The Madras Medical College Magazine

Vol. XIV, No. 1. AUGUST.

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The Madras Medical College Magazine

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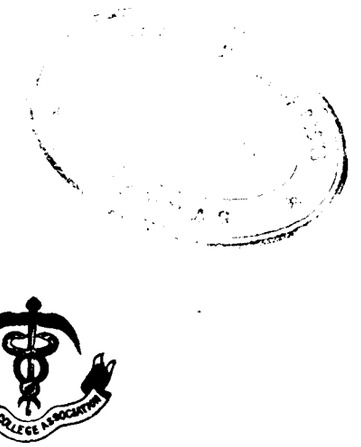

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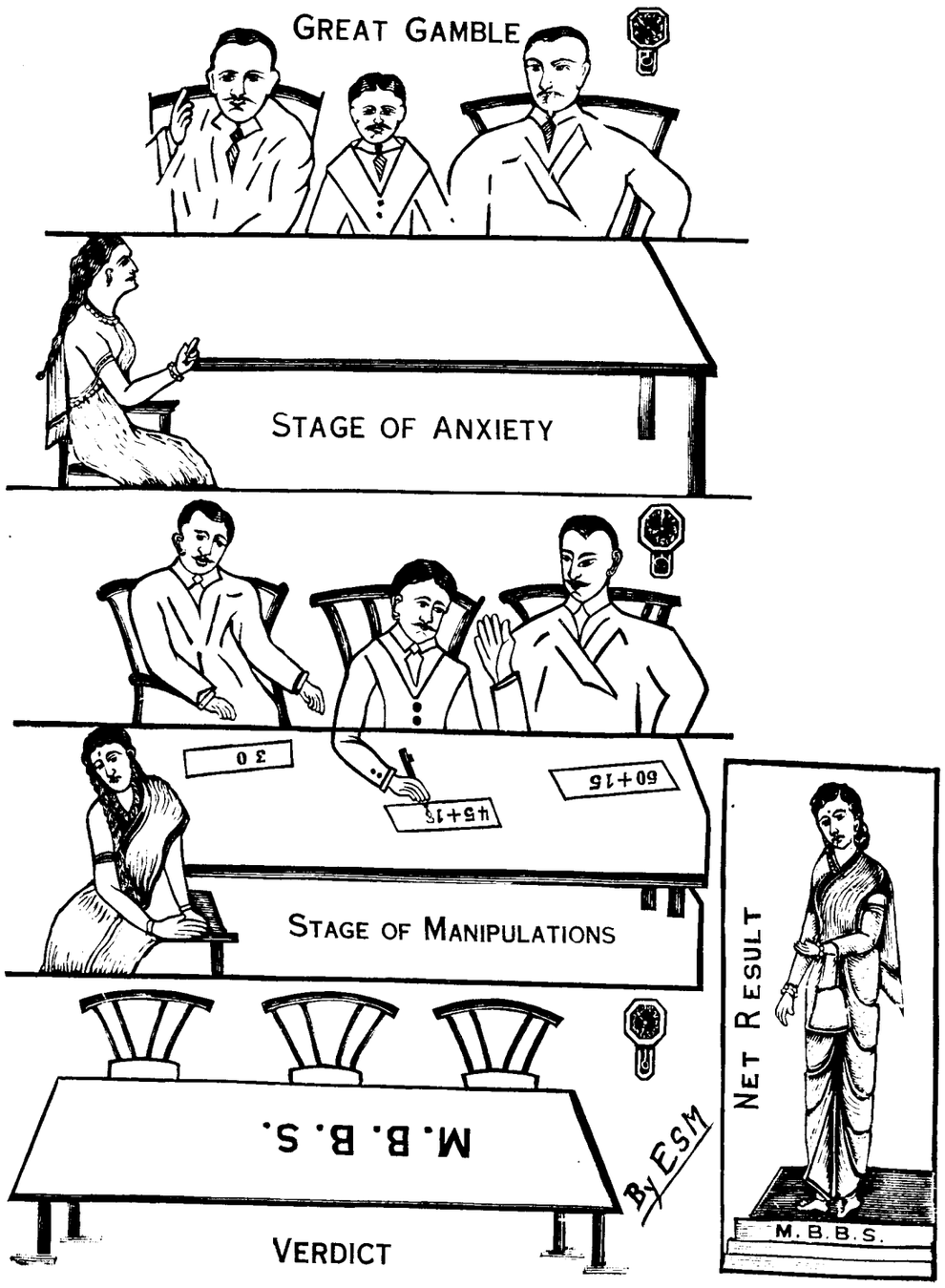

THE MADRAS

Medical College Magazine

VOL. XIV AUGUST 1934 No. 1

Sleep.

By Capt. R. D. Alexander, I. M. S.,

Additional Professor of Medicine.

" Then save me or the passed day will shine
Upon my pillow, breeding many woes : "
—John Keats.

Of the many privileges enjoyed by doctors, that of inducing sleep is surely, one of the most satisfying, and therapeutically it is also a most valuable means of combating disease.

Classification.—The causes of insomnia are numerous, but they may be classified under certain broad headings. Firstly, I would put insomnia due to pain, including physical discomforts, such as hot weather; next that due to various kinds of toxaemia and finally what may be broadly classified as insomnia due to mental causes.

Diagnosis.—" Oh Doctor I have not had a wink of sleep " is a common statement made by the patient to his doctor during the morning visit. Before accepting this pronouncement at its face value it is well to make certain enquiries from those in attendance. It is a matter of common experience that a couple of hours of wakefulness at night may seem an eternity, and though the patient is not consciously exaggerating, he may in fact have enjoyed 4 or 5 hours of excellent sleep. This brings us to the question of what we mean by Insomnia. Various amounts of sleep are necessary for individuals of various ages and the following table (1) gives the figures :—

1st year	18	hours.
2—5 years	14	„
5—6 „	12	„
7—14 „	10	„
15—50 „	8	„
50—60 „	5—6	„
65 and over	3—4	„

It will be seen from this table that what is sufficient sleep in a man of 60 is quite insufficient for a boy of 14. The above table is of course only correct for averages—many persons of 65 and over enjoy 5—7 hours of sleep. It is therefore necessary to find out how much sleep a patient is getting, and then assess how much is necessary for him according to his age and habits.

