extent. Pain is usually referred to tip of penis or perineum. Children may pull at the prepuce and elongate it and even learn the habit of masturbation through this during adolescence. They may take up peculiar postures in voiding urine as for example 'getting on knees and elbows.' If the urine becomes alkaline from cystitis the frequency increases and strangury may be complained of, patient trying to pass urine every few minutes.

Examination:—A bimanual examination per rectum may indicate the presence of hard mass in the bladder. X-ray examination will bring out the shadow of stone. Calcium oxalate stone gives a dense shadow but uric acid and urate stones give less dense shadow. Sounding the bladder may be done. Oxalate stones give a sharper note than urate or uric acid ones. Triple phosphate are much softer and the note is duller. Finally cystoscopy should be done. This will give an idea of the number, variety and size of stones, the condition of the bladder and also any other lesions that may be present.

Secondary stones are either formed round foreign bodies as bits of catheter, hair pins introduced inadvertently or ignorantly into bladder (by girls), round unabsorbed ligatures or parasites as the ova bilharzia. Secondary stones however are more common in obstructive lesions of vesical outlet or urethra as in enlarged prostate, strictures, etc. Such secondary stones are most often multiple and faceted being found in the retroprostatic or other false pouches. Urine in such cases is usually alkaline, as a result of stasis. Diagnosis usually made by history of

the case and the evidence of X-rays and cystoscopic examination.

Treatment—The earlier the diagnosis the better it is for treatment. Small stones except in children are best dealt with by lithotripsy or crushing operation. In children and where the stone is too big, a supra-pubic cystotomy and removal is required. The former entails a shorter stay in hospital and avoids a scar. With the new Cystoscopic—lithotrite this operation can be carried out without any damage to bladder mucosa. Secondary stones round foreign bodies are best dealt with by the cystoscopic lithotrite. But where stones are secondary to obstructive lesions, operation for the primary condition should be done with removal of stones.

TUBERCULAR CYSTITIS.

This is usually secondary to either renal or genital tuberculosis. The majority of cases are the result of descending infection from kidney, some are due to infection spreading from seminal vesicles and prostate which may be either primary in them or secondary to tubercular epididymitis. In the renal type the first lesions in bladder are found round the homolateral ureteric opening. First a redness of ureteric lips with increased frequency of efflux occurs. Soon a little oedema of the mucosa occurs followed by grey translucent miliary tubercles. These tubercles then become yellow and larger from caseation and finally break down into punched out ulcers with undermined irregular edges. The ureteral opening now look patent and the normal vermicular movement is absent. With further peri-ureteral infiltration the opening becomes retracted and quite open and usually referred as 'golf-hole' ureteric opening. Other tubercles form along the blood vessels and break down into ulcers. The process extends to the trigone. Tubercles in the apex are rare. But sometimes these are found owing to the part coming into contact with ulcerated parts during contraction of bladder. The frequency of micturition produces a hypertrophy

of the bladder muscle. There is also a pericystitis. All this gradually reduces the bladder capacity to barely an ounce and called 'thimble bladder.' Retrograde infection of the opposite kidney is liable to take place.

If it is the result of extension from seminal vesicles and prostate the preliminary changes are noticed at the vesicle outlet in the trigone. First oedema of mucosa followed by formation of miliary tubercles, caseation and ulceration, is seen.

Symptoms.—Insidious onset but steadily progressive and occurring in young adults between the ages of 20 to 40. Frequency of micturition not relieved by rest. Urine is acid and sterile on bacteriological examination and culture. Urine leaves a deposit of pus cells and red blood corpuscles. Such a urine should be suspected and guinea pig inoculation should be done. Examination of genital organs should be done, to exclude genital origin. Thickened ureters are palpable per rectum. If the changes are round the ureteral opening the ureteral catheters are passed up and specimens of urine are collected and sent to the bacteriologist and bio-chemist for investigation. Functional tests for the healthy kidney are done.

Treatment:—If renal in origin and the opposite kidney is functionally good and sufficient, a nephrectomy followed by general sanatorium treatment will cure the patient. Genital type is rare. Young advises in such cases removal of prostate, seminal vesicles and epididymis in one mass by the perineal and inguinal routes. After the operation the bladder clears up fairly quickly as patient gains in weight. Occasionally one or two ulcers may persist especially the apical contact ulcer. A little diathermy cauterization of the ulcer will make it heal rapidly (Heitz-Boyar). Tuberculin in these cases is useful.

The late stages of such cases are a painful sight. Secondary organisms give rise to an alkaline cystitis. The frequency of micturition ends in actual strangury. Patient gets no rest. In advanced cases instillation of Gominol 10 ccs. of 20 per cent.

in olive oil or 50 ccs. of aqueous solution of acid carbolie 6 per cent is advisable. Never use silver solution for tubercular cystitis, as the condition becomes worse and more painful.

Neoplasms of bladder.

These may be classified into :—Benign and Malignant.

<i>Benign.</i>		<i>Malignant.</i>
Papilloma 60%	$\left\{ \begin{array}{l} \text{Villous} \\ \text{or} \\ \text{Pedunculated} \end{array} \right.$	both may become Papillary carcinoma Infiltrating „
Adenoma of trigonal glands (rare)		Adeno-carcinoma
Cysts ; epithelial or glandular		Epithelioma
Angioma (rare)		Sarcoma (rare)

Papilloma is the most common of the tumours forming 60%. Each papilla is made of fibrous tissue with a loop of blood vessels and covered by several layers of epithelium. 43% of these occur in the vicinity of ureteric orifices on their lateral and superior aspect, next favourite spot is the 'bas fond.' They are found in adults between the ages of 30-50. They are more common in men. They are soft and friable and easily break and bleed profusely. In the villous type the filaments spring directly from the mucosa, being slender and of variable length. They have no definite pedicle.

The pedunculated type has a more or less well formed pedicle from which the villi spring. The villi are shorter and more closely packed, the whole resembling a raspberry. Their consistency also is firmer. A median section resembles that of a tree with its branches. The mucosa in both is freely movable over the muscularis.

Symptoms.—Painless haematuria of sudden onset which may last a few hours or days and suddenly stop, not to appear again for months. There are no other symptoms.

Diagnosis:—The cystoscopic appearance of these is typical. The villi can be seen to wave like sea weed in the fluid. If the growth be too large or on account of bleeding difficulty of examination may arise. Treatment should be prompt as these growths have a tendency to pass into malignancy. Cystoscopic fulguration is the choice for smaller growths. A general anaesthetic is required for larger growths. The diathermy electrode has a platinum tip and size 5 or 6 F will pass through a catheterising cystoscope. The application may last 10-30 minutes at a time. Coagulation necrosis of the growth occurs. The patient should be informed that when the slough separates bleeding might occur and to report if this be severe. It usually occurs at the end of ten days. Sitzings are repeated every 5-6 weeks till the mucosa appears normal. After this patient should report once in three months for cystoscopic examination. These growths are very liable to recur at the previous site or elsewhere. These growths have a tendency to gradually become malignant and the changes noted in this transition may be tabulated as follows:—

	<i>Innocent.</i>	<i>Malignant.</i>
Pedicle	Long, thin, —>subsessile—>sessile—>infiltrating.	
Villi	Long, fine, sharp, luxuriant,	>Stunted, swollen, closely packed.
Size	Smaller more likely innocent.	The larger more likely malignant.
Number	More often single.	More often multiple.
Base	More delicate, not fixed, no oedema.	Thicker, stunted, fixed bullous oedema around.
Cystitis	Absent or only mild.	Cystitis present and obstinate.
Phosphatic deposits:	Absent.	Present on the growth.

Hæmaturia Painless, sudden profuse, ceases as suddenly. More persistent, pain steadily increases with increased frequency.

Reaction Good Poor, may even thrive.
to Diathermy

Majority of malignant growths are papillary carcinomas, either cauliflower-like growths or sometimes infiltrating ones. These usually arise from papillomas taking a malignant turn. Cystitis is usually present and frequency of micturition and terminal hæmaturia. The condition becomes steadily worse and beyond control unless dealt with early.

Treatment:—Papillomas that show recurrence or any sign suggestive of malignancy should be destroyed by diathermy followed by implantation of radon seeds or radium by applicators through cystoscopes. It is advisable to send a piece of growth for pathological examination. If reported as malignant it is advisable to do partial cystectomy to include the growth and half inch of healthy tissue around. It is necessary to render the bladder extra-peritoneal before cystectomy is done. Care should be taken that no implantation of seedling occur.

Other types of malignant growths are adeno carcinoma, epithelioma and rarely sarcoma. These are rare compared to the previous types. If a malignant growth occurs on the trigone it is advisable to try radium therapy by radium-bomb or direct application by cystotomy. If patient's condition is good a total cystectomy with transplantation of ureters may be tried.

Cause of obstruction at the vesical neck in the old.

1. Simple adenomatous growth of prostate—really an adenomatous growth of one or two prostatic spherules.
2. Adenomas or cysts of peri-urethral glands, and these are (a) sub-trigonal glands, (b) sub-cervical glands, (c) peri-urethral glands.

3. Chronic inflammatory thickening of median bar (posterior bar formation).
4. Chronic inflammatory circular collar formation at vesical outlet.
5. Chronic fibrosis of prostate.
6. Malignant growth of prostate.
7. Chronic prostatic abscess or prostatic calculi.
8. Post-operative fibrosis after prostatectomy from contraction of outlet, bands and adhesions or posterior bar formation.

Conditions 3 to 5 usually give a previous history of gonorrhœa and a long history of difficulty in complete micturition. They usually have no residual urine or only small in quantity. Rectal examination is negative, only a hard small prostate with even surface being felt. Cystoscopy shows only a little chronic trigonitis but well marked trabeculation of bladder muscle. Cysto-urethroscopy may show the fibrosis.

These cases are treated first conservatively. Prostatic massage, diathermy of prostate, neutral iodine intravenously and vaccines may improve the condition. Repeated dilatation with bougies should be done. Failing this punching-out operation is advisable. Young's punch with diathermy electrode attachment is used for producing coagulation necrosis of the bars to render operation blood less. The adenomas are either removed by supra-pubic route or perineal one of Young. The smaller type may be destroyed by fulguration through a cystoscope or urethroscope according to site. Malignant prostate is best treated with radium by perineal route or radical removal may be done.

It is important to have an idea of blood-urea and functional capacity of the kidneys before any operation is undertaken.

DECOMPRESSION OF THE BLADDER.

When a bladder is chronically over-distended as in old people the kidneys have been secreting against intra-vesical tension. Any sudden release of this pressure so upsets the kidneys that they get acutely congested and blood-urea rapidly increases as the kidneys are unable to excrete it. A fatal result may follow in 10-15 days from uræmia. Hence the necessity of slowly lowering the intravesical tension. One should take at least 72 hours to empty such a bladder. Either a Shaw-Young apparatus should be used or a dropper fixed to the indwelling catheter so that urine can flow only in drops. In about 72 hours bladder empties without upsetting the kidneys. Later elimination tests either pheno-sulphonephthalein or Calvert's test are carried out, if satisfactory operative interference is undertaken. In other cases one may wait 1 to 6 months for the necessary condition. This interval should be used for improving the general condition of the patient.