Having come to the conclusion that the patient is getting insufficient sleep, a careful physical examination is necessary to arrive at the cause of the insomnia. Should he complain of pain the cause should be treated and certain drugs administered. These will be dealt with later, but I would like to mention one or two causes of nocturnal pain that are significant, and in which ordinary analgesic methods are not effective.

The first is severe nocturnal headache. This condition is usually associated with organic disease of the Central Nervous System, and this must be carefully sought for, particularly the examination of the eyes for papilloedema, and the cranial nerves, etc., for evidence of cerebral syphilis. The second, is the pain due to duodenal ulcer—pain occurring about 2 a.m and waking the patient out of sleep is almost diagnostic of this condition. The treatment in this case will not be administration of sedatives, but of a large dose of Bismuth Carbonate, or injection of Atropin, last thing at night. This pain disappears rapidly under one of the diatetic treatments for Peptic Ulcer.

The toxic conditions giving rise to insomnia are the fevers, of which the most characteristic example is Lobar Pneumonia. Certain drugs, for instance the over indulgence in tea, coffee,

or tobacco and the withdrawal symptoms of the narcotic drugs must also be classified with toxaemic insomnia. Metabolic toxins, such as accumulate in the blood in Interstitial Nephritis may give rise to intractable Insomnia.

The mental conditions that are common causes of sleeplessness are numerous. Mental and physical activity before bed time is particularly important as a factor in children. Adults often think out or worry about the events of the day, prior to trying to sleep. Anything which fixes the attention is apt to prevent sleep. The emotions of fear and anxiety and also joy often prevent sleep, but sorrow, strange to say, does not do so. The Anxiety Neurosis may be associated with sleeplessness, but not the true Neurasthenic Syndrome.

Insomnia should be remembered as an early symptom of Psychosis, and in cases of Manic Depressive Insanity it may be one of the early symptoms.

Treatment.—This resolves itself into

(*a*) General Measures including Hydrotheraphy.

(*b*) Drugs.

(*c*) Psychological treatment.

General Measures.—If the insomnia is due to acute fevers, the general measures consist of good nursing and hydrotheraphy; this last is also of great value in excitable psychotic patients. It may be administered as either tepid or cold sponging or a cold pack. Strict instructions should be given to the attendants that the patient should not be woken for any purpose. This is of particular importance in Lobar Pneumonia.

In all cases of chronic insomnia, the habits of the patient should be reviewed and corrected, and it may be necessary to enjoin periods of physical and mental rest. It is well known to the lay public that if fatigue is carried beyond a certain point spontaneous rest becomes difficult, and the term "overtired" is

usually applied to this condition. This is also true of chronic fatigue, especially prolonged mental strain and worry, so common in modern times. It is probably partly responsible for the "week-end habit" which has become so indispensable in the rush of modern city life.

A few simple measures may assist in cases where no definite organic disease can be demonstrated, such as the administration of hot milk or ovaltine before going to bed. A small dose of alcohol is effective in certain people, in fact the drink of whisky or other spirit before retiring in known as a "night cap." Some not too exciting book or other quiet occupation should be indulged in for 2 hours prior to retiring and the last meal of the day should be taken about 3 hours before bed time.

It is particularly important that excitement should be avoided in children before bed time. Exciting and energetic games, stories of an exciting nature should be forbidden for at least an hour before bed time.

In India, in the hot weather, clothing must be light, and provided a bath towel is wrapped round the abdomen, chill need not be apprehended. A fine grass mat to sleep on also helps to keep the individual cool, while a slowly revolving ceiling fan is the best of all measures.

Drugs.—The drugs that will assist sleep, may be divided into three classes:—

(*a*) The Sedatives.

(*b*) The Hypnotics.

(*c*) The Analgesics.

The sedatives act by their soothing effect on the nervous system, and of them Bromide is by far the most valuable, though I think alcohol may be placed in this group. It must

be remembered that for Bromide to be effective it must be given a couple of hours before bed time. Sedabral, a combination of Bromide and meat Extract is of value.

Bromides are of great value in those patients who suffer from excessive mental activity after retiring to rest. Such persons often complain that they cannot stop thinking. Bromide prevents this mental perturbation, and sleep follows naturally. The dose of the Bromides is 5-30 grs.

The Hypnotics may be divided into—

(*a*) The Halogen group.

(*b*) The Aldehydes.

(*c*) The Sulphones.

(*d*) The Urea Derivatives including the Barbitone group.

The most important member of the first group is Chloral Hydrate. It is an excellent hypnotic drug of wide application and usually administered in conjunction with Potassium Bromide. The dose is 5-20 grs. and as long as it is used in these doses, its depressant effect on the heart need cause no anxiety.

The second group has only one member of importance and that is Paraldehyde (30-120 minims). It is however an important drug used extensively in toxic states, especially Pneumonia. It is without toxic effect except in huge doses and it may be administered rectally in Olive oil in doses, up to four drachms, thus avoiding the taste. This may also be done by prescribing in Mist. Amygdalae B.P. and also with Brandy. It is a valuable drug in excitable states, expecially Status Epilepticus. It should always be exhibited in full doses.

The third group contain a great many drugs, many of them proprietary preparations. They are powerful hypnotics and have been well reviewed by N. Mutch.[2]

There are many drugs of great value, but it is only possible to refer to a few.

Barbitone (B.P.) 5-10 grs. Syn. Veronal.

Barbitone Solubile (B.P.) 5-10 grs. Syn. Medinal.

Both drugs are useful, but should not be used in renal disease owing to slow excretion and cumulative poisoning effects. This applies to all the Barbitone and Sulphone hypnotics.

Pheno Barbitone (*B.P.*) Syn. Luminal and Sodium Luminal ½-2 grs. These are powerful hypnotics and are useful in sleeplessness associated with excitement.

Allonal (Roche). This is a valuable hypnotic for routine use; it also has some analgesic effect, being a combination of Amidopyrin and Barbitone Derivatives. The dose is 3-9 grs. or 1-4 tablets of the above preparation: 2 tablets are usually effective.

There are innumerable other hypnotics of this class, and their use has become so general that there has been some alarm in medical circles about the possible ill effects of these drugs. The effects of hypnotics have been recently reviewed by Willcox,[3] and his views are extreme, in that he never prescribes the Barbitone or Sulphonal group of drugs. In most of the cases that he quotes, the drug has been administered in full doses for an unduly long period, or else has been taken in excessive doses. Nembutal a drug of this series, while more potent, is also more toxic than others, and has given rise to a number of fatalities, but again with maximal doses.

Willcox's views have been combated by R. E. Gillespie[4] who considers these drugs of great value, provided they are exhibited in moderate doses, over a short period of time.

There have also been cases of Thrombopenic Haemorrhagic purpura recorded after the use of a certain urea derivative, presumably in persons with idiosyncrasy.[5]

To sum up, there seems to be no reason to condemn the whole class of Barbitone compounds. Given in recommended doses, and only for a day or two at a time, there seems no reason to suppose that any harm results from their exhibition. Luminal should not be given for more than 3-4 months at a time in Epileptic cases, but should then be gradually decreased and the dose of Bromide increased until the Luminal may be omitted for a month.

Poisoning by these drugs has become commoner of recent years and it has been found that in addition to the ordinary methods of elimination and stimulation, lumbar and cisternal drainage of cerebro spinal fluid are measures of great value.[6][7]

The fourth group of analgesic drugs may be sub-divided into sub-groups :—

The Coaltar Derivatives.

The Opium Group.

Certain proprietary preparations are a combination of Amidopyrine (Pyramidon) and a drug of the Barbitone series, and some of these have become exceedingly popular. The best known are Veramon and Allonal. They are useful in that they combine mild hypnotic and analgesic properties.

Of the analgesic Coaltar drugs, Aspirin is the most commonly used, and is useful as symptomatic treatment of headache and other mild pains. All these Coaltar drugs are antipyretic and somewhat depresant to the heart, but given in ordinary doses aspirin is a very safe drug of very wide application in the field of therapeutics, and overcomes insomnia due to mild discomfort or pain.

Acetanilide.—This is a powerful depressant and is somewhat toxic. Patients with idiosyncrasy develop alarming symptoms as in the case of the following patient:—*Mrs. F.* aged 40 suffering from Dengue with very severe headache. Acetanilide grs. 2 in cachets was prescribed—to be taken at once and

repeated in 4 hours if the headache is still severe. About half-an-hour after first cachet, the patient complained of feeling collapsed, the respiration was shallow and slow, the pulse feeble and rapid of low tension, the skin became covered with a blotchy erythema. Stimulants were administered and the patient recovered after about 12 hours.

It is better to avoid this drug and to prescribe either Phenacetin Grs. 5-10 or Amidopyrin (Pyramidon) Grs. 5-10, but in debilitated patients it is better to give smaller doses or to use aspirin. The ordinary A. P. C. powder is an excellent routine, mild, analgesic.

Opium and its products still remain our main stand by in the relief of severe pain, and in procuring comfort in some cases of extreme distress, such as congestive cardiac failure. I do not intend to give the opium derivatives as they are well known, and no recent addition has been made to our knowledge of their uses, except that some authorities [8] [9] use Morphine freely in conditions of kidney disease. It has little effect on urinary secretion, and is excreted by the bowel. [10] It is a matter of common knowledge that opium is an exceedingly dangerous drug in children, and should be administered in small doses—the best preparation being Compound Tincture of Camphor and Powder of Ipecacuanha (Dover's Powder); of the latter Gr. 1, t. i. d. for a child of 2 years and Grs. 2 for a child of 5 years may be useful in certain conditions, such as at the onset of Lobar Pneumonia.[11]

It must be remembered that all the drugs mentioned, with the exception of Bromide and possibly Paraldehyde, are capable of producing addiction. For this reason the general rule for administration should be that the drug should be withdrawn the moment it is no longer necessary, in spite of the wishes of the patient. Remembering this point, addiction must not frighten us from giving these drugs freely They relieve much real suffering and render the course of a disease easy for the patient

In cases of Insomnia unassociated with demonstrable organic disease the risk of addiction is greater, but it is as well to remember to give an adequate dose, to produce sleep at the beginning of the treatment, in order to give the patient confidence in the drug, and to break the habit in insomnia; then gradually to reduce the dose without the patient's knowledge until it be omitted altogether.

For cases of this type, tablets are unsatisfactory and the drug should be prescribed in cachets or mixtures, in which forms the dose may be altered without the patient's knowledge.

Psychological Treatment.—In cases of mental disorder causing insomnia, the emotion of fear is usually the cause of the trouble. This is most easily seen in certain children who are profoundly afraid of the dark and who lie awake in an agony of terror. In older people fear of sleeplessness itself, is commonly found, owing to the idea that insomnia leads to insanity. More profound psychological causes for anxiety may be present, while as stated earlier in this paper persistent and intractable insomnia may be the early symptom of a developing psychosis.

The treatment of this group of conditions consists in the first place of re-assurance and persuasion. A child suffering from night fear should be given a night-light and be allowed to sleep in the same room as other individuals or an adjoining room. Patients should be reassured about the question of insomnia giving rise to madness—it has never done so, and never will. For more profound anxiety states, expert psychological treatment will have to be invoked. In all these cases judicious use of drugs may be necessary, especially as stated above, in order to break the habit of insomnia and to re-establish the patient's confidence in his powers of sleep.

These few indications will have to suffice in the present paper, but many cases of mental insomnia will yield to this type of simple treatment.