*The lecture was illustrated with cystoscopic pictures of the various conditions mentioned.

Infant Foods.*

BY DR. M. B. PRAHBU, M.B., M.R.C.P. (EDIN.), M.M. (LOND.).

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Infant feeding on physiological lines is important in pædiatrics. A doctor be he a physician or surgeon, has to deal with infants in his practice and has to prescribe for them nourishing and suitable diet during any illness or operation. If the food is unsuitable, however efficient other lines of treatment might be, they will get diarrhoea or vomiting or will gradually waste and succumb to the disease. The laity are taking an increasing interest in the feeding of infants and is not uncommon for the young mother to inquire of the doctor what she should give her baby, whether she should continue it at the breast or give it one of the proprietary foods. Such being the case, it is necessary we have clear ideas on the values of different infant foods.

Infant foods.—Milk is the food in infancy and human milk is the ideal milk for the infant. Where human milk is not available cow's milk is almost universally used. Cow's milk as is well known, differs from human milk. It is mentioned in books at length how the proteins, fats and carbohydrates differ in the two milks and we are shown how to reduce the proportion in cow's milk to that in human milk. Once this is done, we are led to believe it is as good as human milk and is called humanised milk.

There is difference in the amount of inorganic salts in the two milks. Less attention has been given to this aspect, although the organism can perhaps utilise carbohydrates for the production of fat and can perhaps form sugar from albumen, it is impossible to effect such transformation in the case of inorganic salts.

The inorganic salts in cow's milk are $3\frac{1}{2}$ times as abundant as in breast milk with the exception of iron which is only $\frac{1}{4}$ in

* Abridged from a lecture on February 1933 before the Provincial Medical Association.

amount. Hence when infants are fed on cow's milk they must be given iron, and, recent researches have shown that iron acts best if there is a trace of copper in it.

Even if cow's milk is so modified that the proportion of proteins, fats, carbohydrates and salts is the same as in human milk, we do not get a fluid identical with human milk though it may closely imitate it. Because human milk is a complex fluid with its specific proteins, fats, vitamins, ferments and antibodies.

In the early weeks of human life when the tender organism has to adjust itself to external environments, at a period when growth is active, breast milk is essential. The infant takes to breast milk naturally and there is very little trouble in rearing the infant. But take the new born child away from the mother and straightaway put it on cow's milk and you will be surprised and annoyed at the difficulties that constantly crop up. Cow's milk may be modified, may be peptonised but it is not going to agree so well as breast milk. This is particularly so in the case of feeble and premature infants. Infants fed on cow's milk have not the alert features, the firm muscles, the active movements of the breast fed child, particularly during the early months. This is because cow's milk agrees with difficulty in the first few weeks of life and it is after six to eight weeks of breast-feeding when the child is about nine pounds or more in weight that it has the resistance to digest and thrive on cow's milk.

Proprietary foods.—There are several well-known makes in the market. They have a distinctly useful place in infant feeding. But the manufacturers instead of assisting the doctor in his work, tend to usurp his position and directly educate the public in these matters by attractive advertisements. We are often guided in the choice of milk foods by the advertisements we see in the daily paper or the brochures we receive from time from the agents. Reading this it is natural that the mother's

thoughts should go towards giving the baby the proprietary food instead of cow's milk.

Generally these foods are after all modifications of cow's milk and in a large number of cases cow's milk fresh and pure will be far more preferable to dried milk.

These foods are useful at times. They are sterile foods. They can be easily prepared. They can be taken with us when on a journey. Where fresh cow's milk is not available, they are preferable to stale milk teeming with bacteria. They are more digestible than cow's milk. But when prepared according to the directions they have the composition of cow's milk, and the percentage of cream is rather high. The Indian infant finds it too strong for its digestion. In such cases half cream or $\frac{3}{4}$ cream dried milks are preferable but they are not available readily. These proprietary foods are preferred generally according to the instructions on the tin and one hesitates to change the instructions lest if the child should lose weight, it should be considered as due to the doctor's alterations, sometimes a little more water is added than is advised. Here the main idea is to give a food of definite concentration in the hope that it will suit the baby. Here you expect the baby to suit the milk whereas it is more rational if we prepare the milk to suit the baby. In the case of cow's milk we can modify it in different ways. Here are a few forms of cow's milk, that may be prepared with very little trouble

1. Pure cow's milk.
2. Skimmed milk.
3. Simple dilution with water.
4. Dilution with barley water or lime water.
5. Humanised milk.
6. Citrated milk.
7. Peptonised milk.
8. Whey.

9. Lactic acid milk.
10. Butter milk.
11. Protein milk.

One or other of the above forms of cow's milk, is bound to agree with an infant however feeble or erratic its digestion might be. This is more rational because though we even simplify the art of infant feeding on paper we cannot do so with the same ease in actual practice, because, there are no standard babies and each one has its own peculiarities as regards its weight, digestion activity, etc. As Hutchinson says, "you must individulaise" and realise, what suits one baby does not necessarily suit another.

In case of proprietary foods we have no idea when they were prepared. We do not know if the nutritive value of the foods suffers in course of time. Very likely it will. Some well known makers say that their products keep indefinitely as long as the tins are intact, others advise their products to be used by a definite date. It is high time the medical profession knew something definitely in this matter.

Lastly it may not be out of place if some of the newer preparations of vitamins are considered here. They are used frequently with infant foods and one feels out of date if he does not prescribe them instead of cod liver oil. These modern preparations are rich in vitamins and have been standardised. They may be administered in small doses. Where a child definitely suffers for vitamin deficiency, they may be prescribed for their rapid effects. But as a daily article of dietary I consider cod liver oil preferable to these concentrated products because of its assimilable fat. Infants require fat in their diet. Cow's milk, unless suitably diluted, does not agree with infants, and in such dilutions is poor in cream. If with such milk we give concentrated vitamin products the child will still be wanting in fat. Vitamins cannot replace fat from the dietary and cod liver oil either pure or as an emulsion will supply the necessary amount. Then again fat is rich in calorific value. Not so the vitamins. How much of vitamins are necessary

for an infant we do not know. If vitamins act like hormones or like catalytic agents in chemical processes, a small amount should suffice to initiate and maintain the reactions. Large amounts are not necessary. We do not know the optimum doses in case of vitamins. Animal experiments have shown that large doses of vitamin A cause myocardial degeneration but there is no proof that large doses as used clinically have caused the same phenomenon in infants. Give vitamin A, but, remember it does not replace the fatty constituent in the dietary and has no calorific value.

Something more definite can be said in the case of vitamin D. It promotes the absorption of Calcium and Phosphorus and if it is administered in rickets, calcification takes place in the soft bones. If the vitamin is given in a concentrated form as in the newer preparations, these changes take place rapidly. In rickets very often deformities are present in the bones, either in the ribs or the long bones of the extremities. We have not only to see that proper ossification takes place but also to ensure that the deformities are corrected. It takes time to correct these deformities, and if high doses of vitamin D are given, the bones will be mineralised soon, active rickets will disappear but the deformities will be "set" in their place. When the bones are soft, it is very advisable to see that the deformities are corrected as much as possible and then allow the bones to harden slowly, meanwhile giving an opportunity for the deformities to appear. In such cases, codliver oil is preferable to the newer preparations with their high vitamin content, and in cases where these are used, these must be used in comparatively smaller doses than is recommended by the manufacturer, I had seen a child with bow legs but no active rickets. It had the concentrated forms of vitamin D for a long time as a result of which the rickets had disappeared but the deformity had persisted. Therefore as a daily article of food in an infant's dietary a good brand of codliver oil either pure or an emulsion is preferable to vitamin extracts.



Gumma skull exposing the Pulsating Brain

Case Reports.

By M. RATHNAVELU, L. M. S.

*Honorary Assistant Surgeon, Special Department,
General Hospital.*

Two interesting and rare cases that attended the Venereal Department, General Hospital, Madras, are recorded here.

1. Extra-genital Chancre at elbow.

Mr. J. Moh. M, aged 20, admitted on 11-8-32.

Denies any exposure. Not married. Patient is feeble minded.

There is circular, painless, punched out hard, indurated ulcer, of the size of a quarter-anna piece, on the posterior aspect of right elbow. 10 days duration.

No urethral discharge.

The epitrochlears and axillary on the corresponding side were enlarged, firm and painless. No other evidence of Syphilis. The *Dark round examination* (D. G.) of the sore is positive to *Spirochæta Pallida*. *Blood Test*—Khan doubtful. Wassermann doubtful on 11-8-32.

Gets anti-syphilitic treatment, both Neosalvarsan and Bismuth weekly. Ulcer elbow has healed with 2 injections of Neosalvarsan.

The peculiar feature in this case is the rare site of the extra-genital chancre at the elbow.

2. Gumma skull with the absorption of occipital bones exposing the pulsating brain.

Mr. N., Hindu, married, aged 40, admitted on 11-3-32 and discharged on 11-8-32.

Sore 10 years ago. No treatment.

Large sloughy ulcer skull. 3 years duration.

No sore or scar or discharge.

Groin glands—palpable A few pigmented scars on right groin. An extensive gummatous osteomyelitis of the skull in the occipital

region. Bone completely destroyed, exposing the pulsating brain covered with Dura. Multiple frambesiform syphilides all over the skull.

Pulse. Slow with dropped beats. Heart block?

No mucous membrane lesion.

Kahn positive. Wassermann positive strong on 17-3-32.

X-Ray report.—Gumma skull with the absorption of occipital bone.

The occipital bone appears to have been absorbed and the Parietal bones are also involved.

Was given 1 course of 2·65 grams of Neosalvarsan and '6 grams of Myosalvarsan and 10 c. c. of Bismuth (Hypoloid)

Ulcer scalp was healing but very slowly.

The gap in the skull was protected by a plate of aluminium.

Blood Test.—Kahn doubtful. Wasserman negative on 24-6-32.

After a period of one month rest, the second course was started.

Lumbar puncture was done. Pressure normal.

Cerebro-spinal fluid: Cells. No. Cells.

Albumen 59·4 Mgs. %

Globulin Nil.

Wasserman anti-complimentary.

Goldsol test negative curve.

During the second course patient developed cutaneous irritability and hence the treatment had to be stopped for a while and 10 c. c. Sodium Thiosulphate injected intravenously every alternate day. After 2 injections of Sodium Thiosulphate, itching stopped.

He received '9 gram Myosalvarsan and 12 c. c. Solu salvarsan in the 2nd course. The patient would not stay in hospital to continue treatment and was discharged on 11-8-32.

My thanks are due to Dr. R. V. Rajam, M.B. M.S., M.R.C.P., Venereal Specialist, General Hospital, Madras, for kindly permitting me to publish the case reports and clinical photograph

“The darlings of our College.”