It will be seen that the physician of to-day is exceedingly well equipped for the relief of pain and the induction of sleep. But it is as well for him to start with simple methods. and to use a few well tried drugs, especially those that are to be found in the B.P. rather than change his methods with every bright and attractive piece of literature thrust upon him by an enthusiastic agent of one of the Manufacturing Chemists.

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Vesical Stones.*

BY DR. N. MANGESH RAO, M.B.C.M., F.R.C.S.E., F.R.F.P.S.,

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This is a disease known even in pre-historical times. Ayurveda gives both the signs and symtoms and treatment for the condition. It mentions a supra-pubic method of removal. Susruta gives better description of the disease. He practised a perineal lateral lithotomy without the use of a staff. It is a disease more common in the male sex than the female sex.

Aetiology —The factors that were mentioned under lithiasis are the predisposing causes for growth of stones in the bladder. Most of the vesical stones form round small stones that have come down the ureter and been held up. Majority of these small renal stones are passed out, only a few are held up. During the emptying of the bladder the roof sinks down to the floor and two lateral recesses form. A small stone may easily slip into these and be held up and grow in size and become too large to pass through the vesical outlet. In boys the impact of a stone against the vesical outlet is liable to cause spasm of the small sphincter at the vesical outlet. Anatomical obstructions of prostatic urethra and vesical opening, whether acquired or congenital are liable to cause retention of small stones. Once the stone has grown too large for the outlet it cannot escape from the bladder.

Age.—In boys bladder stones are more common than renal stones. Urate and uric calculi being smooth pass down the ureters without causing much trouble and hence renal stones give rise to no symptoms in children. But owing to reasons mentioned above they get held up in the bladder and grow. But these cases form only a small part of youngsters suffering from

* Reprinted from February 1934 issue of the *Antiseptic.*

uraturia. In girls and women vesical stones are a rarity owing to their short and wide urethra. In adult males a stone that has come down the ureters is unlikely to be held up in the bladder unless there is obstruction at the vesical neck Hence between the ages of 20—40, vesical stones are not as common as renal stones. With advance of age, however, vesical stones become more frequent owing to obstructive lesions at the neck of bladder and prostatic urethra. Bladder stones may be divided into (1) Primary aseptic stones and septic stones (2) Secondary stones which are practically always septic.

Primary stones.—These are formed round small renal stones that have been held up in the bladder. So long as the urine remains acid they grow slowly by further deposit of crystalloids and colloids. Most of these stones are of mixed type, more than one salt being present. Hence lamination is very characteristic of these stones. The quantity of each salt varies with diet, locality of residence and any treatment that has been given. The nuclei of these stones may be fairly pure. Uric acid and urate nuclei occur in about 24 per cent, calcium oxalate in 35 per cent, a mixture of uric acid and oxalates in 16 per cent, phos phates in 18 per cent and foreign bodies in 5 per cent. These primary stones become coated with phosphates if the urine turns alkaline either owing to treatment or infection.

Secondary stones.—These are usually septic and form either round foreign bodies or where there is marked stasis and decomposition of urine.

i. *Foreign bodies may consist of* (1) Surgical-fragments of catheters, drainage tubes, filiform guides, unabsorbed sutures from the bladder, or adjacent structures as in hysterectomy, hernia operation, etc.

(2) Introduced from outside fragments of bullets, shells, bones from factures of pelvic bones or sequestra from a case of osteomyelitis of pelvic bones, etc.

(3) Introduced by patients. This is possible in girls and women owing to the short and wide urethra. It is seen in mental defectives, erotics and girls.

(4) Those arising in the bladder itself; parasites as Bilharzial ova, blood clots, balls of inspissated pus and round growths. In these cases the urine is alkaline and bladder is infected and the stone is made of triple phosphates of ammonium and magnesium, calcium phosphate (amorphous) and calcium carbonate with a little ammonium urate.

ii. *Stasis of urine* soon ends in infection and alkaline decomposition with precipitation of phosphates which form a stone: *e.g.*, in vesical diverticulae, cystoceles in women, post-prostatic pouches in old men, urethral stricture with cystitis, vesical paralysis of tabes or cord lesions.

The vast majority of vesical stones are single, multiple stones being seen more often in the old men with prostatic obstructions. The size and weight of aseptic primary stones vary with length of stay in the bladder. Most are of mixed type with marked lamination. Those formed round foreign bodies are phosphatic throughout.

Uric acid and urate stones.—Small ones are rounded or ovoid and larger ones are ellipsoid. Their surface is smooth or covered with smooth rounded elavations (mammillated). They are usually highly polished, compact fairly hard, breaking with a distinct crack in a lithotrite. Their colour varies from brick-red to light brown. The colour is lighter and stone smoother when urates are present in larger amounts. Urate stones are more common in children, smoother and of golden yellow colour. Even these show varying amounts of uric acid.

Calcium oxalate stones.—More often seen in adults. Their surface is covered with conical projections either slender and long (the star type) stouter and conical or blunt (the mulberry or jack-fruit type). The smaller ones that have recently come

down to the bladder may be covered with sharp glistening crystals. These stones are either dark brown or blackish in colour. Sometimes they may be jet black with a polished surface. The colour depends on the amount of pigment absorbed from urine and blood. Pure oxalate crystals are colourless. These grow slowly and rarely exceed an inch in diameter. They are the hardest and haviest of vesical stones.

Phosphatic stones.—(1) Dense, hard crystalline types are rare. They are white and their cut surface is crystalline and sparkles in strong light. These are harder than uric acid stones.

(2) The commoner type is made of a mixture of amorphous calcium phosphate, triple phosphate of ammonium and magnesium, calcium carbonate and small amounts of ammonium urate. They have a rough powdery surface with a dull white or grey colour. Some are bluish-grey in colour if made of large amounts of ammonium-magnesium phosphates. They may have patches of brown or black pigment on the surface. Most of them are homogeneous when formed round foreign bodies in alkaline urine. Some may show lamination, some are soft like wet mortar held together by thick muco-pus and others are fairly friable. Some may be firmer. They mostly take the shape of containing cavities. In enlarged prostate cases they may be multiple and facetted, their shape varying with size and number.

Secondary phosphatic deposits may occur on aseptic primary stones due either to cystitis or alkaline treatment.

Cystine stones.—These are rare in this country. Their shape is oval or ellipsoid and surface is covered with small rounded smooth elevations. They have a polished waxy surface and are translucent against light. They are yellowish green when removed becoming darker by exposure to light. They are softer than uric acid stones.

Xanthine stones are rare. They are smooth and of yellow colour and may be found as nuclei of urate and uric acid stones.

Indigo stones.—These are rarer still. They are dark blue in colour and leave a blue mark on paper. Indigo crystals may occasionally be found in phosphatic stones.

Calcium Carbonate stones.—Pure stones are exceedingly rare in the urinary tract They are grey-white in colour and very hard. They are found in salivary and pancreatic glands. This salt is found in septic stones with triple phosphates.

Growth of stones.—The primary aseptic stones grow slowly in size by deposit of crystalloids and colloids in layers and lamination results. Sooner or later cystitis supervenes and urine becomes infected. The urea splitting cocci cause a precipitate of phosphates and carbonates and there is a rapid increase in the size of the stone. Stones formed in diverticulae or impacted in the prostatic urethra grow towards the bladder and usually show a constriction about their middle (dumbell-shaped calculi), the bladder end being larger where a stone has remained for a long time.

Site.—Single stones usually lie in the 'bas fond' or on the inter-ureteric bar when large. In women it may lie in a lateral recess owing to the floor of bladder being raised by the presence of the uterus behind. If a stone is formed round a suture or growth it may be attached to the bladder wall. Stones in post-prostatic pouches and diverticulae naturally lie at the bottom of these. All other stones lie free in the bladder but may become fixed by vesical spasm gripping the stone. This is more often seen in children with larger stones or in the presence of cystitis. Spasm is more likely with rough spiky stones or with cystitis. When stones are multiple they become facetted and cuboidal or pyramidal in shape more often seen in cases with enlarged prostates.

Changes in the Bladder.—When a stone has existed for some time in the bladder, its bed becomes slightly hollowed and injected. In long standing cases certain amount of hypertrophy and trabeculation of bladder wall results. Later some hyperaemia of the wall and small haemorrages may be seen in the vicinity of the stone. With the onset of cystitis as a result of infection either haematogenous or instrumental in origin, urine becomes decomposed, the bladder mucosa becomes dusky red in colour and velvetty in appearance Masses of muco pus are seen sticking to the wall and the stone. The stone increases in size by deposit of phosphates. Bullous oedema round the stone appears and increases and may be mistaken for growths. Superficial ulceration of bladder mucosa may occur. Round cell infiltration followed by fibrosis occurs in the bladder wall. This makes the bladder contract down on the stone. The inflammation may extend to the outer layers of bladder resulting in pericystitis, fibrosis and adhesions. The bladder may therefore contract down on to the stone.

Changes in the Kidneys.—Since in a large number of vesical calculi the kidneys are already affected to some extent owing to their forming the renal nuclear stones, when back pressure begins by contraction of bladder other changes occur. First a dilatation of pelvis and calyces with certain amount of fibrosis in the parenchyma occurs. If cystitis supervenes a diffuse pyelonephritis is liable to occur. In any obstruction in the urethra from strictures or enlarged prostates, etc., the damage of kidneys sets in earlier than in cases of simple vesical stones. These are the so called "Surgical kidneys." A stone in a diverticulum is liable to press on the adjacent ureter and cause hydronephrosis and destruction of the kidney on that side.

Symptoms.—History of previous attacks of renal colic or passage of gravel may be given in 15-20 per cent of cases.

Pain is of two types. (1) Pain between the acts of micturition is a dull ache, sometimes a moderate cutting pain and may be referred to penis, perineum, rectum or hypogastrium. It is relieved by rest and increased by movements as jolting, riding, jumping or exercise. The greater the shaking, the greater is the pain caused. This is due to the fact that the stone comes in contact with the sensitive trigone in the erect posture and any sudden movement causes more irritation and pain. Hence nights are comfortable owing to the supine position.

(2) Pain at the end of micturition is more severe and referred to the perineum and along the urethra to its tip. It is a severe cutting pain which commences as the bladder gets empty and rapidly increases as the bladder contracts down on the stone to empty itself completely. In this the sensitive trigone is squeezed against the stone. The pain is most excruciating at the end of micturition. But this occurs only in cases where there is no residual urine or the stone in a diverticulum. Both types of pain are more severe with rough spiky stones.

Haematuria is of two types. (1) Terminal haematuria is characteristic and is accompanied by severe pain as mentioned above. It occurs as a few bright red blood drops flowing out at the end of micturition and is due to the mucosa being rubbed against a rough stone. It is more marked with oxalate stones. In the presence of residual urine it is absent.

(2) Between the acts of micturition there may be some oozing of blood varying in amount with type of stone and work of patient. This blood partly mingles with urine and partly sinks to the bottom of bladder. Hence in a two glass test, there may be only a little blood in the first glass, sometimes seen only under the microscope but the second class often contains visible blood.

The severity of pain and haematuria co-agree, the larger and rougher the stone the greater is the amount of pain and haematuria.

Micturition.—(1) Frequency is increased during the day owing to movements entailed by work and it is relieved by rest, hence nights are more comfortable. The frequency may be hourly or more often depending on the size and roughness of stone, and the type of work done. The desire may be so urgent as to make the patient wet his clothing. The condition becomes worse with the onset of cystitis.

2. Interruption of stream occurs in about 40 per cent of cases. A sudden and painful stoppage with release after a couple of minutes, followed by one or two stoppages may occur in the course of one act. In some these attacks may be absent or occur only occasionally. There is always pain referred to the tip of penis in such attacks. It is probably due to sudden spasmodic contraction of sphincter from contact of stone with the sensitive trigone.

Retention of urine is noticed only in about 5 per cent of cases. Sensation of rolling of the stone may be complained of occasionally. Sudden retention of urine by impaction of a stone in the vesical outlet is rare.