I believe, that it is my duty to apologise at the very outset for the subject of this article, which I am afraid may offend some sensitive souls, or draw praise from others, who, like me, have no eyes for the bright patches, but, only for the dark spots. I really feel very small for washing the dirty linen of my own comrades, just for a steaming cup of coffee, the cost of which, one anna, was reluctantly taken out from the Khaddar pocket of our secretary. A growing sense of inferiority prevails over me—inferiority even to Judas, who at least was promised thirty pieces of silver. With a heavy heart and a lingering pen I set on this unpleasant job, cursing the secretary for his coffee, as Eve would have cursed the Serpent for his forbidden fruit. As my hand is laid to the yoke, I mustn't turn back but go through the ordeal, grinning, to be labelled down at the end as the Tom O' Bedlam and, this piece, as the unhealthy product of a diseased mind. If I seriously offend anybody—God forbid, the fault isn't so much mine, as it is of the God that made me.

As the morning breaks out, our three hundred and odd Adams yawn, wriggle, and struggle out of their beds, to study their morning faces in a mirror and consider what they really lack, either a fairer complexion, a straight nose, a well arranged set of teeth, or a pair of well set eye brows. God hasn't perfectly fashioned any mortal, my dear, and that is the despair of one and all. With the dawn come the thoughts for the day, not so much about their books as sartorial graces. The usual morning bath, a clean shave, and a hasty chota see them dusting their books and finally off in immaculate dresses to different conveyances, speeding towards one destination—their Eden.

When the time for the class comes, boys rush in with a view to occupy seats as much near to the first bench as their masculine strength and elbowing could help them. In the struggle ties get ruffled up, bows incline at comic angles, and some of the well blanched shoes change their desired colour. As they sit with dilated nostrils, parting and heaving, the demonstrator enters the class for the roll call and in his wake sail in the Muses, for whose homage so much dust had risen in the

class, and out of the benches. From a sinking ship they are the first to escape, but in an assembling class they are the last to enter. How could the charming and the sweet stand up to rougher things! The lordly lot of students, who think that they are above lectures, and that the examination is not the acid test for their supposed abilities, for there even a fool can sometimes ask what a wise man may fail to answer, just loll up quite leisurely, with measured steps, past the first benchers, thinking that each in his turn will be the object of attraction. Regarding attendance, there is the demonstrator whose duty as they conceive is to see and mark them present.

Bleeding the lark's purses of their parents, boys of my pattern get money for the latest edition of their text, but instead they purchase a combination of tie and kerchief, or a pair of shoes which they would have seen their favourite 'star' wearing on the screen. They think that Oedipus is dead, and that there isn't another to read their inside. With the maxim that "one guesses the goodness of the posture by the mantle one sees it wears" they work out the little plans of their cherished lives. In 'sybil' one only reads with mild horror the struggle that was going on between the two nations—the rich and the poor, but now in reality one sees and experiences the grim, silent and baneful incompatibility between the two ages—the old and the young. Among the old stand out prominently the fathers, and the teachers, who conventional and experienced as they are, think that the young, unsophisticated fellows like myself or the still unmarried reader—with their false ideas, and stilted ambitions are ill-bent towards destruction. The youths in their turn consider the older a 'old monkey', who are incapable of learning new tricks and eventually keeping pace with the changing times.

Now to the darlings, again, but a trifle different. God knows, what havoc is played by these phileas in flamboyant sarrees—sarrees that suit their sweet charm to perfection, or the palms in high heels on the moon-stricken Endymion in pantaloons. For a kind word they eat their hearts away, starve for a smile, and pine for a glance of favour.

"Fair tresses man's imperial race ensnare,

And beauty draws us with a subtle snare."

Some have been lifted out of the rank, some to the rare heights where breathing is so difficult, some have soared up to the empyrean

and placed on speaking terms with the much coveted "Polly." Occasionally, (but, alas; how seldom) the change has been due solely to luck. Sometimes, accident has provided the 'open sesame.' And the unlucky some, in their effort, fall down with their wings burnt, as the ill-fated Icarus even without the passing tribute of a solitary tear. The moods of the delicate are as unreliable and varied as those of the seven seas. That they could blow hot and cold in one breath is a decided fact. They would without regret cut you dead at one place, and recognize with a gracious smile at the other. So the only sane thing for you, young hearts, is to avoid their path and glue your eyes to the ground before you and go ahead. Very often, I think that God has been too cruel to me in not moulding me as a girl. I would have had their irresistible company for as long as I had wanted and the society for boys, oh, just of the mere winking. Being a staunch believer in the divine justice, I console myself as having been saved from some great calamity. In fact, He has been "cruel only to be kind".

I remember some one under the pseudonym of the 'Jesting Pilate' or the 'Wandering Jewess' remark, that the secretary has 'wiped out all, differences between Harold Lloyd and himself by wearing horn rimmed specs. So far as the "comedy of the identity—disc" is concerned the writer is quite correct, but to go a step further he happily thinks, and I gladly chime in with him, that if a beauty competition is held among the boys of the College, he will surely carry off the palm. A wart on his nose, or a pimple on his cheek causes him many an anxious day. With all that, he is a charming young man, getting prematurely bald-headed. One perhaps to the petty anxieties and the angularities of this life. Whenever he thinks of his falling hair, his thoughts run back to his early youth. But, now he only sees the first foot mark of Time. He knows, that one by one those momentoes will decrease

"And steal youth, beauty, strength away till life itself shall cease." A mere touch makes him dissolve in sentiment and smiles and affords a scene even for the angels to envy. In his leisure hours, one could see him walking about the places, where he most desires to be seen, never taking off his hat fearing that a point would be scored against him.

There is another darling, who differs from the previous one in almost all the essential points. Almost, but not quite. He is tall and slim with strides to match his height; of few words and an advantageously silent nature, which helps him to bear the imperfections of others and conceal his own. In the afternoon he goes to his small, smart car, trying to lay his finger on her defect. He would never offer anybody a lift, but if they jump into it of course, they are taken to their destination. Very obliging, no doubt, but eclipses by the brilliancy of his deeds.

As I am writing this apology of an article I hear somebody whispering in my ears to make the demi-gods descend among us. I grow nervous, and shaky even to think of it and cry out "Retro me Satana Retro me." What to say that they crack jokes (not those music hall ones but highly cultured and polished in the class, and await the smile of approval from the first benchers will assuredly be my carrying my own cross.

The companion of a senior medico as he fondly calls himself is a stethoscope, a companion, which in the early days of its possession is never parted with. Like every other object of desire, it is full of promise till he gets it; and then, it is a last year's rest from which the bird has flown. A couple of fortnights back, I saw a speaking acquaintance of mine on the race course decidedly an unholy place and he was constantly whipping out the steth and putting it back, due perhaps to his assimilation in the general excitement of the place. Our friend was a puntee too, but not a wise one at that! He had backed one horse, which I guessed would be one of the 'also ran's. Near the finishing point, his horse was tailing off last, but it was fun good enough, to see one medico swirl his steth, in the air, lasting, as the thought, the Jockey to make his horse win "hands down" as the punters say. But, this is beside the point. With some, the stethoscope becomes such an inseparable part of their personality, that one could see it on them even in the talkie houses at the night performance. But I haven't seen the lady medicoes with that 'stamp' on such occasions, because I suppose they have no pockets on their sarees.

Now there is another type of students, whose only religion is studies and their bible, the texts. They have no other thought in life, except the adornment of their names with the much sweated for degree. What I usually do is to keep as far away from them, as my indecent manners

would permit, and there contagion fly." If I happen to meet them, or see their industrious faces as the first object on entering the premises of the College, I feel perfectly out of element, as if I had risen out of the wrong side of the bed. A failure makes them climb down from those fashionable heights to a less expensive mode of dress—a dhoti and a tie, which also they would love to discard in that period of sorrow, but for the pressure brought on them by certain departments of studies. Being forced to wear something round their necks, they wreak vengeance in their own way, by ignoring altogether the head-gear, and the food-ware. After success, back again to romance and sentiment.

As for the ladies, if failure marks them for her own, though temporarily, they lose their usual all endearing expression and sentimental smiles, and look a picture of "Niobes in weeds and ashes." For them "the stars turn into mourners and every wind of heaven in a dirge."

Many of you will be highly strung with curiosity to know who I am—well, one who hasn't decided to give up the mute company of the "dismembered dead"; one who is quite content to be one of the crowd of your well wishers with this fervent prayer always on his lips.

"Tho' twain, yet one, and running to one goal,
A chariot wheels, tho' twain, together roll;
Light be your load of life, your pathway clear,
Your common goal when furtherst seem most rear."

"A CYNIC"

A Modern Venus.

BY BOB.

On a glorious evening in the month of December the extensive sandy shore of one of the main sea-ports of South India was thronged with people of all castes and creed, rich and poor, aged and young, educated and uneducated, to appreciate Nature in her true form, and to imbibe the fresh and pure air, which was being continuously blown ashore from the surface of the mighty ocean. The Tropical Sun had already set, and in the distant horizon where the sea and the sky appeared to meet, there were seen clouds of different hue, which enhanced the beauty of that picturesque evening. With the onset of darkness, tiny little stars began to twinkle in the clear sky, and from every one of these, rays of light were shed, to the seething humanity down below. Seated under the blue canopy of Heaven studded with stars of all sizes and brightness, every one was enjoying in some way or other. In one place, a little out of the way from the crowd two happy family groups were seated, and may I now introduce my readers to them.

Besides the elders and the little ones, there were a young man, who appeared to be just in the last stage of his 'teens', with a clean-cut face, and robust appearance dressed though not very gorgeously but decently enough, and young lady, whose very look indicated that she was still in the budding stage of her youth, a little younger than the young man, but physically well developed, possessing a fair complexion and round face, and for brevity sake, I am forced to give up a graphic description about her. The children were busy playing on the sands, and the elders as usual, were discussing about this and that, which in no way seemed to attract the attention of neither the young man, nor the young lady. They appeared to be watching the children play, the waves of the sea dashing against the shore a few feet away, eagerly following the progress made by a cargo steamer, and the innumerable fishermen's crafts with which the whole sea appeared to be full. Who knows whether the following lines of Shelley were not in their minds all that time?

A Modern Venus

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"The fountains mingle with the river
And the rivers with the ocean.
The winds of heaven mix for ever
With a sweet emotion ;
Nothing in the world is single,
All things by a law divine
In one another's being mingle
Why not I with thine?"

Nearly half an hour elapsed in this way, and then a man with a basket of oranges came up to them, and shouted his usual rhyme of "Orange", "Orange". This put a stop to the various activities of the children on the sand, and each in turn came and surrounded the orange-vendor and at once the young man purchased about a dozen fruits and distributed them to the children, who over-joyed at the possession of an orange each, went away immediately in pursuit of their respective games. There were a few extra ones left, and our young lady took one of them and with her delicate hands peeled the skin off and distributed to all. It was just after she offered one piece to the young man that these elders realized the great injustice done to the younger generation for not introducing them earlier. Even before the formal introduction the young man had accepted the orange piece and had promptly thanked the donor.