In Boys about the age of puberty priapism may be present. They often complain of irritation at the tip of penis and pull at the prepuce and penis, both of which may become elongated. Boys are liable to acquire the habit of masturbation from this. Nocturnal incontinence may occur in boys under ten. Pain in children is more severe and they scream with each act of micturition. Children also soon learn to pass urine either on "all fours" or lying down on the side as they learn that it is less painful and interruption of stream is absent.

Women.—Symptoms are more like those in children. Pain is intense and referred to external meatus. Haematuria is constant and interruption of stream is also more common. But in cases of cystoceles with residual urine the symptoms are much milder.

Elderly Men.—Vesical stones may be silent as a good number of these have enlarged prostates with residual urine. The stones lie quiet in the post-prostatic pouches. But these may complain of a dull ache in the rectum, anus or perineum with frequency of micturition afrer exercise riding or due to jolting. Microscopic haematuria is constantly present. Passage of small calculi may occur in a few. But when these cases lead a catheter life and completely empty their bladders, both terminal haematuria and pain occur. They soon learn to leave some urine behind.

Infected case.—Owing to cystitis the frequency is increased both by day and night. Rest gives no relief and sleep is broken. Urgency is now more marked. Pain starts as soon as bladder is full and is referred to hypogastrium or root of penis. It is more severe at the end of micturition. Scalding or burning of urethra during micturition may be complained of. In acute cystitis the urine is blood stained throughout but in chronic cases it is masked by mucopus. Terminal haematuria is brown or dark in colour. Patient loses weight and becomes pale, flabby on account of want of sleep and from toxaemia. In neglected cases pericystitis and pyelo-nephritis set in with a rapid loss of weight and appetite. Tongue becomes glazed and dry, later a brown coating forms. There is great thirst and gradually uraemia sets in. Patients usually die of uraemia and toxaemia.

Vesical infection may be haematogenous or after instrumentation. Staphylococci associated without coli group are chiefly found. Urine becomes stinking and throws down a copious deposit of mucopus and phosphates. The stone rapidly increases in size by the deposit of triple phosphates, this layer being soft and friable.

Examination —Palpation—In children large stones may be felt by bimanual examination with the finger in the rectum. They should be examined under a general anæsthetic. In adult

women a vaginal examination may give good information. In men neither palpation nor rectal examination may show a stone except when it is in a diverticulum. But rectal examination may show the condition of prostate. Pain and tenderness in the trigonal area is however suggestive.

Urine examination.—Chemical. The presence of pus, albumin, etc., may indicate the condition of bladder and kidneys. A microscopic examination of deposit would show red blood cells, and bladder epithelium. Deposit should also be stained and examined for organisms. If urine is acid cultures may have to be done, to exclude tubercular nephritis, etc.

Sounding for Stone.—Bladder should be gently washed and filled with 4 ozs. of fluid and a sound of 6 E size used. Patient should be flat with a pillow under the hips. The sound is passed in and the beak is turned down and rotated from side to side as it is slowly withdrawn. Lastly the roof and anterior surface are sounded. One can make out the size and whether the stone is soft or hard. A stone in the diverticulum or pouch may be completely missed. Phosphatic crusts on a growth may be mistaken for a stone. Bars and trabeculation, etc, may be mistaken for a soft stone.

Cystoscopy.—This is the most important and definite examination. The size, the type of stone, the presence of cystitis and its extent, diverticulae, growths, enlargements of prostate, the number of stones, etc., can be made out in some detail. In addition to the examination of ureteral mouths, the character and frequency of efflux can be judged. Chromocystoscopy will give a fair indication as to the working capacities of the kidneys. An experienced surgeon can make out these details and decide the proper operative treatment indicated in the case. The bladder should be washed through a soft catheter till the return flow is clear. This should be done gently without using force to distend the bladder which may be in an irritable condition. Four ounces of sterile boric lotion should

be left in and cystoscope introduced for examinatton. A spinal or caudal anaesthesia is advisable where bladder is irritable as in long standing cases.

X-rays.—Pure uric acid and urate stones especially small ones may give no shadows or only faint ones liable to be missed. Growths covered with phosphates will give shadows. Bladder stones usually lie in the middle line with their long diameter horizontal. In women the stone, usually lies in the lateral recess. Stones in diverticulae also lie on the lateral sides. To bring out negative shadows in the case of uric acid and urate stones the bladder is filled with 4 ozs. of a 10 per cent sodium iodide solution and a picture taken; then the bladder is emptied and distended with an equal amount of air and another picture is taken. In the first plate clearer areas in a dark back ground are suggestive. In the second picture these stones can be seen distinctly being stained by the iodide solution. It will also bring out any diverticulae that may be present. Fallacies may occur owing to shadows cast by faecal lumps in the rectum, calcified glands, foreign bodies in the rectum and vagina, calcified myoma of uterus, ovarian dermoid, etc. These should be excluded. Phleboliths lie along the bony border and are small in size.

Diagnosis should be easy if a thorough examination has been done. Only two conditions may resemble this but only as regards symptoms. These are, tuberculosis or malignant growths of bladders but these can be made out by cystoscopy easily.

Treatment is only surgical either by Litholapaxy or suprapubic Lithotomy.

Litholapaxy should be done in uncomplicated aseptic stone cases if the stone be not too large or too hard to be grasped by the jaws of a lithotrite that could be introduced without damaging urethra. The operation shortens the stay in hospital and

does not weaken the abdominal wall by a scar. Experience and skill are however, necessary.

The sizes that can be used at the different ages are:

Male adults:	sizes	16-18	E (26-30 F)	Maximum diameter of stone that can be grasped is 2 inches
Boys 14-16:	„	10-12	E (18-21 F)	„ 1 inch
Child 3-4:	„	6	E (12 F)	„ ½ inch
Child of 1:	„	4½	E (10 F)	„ ½ inch

In female children a size 2-3 F larger than mentioned above can be used.