"Excuse me Joy, I am so sorry I forgot to introduce my niece Moley to you. She is studying in the College, and is now spending the holidays" said a middle aged lady. The other lady in the group who was a little stouter than Moley's aunt added "Oh! I thought you knew each other Moley. This is my brother Joy, who has just come down to spend a few days with us." It took comparatively no time for Joy and Moley to exchange a look of recognition accompanied by a faint smile. Now that they were formally introduced, both began to apologise each other for not starting the conversation earlier, and added that they had heard about each other from their relations. Their subject of talk soon developed to studies, and Joy began to speak about the line he has chosen, and he brought forth so many arguments to prove the superiority of his line of study. It was more of a casual talk than of actual friendship, because they were introduced only a few minutes back, but any onlooker would have easily said that both Joy

and Moley were enjoying their company only too well, and in their heart of hearts, they had the desire to stay rooted to the same place for hours more, but in an hour's time the children began to show signs of 'homesickness', and so they had to part much earlier than they expected. But before they rose up, Joy wished Moley good night, and added that he hoped to see her again.

"She gazed as he slowly withdrew,
His path he could hardly discern;
So sweetly she bade him adieu
He thought she bade him return."

Little did I then dream that this first meeting between Joy and Moley will be the root cause of a strong and devout love that soon sprung up between them, and had I then realised it, I would certainly have asked them to bear in mind that:--

"Our lives we cut on a curious plain,
Shaping them as it were for man;
But God with better art than we,
Shapes them for Eternity."

As ill-luck would have it, Joy had to leave the place the next day, because duty demanded him, and before he left, he went over to the house of Moley, and wished every one good-bye, and how earnestly he longed to meet her before he left the place. Fear of the elders, or the inborn shyness peculiar to that sex, or sorrow at the unexpected parting, which ever it was, Moley did not come out of her room, and feeling this lack of reciprocation from her, he soon left the house, and got into the carriage which was waiting for him at the gate. Some inner soul in him urged him to look through the window of the carriage, in the direction of Moley's house, and what a lot of consolation and mental comfort did he derive, when he saw her furiously waving her small handkerchief, from one corner of the upstairs verandah, unobserved by anyone.

Two long years passed without Joy or Moley meeting each other, but they used to get all available information about each other from their respective relations. Fortune seemed to be favouring them, because quite unexpectedly Joy's relations had to leave to the place where Moley had gone to prosecute her studies. From that time they used to meet

often, and talk a few words, and although both of them wanted to speak their minds openly, some how they postponed. Months passed and Joy finally decided to open the topic somehow.

Every true son of our Motherland will remember the day on which Mahatma Gandhi began his famous Dandi march, and it was on a 3rd of March that Joy asked her about her future, and unhesitatingly she made him understand her absolute willingness for becoming Joy's partner for life. On that day itself they decided that 3rd of March every year should be remembered by them, not only for its Political importance, but mainly due to their personal interest. Their parents and relations did not know the decision they had reached, but they had strong doubts. Both of them knew that there were a few obstacles in the way of their union, but they had resolved to encounter them one by one, and with a determined effort they began to toil night and day for the realisation of their hopes.

Absolutely contented in their respective spheres of life, they allowed matters to progress smoothly, and on February 7th of the next year there occurred some slight misunderstandings, but Joy, who was fully confident in his Moley, openly declared that he was not the person to believe anything, unless Moley herself openly tells him, and as expected by him, she never failed him at that hour of need. That incident only added to their love and faith in each other. Their motto as dictated by Moley to Joy was "As ages advance, let us get on in all love and confidence," and they were always ready to strictly adhere to their motto. Both of them had realized by that time that,

"Foul words and frowns must not repel a lover:
What though the rose have prickles, yet it is plucked,
Where beauty under twenty locks kept fast,
Yet love breaks through; and pricks them all at last."

Meeting each other daily, and confiding their cares, worries and trials of life, became an every day affair for them and they had made up their minds to meet at least once a day some-how or other. Fearing the evil tongues of enemies and scandal-mongers, they were forced to fix up beforehand certain time and places to meet safely, and there they often shed tears of a mixed origin, namely of joy at their meeting and sorrow at their difficulties and their parting. Days and months

passed on, and he made it a point to make her life as care-free as possible, and except for a few faithful friends of theirs, no one had ever realized that they were worshiping each other. Longing for the day to dawn, when they will be inseparably united before the eyes of their fellow human beings, they struggled on, and Joy revealed his life's secret to his parents, which was soon followed by Moley. Their happiness was magnified when the formal consent was given for the realization of their hopes, and to reap the fruits of their labour of the past few years. But they had much to be accomplished before they could fix it up definitely. Many a time they thought of ending their lives together when some obstacle or other used to spring up between them, but they pulled on hoping against hopes, that the day is not far ahead when all their troubles will be over.

Never had two people loved each other better than they did, and it was a pleasure to watch them progressing very slowly, yet steadily, with their pure and innocent love. Often they used to write each other :--

" For I have loved thee with a love,
No mortal heart can show ;
A love so deep, my Moley (Joy) dear,
Its depths can never know."

Love in its unadulterated form was clearly seen from them, and some of their enemies were jealous at them. May 18th of the same year was a day of trial for both of them, because some scandal-monger told Moley's parents that Joy had changed his mind due to some external pressure, and the poor girl had an ordeal to go through that day and blindly believing the story, she decided to fight the battle of this world all through her life singlehanded, because she had given all her affections to him. Joy who was then miles away, did not know anything about this incident and it was only after so many days, that he realised that something was wrong somewhere. Distance was nothing to him and he sped home to her, and at the sight of each other all their misunderstandings have vanished. Forgiveness,—that Divine gift of God—did all the rest, and their love was allowed to grow at a much quicker rate. Watered by their tears, and protected from the scorching heat of their enemies words by their absolute secrecy, their love grew up unchecked and little caring for the rest of the world, they

got on, and every evening they were able to speak to themselves, that they have achieved something or other that day.

Quite unaware of the real nature of a few of their friends, they had confided too much of their secrets, and a few of them, tried to abuse the trust they were entrusted to by Joy and Moley, but due to the absolute faith she had in him those days, he was able to frustrate and nip in the bud itself, certain villainous attempts made by these false friends, who later on proved to be the most despicable wretches, and all the while they were putting on smiling faces to our young lovers, they were actually grinding their Molars, when once the backs of Joy and Moley were turned at them. It is always a great task to differentiate between real and seemingly real friends. A real friend is the most valuable treasure one can get, during the short span of one's life in this world, and it is only to a friend that one will open the most secret recesses of one's heart.

No I have to begin the most sad chapter of this story. " After a storm there is a calm ". Joy who had staked his everything for the sake of Moley, believed blindly every word she used to say and in those days, if any one had dared to speak to him that most girls are fickle-minded, and can be made to sing to the tune of any determined individual, he would have certainly resented it. But later events proved it to be so.

" What female heart can gold despise "

A few days of unavoidable separation between them, resulted in a radical change taking place in Moley, and she, who used to cherish the image of Joy for a long term of years, forgot about his existence a few hundreds of miles away and without in the least considering about the gravity of the gross injustice she was knowingly or unknowingly doing against Joy, she began to bestow her affections on some one else. Recouped in health, and overcoming even the last obstacle which lay in his path, Joy anxiously returned to greet his dear Moley, and the look of coldness depicted on her face took him by surprise. Disbelieving his own eyes, he narrated the incident to his " friend, philosopher, and guide," and he too experienced the same coldness from her. He who was once believed and respected by Moley, and he in whom she used to count as the most valuable treasure she has in this world, was looked upon with an air of indifference. But Joy in his usual magnanimity was quite prepared to forgive her on condition that she must tell the affair to him

in its minutest details. He had forgiven her on more occasions than one, and this time also he was quite prepared. If only she had told the truth, But instead of that, Moley who seemed to be off her head, or as one under the spell of some evil charms, remained mute, and the net result was that Joy, with feelings which were quite inexpressible by him, demanded an explanation from her, but still she refused to comply with his request. Finding no way open to him for clearing all doubts, he most generously, yet with a breaking heart, informed her, that through her own fault, everything between them has come to an end and in future they are to get on as casual acquaintances to each other. His final message to her were as follows:—

"In joy once joined, in sorrow now for years
Partner in grief, and sister of my tears
Moley, accept this verse, thy mournful due"

Speaking of the past—which he used to avoid as far as possible.—
Joy found consolation in a few lines of Shunstone.

"Alas from the day that we met
What hope of an end to my woes?
When I cannot endure to forget
The glance that undid my repose.
Yet time may diminish the pain
The flower, and the shrub and the tree
Which I reared for her pleasure in vain
In time may have comfort for me."

He remembers Moley still, and I am sure, he does not bear any grudge to her, but is only sorry for her failing him at the last moment, when every obstacle was overcome, and at a time when he expected words of encouragement and undying confidence, he rewarded him with absolute desertion. Years of love resulted thus, and as such, I wonder as to how one can put faith in the words of these 'daughters of Venus. To such persons as Moley, Joy recommends the following lines of Young.

"Keep thy conscience from offence,
And tempestuous passions free,
So, when thou art called from hence
Easy shall thy passage be;
Easy shall thy passage be;
Cheerful thy allotted stay
Short the account 'twixt God and thee,

A Modern Venus

Hope shall meet thee on the way;
Truth shall lead thee to the gate
Mercy's self shall let thee in
Where its never changing state
Full perfection shall begin."

There are many more Joys and Moleys in our midst, and to all of them I appeal to think twice before you say or do anything. In these days of civilisation, we ought to have a broader outlook on life, and some of the time-honoured, moth-eaten habits and laws, are to be discarded, and fresher ones are to be replaced forthwith.

Joy recently happened to read Shakespeare's "Venus and Adonis" and Adonis has described love and lust as follows:—

"Call it not love, for love to heaven is fled
Since sweating lust on earth, usurped his name
Under whose simple semblance he hath fed
Upon fresh beauty, blotting it with blame;
Which the hot tyrant strains, and soon bereaves
As caterpillars do the tender leaves
Love comforteth like sunshine after rain
But lust's effect is tempest after sun;
Love's gentle spring doth always fresh remain,
Lust's Winter comes ere summer half be done,
Love surfeits not, lust like a glutton dies
Love is all truth, lust full of forged lies."

Now the moral to be learned from my short story is to definitely understand what is love, the difficulties and pitfalls of lovers, and before one begins to soar high on the wings of love, one should think whether a place of safety can ever be found, where one can take refuge for the rest of one's life, and under no circumstances should one allow oneself to drift hither and thither, when once one decides to love or to be loved. Finally I must remind all my readers that the entire story is a dream of one of our budding medicoes, whose identity for certain reasons of his own, I can't give out, and that nothing personal is meant anywhere.

"OLD MEDICOES NEVER DIE
YOUNG MEDICOES ALWAYS LOVE"

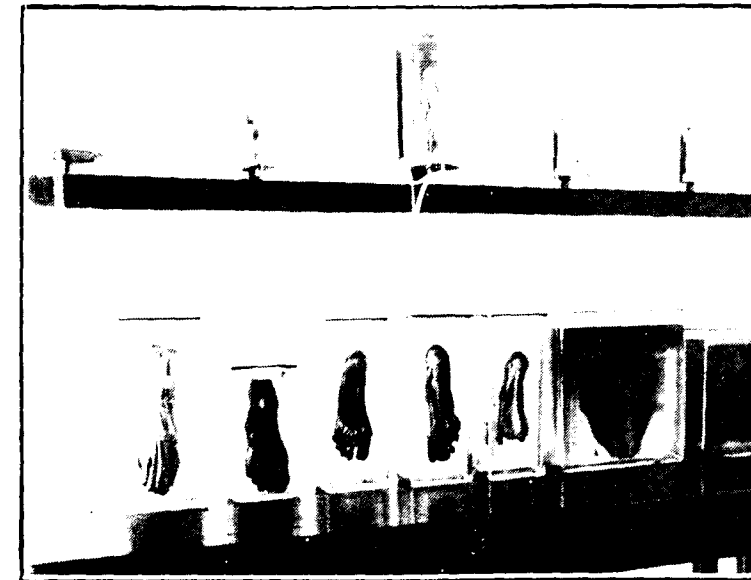
Our Anatomy Museum.