Sizes of Lithotrites and the largest diameter of stone that can be grasped by its jaws are: Size 4½ E-½"; 10 E-1"; 12-E-1¼"
„ 15 E-1½"; 18 E-2".

Contra-Indications are.—Where skill and experience are wanting, in small children, in "Surgical kidneys" where they are badly damaged, where stone is too large and hard for the lithotrite that could be passed in easily, where stone is formed round a hard foreign body or round a piece of rubber material, if there be chronic foul cystitis, diverticulum, or enlarged prostate and in cases of vesico-prostatic calculus, in all these conditions, a supra-pubic lithotomy is indicated. If mild cystitis be present this should be treated and lithotrity performed after it has subsided. Urethral stricutures should be fully dilated, if necessary after an internal urethrotomy and seven to ten days later a lithotrity could be performed. Callous strictures with fistulae should be first treated for this condition and later the stone attended to.

Operation.—Pass in sounds first up to the largest size possible without damage. Next pass a rubber catheter, wash the bladder till return flow is clear. Leave 4 ozs. of fluid in the bladder. Next pass a lithotrite, (Freyer's) pulling the penis on the shaft to stretch the urethra, the instrument slips in by its own

weight. Hold the shaft at 45° to the horizontal, the beak just pressing the floor of the bladder. Unlock the instrument, withdraw the male blade. After a few seconds push the blade down. If the stone has fallen into the jaws they cannot be closed. Now lock the instrument. Lift the beak a little. Slowly use the screw movement to close the jaws. One soon hears a crack of breaking of stone. Unlock it withdraw the male blade and after a few seconds again push the male blade in. It is held up by a large piece of stone. Lock it and slowly use the screw movement. Repeat these movements till the stone is well powdered as shown by the male blade going home each time. Next pass a large canula and wash out the contents. When no more is coming out, put in 2 ozs. of fluid and attach an evacuator and raise it to bring the tip of canula to the floor and give a sharp compression to the bulb of evacuator. With each compression and relaxation fluid rushes into the bladder and brings back debris of stone in the return flow, which sinks into the glass vessel. This is repeated till no more debris returns. Change for a new evacuator and repeat the movements. Then turn the beak so that the fenestra is towards the floor. When nothing comes out bladder is washed till clear and about 6 ozs. fluid left in and canula is replaced by a cystoscope and an examination is done to see that no pieces are left. After the operation is completed a catheter should be tied in for three days. This is not necessary for small stones with healthy bladders. Patient should be on hexamin from the day of admission. Bladder is washed twice a day with warm weak silver nitrate solution. As soon as urine is free from blood, catheter can be removed and he can be discharged three days later.

Accidents: Failure to find stone is due to its being in a diverticulum, or a pouch especially in prostatic cases or from overdistension of bladder. Occasionally the bladder may be tightly contracted on the stone and may not yield even under anaesthetic. Bladder refuses to allow any fluid to be injected. These cases should be done by cystotomy.

Injury to bladder wall.—This is avoidable. If bleeding does not stop in three days, this should be suspected and cystoscopy done to confirm. If blood clots are present they have to be evacuated by cystotomy. Some haemorrhage always occurs but stops in a day or two with bladder washes.

Epididymitis.—Not common. It occurs where urethra has been damaged. Hot fomentations are applied. It is liable to end in abscess at the globus minor which should be promptly drained to save the testis.

Supra-pubic lithotomy. Indications are.—If stone is too large, if it is adherent to the bladder, in a pouch of diverticulum, or formed round a foreign body as tubing, if marked cystitis is present or enlarged prostate or diverticulum of bladder is also present. Where no suitable instrument is available nor experience of litholapexy. In children any stone over ½" diameter would require supra-pubic lithotomy.

Operation.—The bladder is washed through a rubber catheter and filled with 6-8 ozs. of lotion. A supra-pubic midline incision with retraction of recti exposes prevesical fat. This is snipped just level with symphisis and pushed up with gauze. This exposes the vertical muscle fibres of the bladder which has been distended with fluid. Now a stab incision is made into it and opening plugged with finger. The fluid is let out. The incision is enlarged taking care not to open the peritoneum. The stone can be removed by a little manipulation. Large ones should be broken by a straight lithotrite and fragments removed. Wash the bladder well. Then perform a finger exploration. Any complications may be dealt with now or at a second operation. The bladder is closed round a drainage tube and space of Retzius is also drained. Bladder is daily irrigated out. The drainage tube of bladder is replaced by a smaller one on the 4th day. This can be removed on the 10th day and a soft catheter is tied in per urethra till wound closes. Primary closure of bladder can

be done if there be no cystitis or other complications and the stone is small. A catheter should be tied in. If blood urea is very high from damage to kidneys a simple cystotomy is done and later when blood urea has come down, the stone is removed.

Complications.—Peritonititis. This is avoidable with some care. If it occurs, immediate drainage should be established. 2 pelvic cellulitis can be prevented by draining the space of Retzius. If it occurs, wound should be opened and counter-incisions put and part drained.

3. Presistent fistula is due to obstruction at the neck, enlarged prostate or urethral stricture. These can be dealt with. Sometimes bladder may become adherent to symphisis pubis and the fistula persists. It is best to cutdown and separate the bladder after excising fistula and close it completely and tie in a catheter.

Mortality from litholapaxy in experienced hands is 2-3 per cent but mortality by supra-pubic lithotomy is about 9 per cent. Of course the latter operation has to be done in more complicated cases. Any complications that are present should also be dealt with either at the same sitting or at a subsequent operation as indicated by the condition of patient.

The Treatment of the Enteric Group of Fevers

(A REVIEW OF 100 CASES)

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There is at present considerable divergence of opinion among the profession regarding the best line of treating typhoid cases. From September 1932 to March 1934, in the above hospital a hundred cases were treated. I propose in this paper to describe in detail the routine method employed and to discuss its rationale.

Diet.