(BY BABU RAO, III YEAR.)

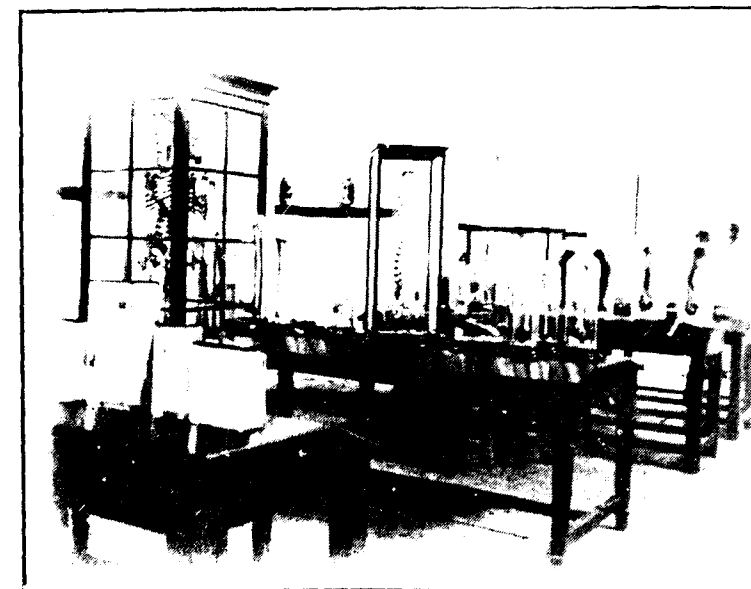
One may, with pride record in the pages of this Magazine, a few words of appreciation of Our Anatomy Museum. The subject of Anatomy, though apparently dry, is the basis of our Medical knowledge, and as such, there will be no gain-saying the fact that a fundamental knowledge of the subject is highly essential. As is well seen, Medical knowledge is growing in its importance to humanity. And, this, only enhances the value of Anatomy.

It is a practical difficulty experienced by every beginner to spot out the various structures of the human body, and more so, to understand their relative positions. Indeed, it is extremely helpful to the students to have dissected specimens showing the various organs and structures *in situ*, and, thus, facilitate a thorough understanding of the subject. This seems to be the aim of our Prof. of Anatomy, Dr. P. K. Koshy, F.R.C.P. Edin. Much pain has been taken in equipping the Museum with the very many valuable dissections, and they have been decked in cases of artistic taste. The accompanying photographs will well illustrate the arrangements of the specimens. Wet ones have been mounted on Plaster-of-Paris blocks, and put into glass jars containing preservative fluid. Dry ones have been, partly placed on tables, under protection of Bell-jars fixed to revolving platforms, and partly fixed to the walls, encased in revolving glass cylinders of a type, peculiarly their own.

Let us hope, that, ere long, this Museum which is now in its adolescence, will blossom into its adult life!



Anatomy Museum.



Anatomy Museum.



APRIL 1914



Editorial.

Lt.-Col. R. G. G. Croly, I.M.S., on return from leave is posted as Superintendent and Surgeon, General Hospital, Madras.

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Lt.-Col. J. M. Skinner, I.M.S., has proceeded on leave pending retirement. A number of private and public entertainments, teas, dinners, dances, etc., shows his immense popularity. A few of the functions were reported from time to time in the local dailies of the city. A brief sketch of his career appeared in the "Madras Mail" two days prior to his leaving Madras.

* * * *

Dr. C. R. Krishnaswamy and Dr. Narasimha—Rao two of our distinguished old students—were successful in the recent University examination, the former securing his M. S. and the latter M. D. (Tropical Medicine).

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Capt. R. D. Alexander, I.M.S., is posted as Physician to the General Hospital from 3rd April. He will also do duty as Additional Professor of Medicine, Medical College, Madras.

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Lt.-Col. A. P. Lorimer, I.M.S., Col. C. W. Paton, I.M.S., and Major P. Verdon, I.M.S., have proceeded to United Kingdom on leave. Rao Bahadur A. Lakshmanaswamy Mudaliar, B.A., M.D., F.C.O.G., will act as Professor of Midwifery and Superintendent, Women and Children Hospital and Dr. Koman Nayar, L.R.C.P., L.R.C.S., D.O.M.S.,

as Professor of Ophthalmology and Superintendent, Ophthalmic Hospital.

We heartily congratulate Dr. M. R. Guruswamy Mudaliar, B.A., M.D. & C.M., on his appointment as Professor of Medicine, Medical College. The members of the Provincial Service should be highly proud of one of their members who has all along distinguished himself in many ways. As early as 1917, his clinical acumen and capacity for teaching came under notice of authorities, and he was appointed as acting 2nd Physician. He held the chair of Professor of Therapeutics after he vacated the chair of Materia Medica. Now he has reached the topmost rung of the ladder as Professor of Medicine, for which post he is well-qualified and better evolved through a number of posts which are really handmaids of Medicine. We wish him a long tenure and more distinction in his present sphere.

Our Petrified Progenitors.

(BY A. BABU RAO, III YEAR.)

Labouring for peace—a world peace—which implies deracilisation, or in other words, a pooling of the blood of men of all colours—black, yellow, brown and white,—Sir Arthur Keith holds that “(there is) a better way of solving the more acute difficulties of race, and thus obtaining, if not a profound, yet a partial peace”. He proceeds, “I think there is only one way. Men must be convinced that evolution is true, in everyday life as well as in the laboratory.” May I say with him that if only, men are convinced that the evolution of man is no longer a theory, but is a truth, there will be no race animosity; shall I add, too, much less distinction of caste, creed or religion may! Then, Science will become a universal faith, and evolution a universal religion.

“We must, however, acknowledge, as it seems to me, that man with all his noble qualities, with sympathy which feels for the most debased, with benevolence which extends not only to other men but to the humblest living creature, with his God-like intellect which had penetrated into the movements and constitution of the solar system—with all these exalted powers—Man still bears in his bodily frame the indelible stamp of his lowly origin.”

Charles Darwin.

Rev. W. A. Williams may remonstrate as he does in his work, “Evolution disproved,” that it is highly offensive to attribute a simian ancestry to man. To many others it may be repugnant. But, to all such, who are not amenable to reasoning, and refuse to be convinced of the above statement, one can only say that they have to accept the alternative, that, “to hold their view of special and individual creation, is only to admit, that, our own structure and that of all the animals around us, is a mere snare laid to entrap our judgment,” for, it cannot otherwise be explained than by the doctrine of evolution, why “man and

all other vertebrate animals have been constructed on the same general model, why they pass through the same early stages of development and why they retain certain rudiments in common."

Before the dawn of humanity on this world, there lived the man-like *Pithecinthropus erectus*, or the Java Man. This two-legged mammal had a much receding forehead balanced by a very protuberant occiput, very prominent superciliary ridges, a large nose and an extensive subnasal space, a large mouth bounded by simian lips, a massive and receding lower jaw presenting no chin, and short legs with bent femurs indicative of an attitude not quite erect.

The earliest man would not have been much different from the Java Man. He would have had also the receding forehead, protuberant occiput, prominent orbital ridges, etc., he would have been covered with hair except on the palms and soles of his feet. Scott Elliot describes that on his head the hair grew long and thick and was continued down the cheek and chin forming a combined beard and whisker-fringe. He picturesquely proceeds, "Should a raging gale, with sheets of driving rain, fall upon him he would still sleep on. The rain would be conducted away by the hair and beard, by his elbows and hips, and so as to drip nearly clear of the face and body." He adds, that on a tree nearby would be his wife and child also comfortable and unperturbed by the rain.

If this Early man was cornered by his contemporary, the Felis,—a fearsome creature half-lion and half-tiger, then, he would at once draw himself up to his full height, exercise his power of speech, yell, howl, and resonant exclamations, and perhaps, would, also, throw stones, sticks, fruits, or whatever came to his hands, at the enemy. All these, the energetic exclamations, the imposing creature, and the frightful gestures, would surely confuse the primitive brain of the Felis,—and he would probably retire, with dignity, to seek some easier prey.

The semi-simian characters of this dawning man vanished with time. With the assumption of the erect position his hands became free, and he began experimenting thus developing intelligence. This involved the enormous increase in size of the brain, especially the frontal lobes. Thus, by slow degrees, the receding forehead rose into the tall forehead of the Hominians of to-day; the protuberant occiput assumed a smooth

contour and gave the vertically compressed cranium an elevated roundness; the prominent superciliary ridges became scarcely perceptible; the large nose with the nostrils looking more forward than downward, assumed the refinements of the day; the subnasal space was reduced as a consequence of the recession of the projecting upper jaw; the lower jaw lost its receding character and was moulded into the well-cut chin of the present; the mouth, as a result, became small and the lips compressed; the legs grew longer; and, finally, all trace of the simian qualities disappeared—only apparently.

As these transformations took place gradually, there appeared successively groups of men in the various ascending stages. The earliest of them left us no traces of their existence, as they had not learnt to bury their dead. Hence, the dead were subjected to the manifold agencies of destruction, and scarcely any has been preserved for us; for, preservation of animals remains over such a long period of time involves fossilization,—the process by which bone loses its organic matter and becomes pervaded with mineral matter. This fossilization is dependent upon the nature of the soil. Further, even those remains that have been preserved by nature could not be unearthed, because, it is impracticable to dig out the earth all over the world. But some skeletons and parts of skeletons have been disclosed to us during certain excavations and these speak about certain races and species of primitive men that have lived very many years ago, as indicated by the degree of their fossilization, by the depth at which they were met with, and by the nature of the layer of the earth's crust in which they were embedded. They are the Grimaldi race, the Cromagnon race, the Chancelade race, *Homo-Neanderthalensis*, *Homo-Dawsoni*, *Homo-Heidelbergensis*, etc.

Near Piltdown in Sussex, have been discovered in a field, some remains of a primitive human being. It was called *Eoanthropus Dawsoni*,—an expressive name indicative of the dawn of humanity. It is otherwise known as the Piltdown Man. Till recently this being stood as the next higher type to the Java Man, the *Pithecanthropus*. But in the years 1928 and 1929 certain skeletal remains of great antiquity have been discovered in Peking in China, and these represent a type of being intermediate between the Java Man and the Piltdown Man. This new link has been named *Sinanthropus pekinensis*.

Homo-Neanderthalensis represents a species of extinct *Homos*. The first skeletal remains of this species was found in Neanderthal in

Rhenish Prussia, and later more skeletons of the type were disclosed from other places.

The Grimaldi race represents a type of Negroids. The first skeleton was revealed to Prof. Verneau, among the several other human remains that were exhumed in the Grotte des-Enfants during an exploration in the Grimaldi caves.

The Cromagnon race is a type of fossil Homo-sapiens. In 1868 in the rock-shelter of Cromagnon five human skeletons were discovered. These presented all the features of the modern man, but were fossilized. Later many other representatives of this race were found to have existed throughout a great stretch of Europe. According to Dr. Collignon this Cromagnon type is still persisting in Dordogne.

It is interesting to speculate where the first group of Hominians would have originated. Central Asia has been suggested by some, and Africa by some others. But, as there is no decisive proof, it is yet a controversey. The recent discovery of the remains of *Sinanthropus pekinensis* in Eastern Asia, and the discovery of the *Pithecanthropus erectus* in Java, afford—it is assumed by some—definite evidence for locating Asia as the original home of the Human family. Darwin has said many years ago, that "it is somewhat more probable that our early progenitors lived on the African continent than elsewhere." And G. Elliot Smith holds, too, that Africa is the original home of man. He says, "I am still inclined to accept the view expressed by Darwin, in 1871, that, while evidence is not yet available definitely to answer the question, Africa seems to be a more likely home for the human family."

Many regions are yet unexplored and we do not know what great secrets they have in reserve for us. Let us bide time in eager hope of being further enlightened on the history of man's life on Earth. I may conclude with the words of Donald Mackenzie that "the study of ancient man is withal a facinating 'hobby' for our leisure hours, which can be persued in any part of the world, and no matter in what walk of life we may be engaged. Fresh evidence is constantly coming to light, and much remains to be discovered so that our knowledge may be extended and our mutual interest in life further enlarged."

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Photo taken on the occasion of Farewell to Lt.-Col. J. M. Skinner, I.M.S.

Reflections of the Student Editor.

Lt.-Col. J. M. Skinner, I.M.S.

The close of the last academic year was marked by sorrow at the retirement of our popular principal Lt.-Col. C. E. F. Hingston, I. M. S. Again this year it is Lt.-Col. J. M. Skinner, I.M.S., Professor of Medicine, First Physician and Superintendent of the General Hospital who is leaving us for good.

On the 30th of March, the staff and senior students of the college met together at the college grounds to bid him farewell on the eve of his laying down the office on long leave preparatory to retirement.

After tea, the assembly gathered in the Library Hall, under the presidency of Lt.-Col. C. Newcomb, I.M.S. The president, briefly reviewed how Lt.-Col. Skinner has acted successfully in various capacities in the medical department and expressed his sorrow at the loss caused by his retirement. Next Capt. B. T. Krishnan in the course of a short speech pointed out how Lt.-Col. Skinner was universally liked and has been uniformly good to the students as well as his assistants. Mr. Subramania Sarma speaking on behalf of the students quoted a few incidents how Col. Skinner tried to understand the difficulties of the students and always tried to help them.

By the retirement of Lt.-Col. Skinner, we lose an able physician, clinician and a very fair and kind examiner. We wish him bon voyage and may he live long to carry on the noble work.

Lt.-Col. W. C. Paton, I.M.S.

We are sorry to lose Lt.-Col. W. C. Paton, I.M.S., who is soon proceeding to England on leave. After the holiday, we hope he will soon join us to take up the heavy responsibilities of the regular work of the Maternity Hospital.

In the short time he has been with us, by his love for the students and the interest he has taken in their studies, he has made himself loved and respected by all. Though we will all miss him very much, it is a

consolation that he will be absent only for a short period and we hope he will rejoin us quite fit at the end of the term of leave.

Unveiling of the Portrait of Our Former Principal.

A pleasant function was witnessed at the Library Hall on the 31st of March when Surgeon-General Sprawson unveiled an oil painting of our Retired Principal Lt.-Col. C. E. F. Hingston, I.M.S., O.B.E.

The Surgeon-General while briefly sketching the career of Col. Hingston stated how he had successfully served in all branches of the Medical Department. His speech was followed by that of the Secretary in the course of which he said that Principal Hingston was always the champion of the students' cause which has made him the idol of the students.

It was a real pleasure to all that Col. Hingston found it possible to be present on the occasion.

The oil painting was done by one of our college students, Mr. Madhasudhanam Thampi, who deserves to be congratulated on the neat execution of the same.

Sports

The Medical College can rightly be proud as being the best in all the sports events of the year.

Our college team annexed the Chettinad Shield of the Annamalai University and the coveted Travancore Shield in the Inter-Collegiate Sports. While congratulating all the members of the team on their excellent performance, special mention must be made of Mr. D'Costa, our champion athlete, and Mr. Mc Innes a close second.

Mr. D'Costa again won this year the championship of the Madras Olympic Sports besides the championship of the Medical College and the Inter-collegiate sports. We hope he will win more laurels for the college in the coming years and we wish him all success.

Our college acquitted herself very creditably at the Inter-collegiate Boxing matches, the final of which was conducted at the Port Staff Club. Our hearty congratulation to Messrs. Littles, Herd and Clarkson.

Though our Sports Secretary is mostly silent about the activities of the various teams we have good reasons to believe that our teams put up a good fight in all events though good luck did not favour us always.

It is to be regretted that our College did not send her representatives for the Inter 'Varsity Tennis Tournament this year.

Perhaps it was by way of protest against not providing us with the much-rumoured-about Tennis Courts. It is indeed a pity that the premier medical institution of the Presidency should be without Tennis Courts for the last three years.

Now that the P. W. D. has undertaken the construction of a road along the border of our compound, there is little hope of anything being done towards the construction of the courts unless the authorities concerned take it up and press the matter further. We hope the Sports Committee will see that something is definitely done by the beginning of the next year.

The College Sports Day.

The College Sports Day was a success in every way. The programme included some very interesting items, of which the Ladies' obstacle race evinced great interest. The Tug-of-War between the staff and the students, put the members of the staff on their mettle. Besides demonstrations in the latest methods of pulling, they even frightened the youngsters by pulling them over the line once. But in the end youth triumphed over age.

The Disguise competition brought out some original ideas in that direction. The Bullock Cart Driver (Mr. Venkatachari) acted his part so well that it drew a comment from the audience that, should the retrenchment still further affect the Medical Department, this particular Medico will not be stranded for want of a job.

Mr. Venkatachalam as the woman grass-cutter was so realistic in his disguise that the gate-peon wanted to chase him (or her ?) out of the compound.

Mrs. Hensman gave away the prizes to the winners.

The success of the day was greatly due to the energetic efforts of the Sports Secretary Mr. Jagannatha Rao.

The College Crest.

At the meeting of the Executive Committee of the College Association held in February, it was suggested that our College should have a college crest which we can call all our own, in view of the fact that the crest as it is now worn has been copied by other medical institutions. The topic was talked out at length and special emphasis was laid on the fact that we would like to maintain the same crest that has been in use ever since the establishment of this institution, which is well over a century—and we would see that nobody else infringes upon our rights. But it was also pointed out that the crest as it is now is not the exact copy of the original crest which in addition to the 'W' and 'S' and Snakes had also 'a eye' on the top and the stars at the bottom together with the words "Madrass Medical College" and the date "1835". (The original design is on the College Emblem kept in the Principal's Office.)

So it was decided that our College must have the complete design of the original crest which will distinguish the College from everywhere.

The College Library

This is neither the place nor the occasion to discuss the important part played by the Libraries in every educational institution. But the usefulness of a Library is not in the number of books it possesses, but in the number of books that is being used.

Unfortunately, for want of attention in former years, the Library hall is being used both as a sitting room and a store room. The state of affairs was bad enough. Still it was possible for anybody who wanted a book, to take it from the Library anytime between 10 a.m. and 9 p.m. and make the best use of it if he wanted. But now, somebody in the staff has taken it 2 months ago and has returned it yet.

But now according to the latest regulations of the Library rules, the library is open only between 4 and 9 p.m. This has necessarily meant that books will not be available even for reference before 4 o'clock in the evening.

For one who knows about the routine of work in the medical college with its odd and irregular hours of working, it is easy to understand how it is impossible for the students to finish their work

early in the afternoon, to wait till 4 o'clock to get a book for reference. The natural result has been that, except for the handful of students who come to the library in the evening hours between 4 and 9, the library has ceased to be any use to the majority of the students.

The reason for this unwelcome change seems to have been the cutting down in the number of hands in the library staff. For the sake of a little saving, to make an useful and necessary part of the institution of little use to the majority of students is to reduce the department itself next to uselessness.

We hope this arrangement is only temporary and the authorities will do the needful in this urgent and important matter.

The Examinations.

The April Examinations are at hand. The examinations are a necessary evil and we wish everybody the best of luck.

Results of the Final Examination of the last few years offers a very gloomy prospect to the students. It is enough to send a chill through anybody's heart when one looks back and recollects that in 1931 December out of 29 freshers that went up for the final examination, only *one* man got through completely and in 1932 December out of 43 freshers, again only *one* man managed to get a complete pass.

Evidently there is something wrong somewhere, and there must be a remedy for this state of affairs. We hope the future will hold out a brighter picture and there will be no reason to be disheartened.

Lt.-Col. R. G. G. Croly, I.M.S.

Lt.-Col. R. G. G. Croly, I. M. S., has returned from home after a holiday and taken charge as the First Surgeon, General Hospital. We welcome him back to our midst.

Lt.-Col. F. J. Anderson, I.M.S.

Lt.-Col. F. J. Anderson goes back to Vizagapatam to take charge as the Principal of the Medical College and the First Surgeon in the King George Hospital. We are sorry to lose him and we will miss his forcible personality and his instructive Group Classes. What we have lost, the Vizagapatam College has gained.

Medical College Magazine

Ourselves.

In closing I would like to say a few words about Our College Magazine.

It is now three years since an experiment was started to make the magazine more of a College Magazine than a Medical Journal. Having had the privilege of being connected with the Association Committee for these three years, I have watched with interest the reaction that the change has brought about.

The idea was to make the College Magazine, a magazine of the students, for the students, by the students, of course, the staff also contributing its quota of learned articles. The students at first showed much zeal, but the first few sparks of enthusiasm soon fell away. Soon a lethargic stage was reached when all possible effort brought but little response from the students. Excepting a few students who would casually ask the Student Editor "when is the next issue of the Magazine coming?" others showed little interest.

The members of the staff also showed some waning in their interest and were more inclined to shove all the responsibilities on to the tender shoulders of the youngsters.

The inevitable result was that those who were concerned with the getting up of an issue every quarter, were often in a fix, waiting for articles which never came.

Of course, one must realise that it is the transitional period which is the most critical period in the life history of an individual. The magazine having successfully pulled through this period, I hope it will be able to hold its ground in the future.

I would appeal to the younger blood to come forward and make use of the opportunity afforded and I am sure in most of them burns the flame of literary genius which needs only the slightest amount of fuel to flare forth into great dimensions. Should I remind them that the medical students from time immemorial have always risen to the occasion especially when such is demanded of them to uphold those noble traditions and customs of the college, which has made its name immortal?

I would also request the younger members of the staff and the newly qualified doctors to contribute articles of interest as often as possible which will also help them to be in touch with the *Alma Mater*.

While thanking the members of the staff for the interest they have taken and for the advices given, may I request them to continue their interest and benefit us by their mature experience.

I take this opportunity to thank those who have kindly contributed articles to this magazine and hope they will continue their interest in the magazine.

I must also express my thanks to the ladies' representative Miss P. Komen for the co-operation and help willingly given.

Dr. S. Thumbiah was the life of the magazine. His unfailing energy and unceasing effort were the chief factors that kept up the life of the magazine during the difficult period.

We were fortunate in having Dr. Guruswamy and Dr. Mangesh Rao in the staff whose long association with the magazine was a great asset.

Dr. Narayana Pai, the Honorary Treasurer, had his fingers on the pulse—I mean the finance—of the magazine and he assures us that we are stronger than ever as regards the finance is concerned, though due to the Trade depression, many of the firms withdrew their advertisement from our Magazine.

Good-bye.

Mr. P. V. George and myself sever our connection with the magazine with the issue of this number and we wish to say good-bye to all its readers. We count it a privilege to have been connected with the Magazine and we will always watch with interest its progress. May the Medical College Magazine live long in prosperity. Good-bye!

GEORGE FLETCHER,
Student Editor.

The Madras Medical College Association.

Minutes of the General Body Meeting held on 12th July 1932.

1. The Annual Report and accounts for the year 1931-32 be passed. Proposed by Mr. P. T. Gopalan Nayar, seconded by Mr. P. I. George and carried unanimously.

2. That Messrs. K. John & Co. may continue to be the Auditors for the year 1932-33. Proposed by Mr. P. T. Gopalan Nayar, seconded by Mr. K. C. Koshy and carried unanimously.

3. That Lieut-Col. J. M. Skinner, I.M.S., and Dr. A. Lakshmanaswamy Mudaliar may continue as Vice Presidents and Dr. M. Narayana Pai as Honorary Treasurer of the Association; that Drs. M. K. Guruswami Mudaliar, N. Mangesha Rao and S. Thambiah may continue to serve on the Magazine Committee as President, General Editor and Associate Editor respectively. Proposed by the chair, seconded by Mr. P. T. Gopalan Nayar and carried unanimously.

That Mr. George Fletcher and Mr. P. V. George be elected as Student Editors proposed by Mr. P. I. George, seconded by Mr. K. C. Koshy and carried unanimously.

Nominations of (1) Assistant Secretary and (2) Sports Secretary.

1. Mr. A. V. S. Sarma was proposed by Mr. P. S. Krishnamurthy and seconded by Mr. Kasiviswanathan.

Since no other candidates were proposed, Mr. A. V. S. Sarma was declared duly elected as Assistant Secretary.

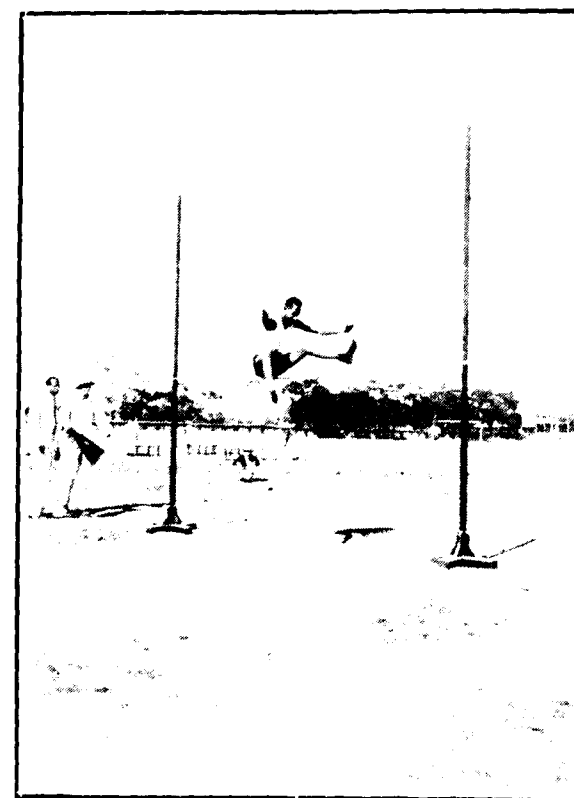
2. Mr. P. V. Jaganatha Rao was proposed by Mr. A. V. S. Sarma and Seconded by Mr. P. Z. Abraham.

Since no other candidate were proposed Mr. P. V. Jaganatha Rao was declared duly elected as a Sports Secretary.

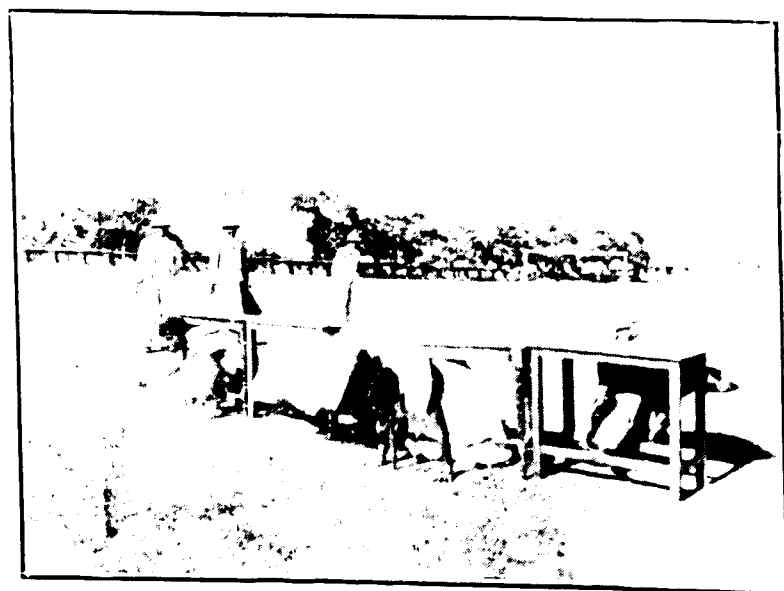
4. A vote of thanks to the retiring Office bearers was proposed by the President and seconded by Dr. Narayana Pai and carried unanimously.



"Tug-of-War" Staff versus Students.



High Jump.



1. *Introduction* 1



Ladies 100 yards dash.

*Minutes of the Executive and Magazine Committees meeting held on
Thursday the 28th July 1932.*

1. The minutes of the General Body meeting on 12th July 1932 were found correct and passed.
2. Rupees fifteen was allowed for the year to Clerk Mr. Ranganathan as remuneration for collection of subscriptions from students (Magazine).
3. The correspondence regarding the rent to be paid by the tiffin vendor was left to the Principal.
4. The purchase of an Almirah for the Association was sanctioned (the cost not to exceed Rs. 35.)
5. The Graduates' Entertainment and social was decided to be held at the Museum Theatre on Friday 5th August 5 P.M. It was decided to ask Dr. Miss Lazarus to address the Graduates of the year. Tea and other arrangements were left to the Treasurer and the Secretaries.

*Minutes of the Executive and Magazine Committees meeting
held on 2nd November 1932.*

The minutes of the Executive and Magazines Committees meeting held on the 28th July were passed.

2. That the sum of Rs. 1,550 from the Magazine fund be set aside for the purchase of Post Office Cash Certificates to the face value of Rs. 2,000. This to be held in the name of the President of the Association and that Fixed Deposit for Rs. 1,300 and odd in the name of Dr. Guruswamy Mudaliar to be utilised for this purpose.
3. The theatrical expenses account incurred for the Graduates reception were passed.
4. The Secretary was authorised to represent the matter concerning the election of the captains for the various teams, to the Executive Committee of the Athletic Club for disposal.
5. Prizes up to the value of Rs. 60 to be given annually for the best article from students published in the College Magazine. The nature and amount of the prize to be left to the Magazine Committee and the amount to be debited to the Magazine Fund.

6. Steps to be taken regarding the Marie Scharlieb Memorial Fund was left to the Principal.

Minutes of the Executive and Magazine Committees meeting held on 13th February 1933.

Minutes of the Executive and Magazine Committees meeting held on the 2nd November 1932 were passed.

2. It was decided to invite the Surgeon-General to unveil the portrait of Lt.-Col. Hingston. The sum of Rs. 42 was sanctioned from the Magazine Fund towards cost of the portrait.

3. The Secretary was authorised to send the following resolution to the President, Medical College Council: "That the Executive Committee of the Madras Medical College Association be authorised to elect two members from the staff to serve on the Executive Committee of the Madras Medical College Athletic Club.

Minutes of the General Body meeting held on 17th March 1933.

1. Nomination for the General Secretaryship.

Mr. M. Asirvadham was proposed by Mr. P. Devadoss and seconded by Mr. P. V. George.

Since no other candidates were proposed, Mr M. Asirvadham was declared duly elected as General Secretary.

2. The following resolutions were carried :

(1) The election of the Captains of the various teams of the College shall be made by the General Body instead of by the members of the teams as done at present, provided that the Captain shall be one who has played in the College team.

(2) Vice-captains for the various teams should be elected by the whole body provided the vice-captain shall be one who has played in the College team.

(3) The selection of the college teams should be made by a selection committee, the personnel of which to be decided by the Executive Committee of the Athletic Club.

3. "That the Athletic Club be asked to provide facilities for daily games " proposed by Mr. Eapan, seconded by Mr. V. K. Doraswami and carried unanimously.

ANNUAL REPORT, 1932-33.

The activities of the College Association started as usual with the holding of the first General Body Meeting. This meeting came off on the 12th July, when all the office-bearers were elected unanimously.

The Association has always been passing through hard times just managing to live a 'hand to mouth' existence. This is quite evident from the balance sheet published elsewhere. For any activities of the Association other than the normal routine, it is found that the expenditure incurred has to be met by raising subscriptions from the staff and students of the College, or by sanctioning it from the Magazine Fund. Taking these things into consideration, and to place the Association on a sounder basis it would be only proper to raise the annual subscription from the students from Rupee one to Rupees two. This would promote healthier working of the Association and its growth, as otherwise it is liable to get stunted, because of the everlasting fear of the expenditure exceeding the receipts. The balance if any can be spent for the comfort of the students.

Reception to the New Graduates.—Following last years' example and for the same reasons, the reception to the New Graduates was held in the Museum Theatre on August 5th. Lt.-Col. C. Newcomb presided and Dr. Miss H. M. Lazarus addressed the graduates. Next year it is hoped it will be held "under the benign wings of our Alma Mater."

Lectures.—As regards lectures only one meeting was held during the course of the year. It was delivered by Dr. Philip Resek from Vienna on "The Differential Diagnosis and Prognosis of Angina Pectoris," Dr. T. K. Krishna Menon presiding. The attendance at this meeting was really encouraging to hold more meetings. But since the University extension lectures were held every other day at the College which were of a scientific nature, the idea of holding more meetings had to be dropped as it is found generally that students take little interest in lectures other than scientific.

Condolence meetings.—During the year under review the Association held two condolence meetings to express grief on the death of

1. Mr. S. O. Mahar a second year student of the College.
2. Mr. C. David a final year student of the College.
3. Mr. V. Gopalakrishna a final year student of the College.

The condolence resolutions passed were sent to the members of the bereaved families.

Magazine.—From the statement of accounts published elsewhere we find that the magazine has a substantial reserve fund. It is only proper that more money should be spent on the Journal as its present condition leaves ample room for improvement. A step has been taken in the right direction by its Editor Dr. Mungesha Rao by putting forth the proposal of instituting three prizes, to the value of Rs. 100 each, for the best articles. If this proves a success, it is hoped the value of the prizes and their number will be increased. Getting useful scientific articles from the staff is found to be as difficult as it ever was and it really ought that the members of the staff instead of trying to raise the standard of the magazine should think that the Journal should follow the standard for the publication of their articles.

We here express our sincere gratitude to Dr. S. T. Rao, who despite his heavy work, willingly took up the responsibility of running the magazine.

Our thanks are also due to Mr. George P. V. George who have done all the work for the Journal.

Unveiling of Col. Hingston's Portrait.—This pleasant function came off on the 3rd March when the Surgeons General unveiled the oil painting of Lt.-Col. Hingston, the Ex-President of the Association and Ex-Principal of our College; it was a great pleasure to have Col. Hingston amongst us on this occasion. The painting was executed very well by Mr. Madhusudhan Thapli of the 1920 year class, who deserves our congratulation. In unveiling this portrait we have only done the work the ex-Secretary of the Association had begun.

Sports.—Touching on the Athletic side of the College, the members of the Association do not seem to be keeping the Association to hold a

General Body meeting to consider certain resolutions regarding election of Captains signed by over a hundred members was forwarded to the Secretary.

The following resolutions were passed at the General Body meeting and forwarded to the President, Athletic Club for necessary action.

1. The election of the Captains of the various teams of the College shall be made by the General Body instead of by the members of the teams as done at present, provided that the captain shall be one who has played in the College team.

2. Vice-Captains for the various teams should be elected by the General Body provided that the Vice-Captain shall be one who has played in the College team.

3. The selection of the College teams should be made by a Selection Committee, the personnel of which to be decided by the Executive Committee of the Athletic Club.

4. The Athletic Club shall be asked to provide facilities for daily games.

It is a regrettable feature of our Athletic club that there are no tennis courts in such a premier institution as our College.

Election of the Secretary.—The atmosphere at the General Body meeting held on the 17th March, when the Secretary for the year 1932-33 was nominated was as smooth and clam as it was at the first General Body meeting. Mr. Asirvadham was elected unanimously as General Secretary for the year 1933-34.

It is really pleasing to note that the President of the Association is taking an active interest in its affairs. He has been always trying to help us whenever possible, and has presided over all our meetings, Committee as well as General Body. It is because of this active interest on our President's part that we owe mostly, the satisfaction of finding our Committee meetings always full, and the harmony which prevails in our General Body meetings. While expressing our sincere gratitude to Lt.-Col. C. Newcomb, we cannot forget Dr. M. N. Pai, the Honorary Treasurer who has been doing a lot of work for us. Without his help

In Lighter Vein.

Biology Department.

Staff.—“Why were you absent yesterday?”

Lady student.—“I was sick, sir.”

Staff.—“What YOU sick, fever?”

Lady student.—“Yes, sir.”

Staff.—“What fever, malaria?”

Lady student.—“Yes sir.”

Staff.—“What type of malaria? B.T., M.T., G.T.?”

Lady student.—“I don't know, sir.”

Staff.—“Did I not teach you how to diagnose it?”

Lady student.—“Yes, sir?”

Staff.—“All right, get quinine and you will be better.”

Lady student.—“Thank you, sir.”

On Board German Cruiser *Cologne*.

Speaking about his experience a veteran sailor pointed to an area of his chin absolutely devoid of hair, said, “Oh I got it during the Great War.” Our secretary who was close by attending to all what the sailor was speaking, promptly took off his hat and showing his patch of alopecia said, “And I got this during the Moplah Rebellion.”

Labour Ward of Maternity Hospital

Student to Red Jacket.—“What child, male or female?”

Red Jacket.—“No sir, woman, sir.”

Police Commissioner's Orders.

“Bald headed motor cyclists should go about in the Corporation limits only with hats on, whether night or day. Any person violating this order is liable to be prosecuted under Section N 10 of the

In Lighter Vein

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Emergency Power Act of 1933.” I understand that this order was enforced as a result of the investigations regarding a motor accident in Mount Road, and it was proved that the accident was as a result of the driver of a car being dazzled by the Billiard-Ball head of a motor cyclist going in front and I suppose this has put a stop to our Venerable Secretary's perambulations of his latest model motor cycle. Hope others will follow his example.

Surgical Wards of the General Hospital.

Surgeon to an unfortunate student who yawned in the wards.—
“You 5₁, 5₂, 5₃, 5₄,.....5_n”

Student.—“5₈, sir?”

Surgeon.—“Alright, what is the ætiology of yawning?”

Student.—“I don't know, sir.”

Surgeon.—“You, you, you, you,.....” And getting no answer, he said, “1. When one feels bored

2. when one is in love.” And now what is your case?

Student.—“No. 2, sir.”

Out Patient Department of General Hospital.

A first year student who wanted admission as an inpatient on being asked what he is, replied, “I was 9th in the presidency for S. S. L. C., 7th in the Presidency for Intermediate, and 1st in the Pre-Registration from both Madras and Andhra Universities.”

Out Patient Doctor.—“But what are you now?”

Student.—“I am a first M.B. student of the Madras Medical College.”

Doctor.—“Yes that is what I wanted.”

Overheard during Anatomy Oral Examinations.

Examiner.—“What is ligamentum arteriosum?”

Student.—“It is the main ligament that prevents the arch of the aorta from straightening itself during forcible contractions of the heart.”

Examiner.—"Yes, what is your number? You can go."

Doctor.—"Well Mr. Brown how are you feeling this morning."

Mr. Brown.—"Much better, thank you. The only thing that troubles me now is my breathing."

Doctor.—"Um Yes. We must see if we can do something to stop that."

One of the replies to an advertisement for an organist was as follows:—

'Dear Sir, Noticing you have a vacancy for an organist and choir master, either a lady or a gentleman, having been both for several years, I beg to apply for the position.'

The woman who sat next to the eminent doctor at the dinner party thought she would make the most of her luck. 'Do you know doctor, sometimes I feel so tired that I can scarcely walk to do my morning shopping. Is there anything you could recommend me to take.' "Certainly" the doctor replied genially "take a taxi."

A professor of absent-minded habits fell in love with a young graduate and married her. They went on their honey moon and in the morning the professor awoke, looked at the other occupant of the bed room and said in a shocked and incredulous voice "Miss Grey, what are you doing here?"

Not so soon.

"Henry" said the wife in tearful tones.

"Yes, my dear, what is it?"

"If I were to die to-night, would you marry again?"

"Not to-night."

Teacher.—"How old is a person who was born in 1894."

Johnny.—"Man or woman?"

Class Teacher warning her class that kissing pet animals is dangerous to make it more impressive asked Joe to give an example.

Joe.—"My aunt used to kiss her cat."

Teacher.—"And what happened?"

Joe.—"The cat died."

Nurse.—"Every time I take the patient's pulse, it seems to go faster. What is to be done?"

Doctor.—"Blindfold him before you take the pulse."

"This modern science has cost me two years of my life."

"A badly managed operation?"

"No, this finger-print system I mean."

"This locality has a healthy and bracing climate-except the doctor nobody has died here for the last five years."

"What did the doctor die of?"

"Starvation."

The difference.

Doctor.—"How much of sleep do you get?"

Patient.—"Three or four hours a day."

Doctor.—"That isn't enough. How can you ever manage on that?"

Patient.—"I sleep from eight to nine hours in the night also."

A lesson for Tommy.

Johnny.—"What is that bulging out of your pocket?"

Dick (in whisper).—"Dynamite. I am waiting for Tommy. Every time he meets me, he slaps me on the chest and spoils the crease of my coat. This time he does it he will blow his hand off."

Done it before.

Foreman.—"I don't think you are fit for hard labour."

Applicant.—"But some of the best Judges in this country have thought I am."

Doctor.—“ Did you take my advice and sleep with all the windows open ? ”

Patient.—“ Yes, doctor.”

Doctor.—“ And the cold is gone ? ”

Patient.—“ No, doctor. Only my best suit and my gold watch and chain.”

A deserving Case.

The youngest boy in the family came home from class carrying a prize. His elder brother asked him what he had gained it for.

“ For politeness, you silly ass ” he replied.

The Way it is done.

“ The doctor has advised my wife to take exercise.”

“ And is she doing it ? ”

“ If jumping to conclusions and running up bills can be called exercise.

Lady.—“ Is this sleeping mixture really effective ? ”

Druggist.—“ Very effective, Madam. If you take the larger size, we give with it an alarm time-piece free.”

Howlers.

The Olecranon ossifies in the eighth year of foetal life.

A fourth year student has recently made known his discovery in his answer paper that Syphilis is a water-borne disease.

Found in a case sheet

Previous History.—The patient has never been fatally sick before.

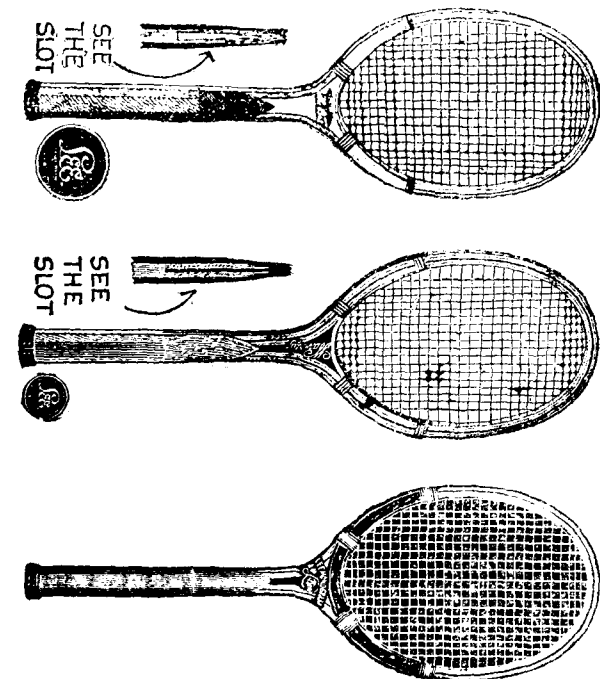
Family History.—The patient's mother died in her infancy.

Local condition.—A hard tumour, the size of a Coorg orange on the posterior aspect of the cough.

(The Student Editor acknowledges with thanks all contributions to the *Lighter Vein* pages.)

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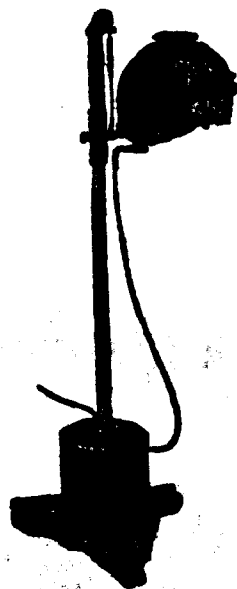
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