The febrile period of typhoid fever lasts a month or more and is attended with serious toxic destruction of tissue proteins. In choosing a system of diet suitable to such an illness, the following considerations have to be borne in mind :—

1. It should be sufficient to repair the tissue waste.

2. It should be of such a nature as not to injure the diseased bowel in any way.

3. It should attempt to maintain the metabolic equilibrium of the body.

It is of no advantage to starve a typhoid patient. It is on the other hand dangerous to do so. Starvation leads to intestinal and cardiac atony. We believe that it is a physiological principle that an organ which is not kept working up to its capacity to work tends to degenerate, *e.g.*, in health a muscle not fully used tends to become flabby and fatty ; the diseased heart if not given the work that it can do takes longer to recover than one getting the optimum amount of work ; the

diseased pancreas if sugar entirely withheld from the diet tends to lose its remaining power to deal with sugar. So with the intestine in disease. If it is not given as much work and nourishment as it can deal with, it tends to lose its tone. Peristalsis is not so active, atony supervenes, distension follows and in its train the dreaded complications of meteorism haemorrhage, perforation, etc.

Starting from this physiological principle, we believe that the intestinal complications of Enteric are more likely to occur in a patient who is put on a starvation diet than in one who gets a diet as liberal as he can deal with. The diet of an adult Enteric patient in our hospital if he is a non-meat-eating Hindu consists of the following :—Milk 2 pints, rice 4 oz. bread 4 oz. pepper water half pint, oranges 2, coffee one pint, sugar one oz.

(Formulae, giving 1700 calories)

Proteins 57 gms : Carbohydrates 220 gms. Fats 40 gms.

Good milk obtained under hygenic conditions is an excellent article of diet for typhoid patients. We have found that it is well tolerated by the patients. In cases where the digestive capacity is very poor as in children, it may be skimmed and acidified. It is given in three hourly feeds.

Rice has a high calorific value. It does not leave any coarse residue, for by the time it reaches the ileum it is in the liquid state. It is mostly carbohydrates and is easily digested. Pepper water is a stomachic as well as a carminative.

Oranges are given for their vitamin content. The juice of it is squeezed out and given as the first thing in the morning.

Coffee is a good stimulant and acts also as a diuretic.

For patients who have no restrictions in their choice of food, we give *from the very beginning* a diet composed of minced meat, pounded fish, lightly boiled eggs, custards, jellies, rice

bread, tea, coffee, any article of diet in fact which has good nutritive value and does not leave a coarse residue by the time it reaches the ileum.

In addition to this diet, patients are encouraged to take additional carbohydrate in a form that can be easily assimilated. Parry's boiled sweets, well known all over Southern India, form an excellent, palatable, agreeable, and safe form of giving additional carbohydrates. One or two ounces of these sweets may be given in the course of the day at the end of meals. For those who can afford it, and like it, honey may be used in ths same way.

Fats are usually withheld, especially during the early stages of the disease. It may be given during convalescence. When fat is given, acid hydrochlor dil is always administered along with meals.

So long as the tongue remains clean, the abdomen not distended, and the stools all right, we push the diet on and if necessary vary them so as to suit individual needs. In children and comatose patients plenty of water is administered to prevent dehydration. After the temperature has remained normal for three consecutive days the patient is put on a full ordinary diet.

Drugs.

The drugs usually employed are (1) Calomel (2) Pyramidon and (3) Tr. Iodine (Rect).

Calomel.—We are in favour of the eliminative treatment. Our experience shows that gentle purgation is the only satisfactory method of eliminating toxins in this disease. Calomel is given to every patient as a routine measure. It is best given in divided doses, preferably gr. i, every hour till bowels move, not more than gr. iii, being given in 24 hours. If calomel fails to act next morning an ounce of castor oil is administered, the

object of the physcian being to secure 2-3 good stools every day. Besides acting as a laxative, calomel also stimulates the liver, the great detoxicator in the body, and increases the flow of bile. The main defect in calomel treatment is that in some people it very soon gives rise to stomatitis. The nurse is therefore specially instructed to keep the mouth clean by using Alum gargles every three hours. The administration of calomel is withheld as soon as any mouth symptoms appear.

Pyramidon is the antipyretic drug employed. Five grains of it is administered as soon as the temperature goes over 101° and repeated as often as it is necessary. Besides bringing down the temperature it relieves headache and promotes sleep. We never resorted to hydrotherapeutic measures. We do not depreciate its value, but do not think that it forms a very essential part in the treatment of this disease.

Tincture Iodine (Rect) in 5 m. doses is administered in every case three times a day between meals. The thyroid gland in the body deals with the intestinal toxins and the iodine is given with a view to stimulate it. Mc Carrison says that 'the iodine is to the thyroid just as the oil is to the motor engine.'

Treatment of Complications.

I do not propose to discuss the treatment of the various complication, for I believe they are to a very great extent preventible. Early hospitalization, liberal feeding, skilled nursing, good clinical judgment on the part of the physcian—these in my opinion should lessen the incidence of complications in this disease.

Results.

The total mortality was six per cent. The mortality among those admitted during the first week of the disease and treated on the above lines was *nil.* Not only was the mortality *nil,*

but also none of them suffered from any of the complications. The whole of the mortality was accounted for by cases that came to the hospital late in the course of the disease and very toxic, *i.e.*, after the second week. Three of the cases that died were in fact admitted in a moribund state. Relapses occurred in a few cases, but they were of little significance. There was no case of perforation. Haemorrhaged from the bowel occurred in two cases, but it as only slight and was quickly controlled by the usual measures. There was no case of severe tympanitis or diarrhœa. The convalescent period was very short and many patients were able to return to their work in a short time. Almost all the patients were well nourished and did not look as if they had gone through such a long period of illness. 'The cracked lips, pale face and dull eyes' described in many a text-book as being so typical of the typhoid state is a picture which is not seen in cases admitted during the first week of the disease and treated on the above lines.

In conclusion, my thanks are due to Lieut.-Col. Leslie, I.M.S., for kindly permitting me to publish this paper.

The Soft Sore.

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The soft sore or chancroid occurs round about the genitals within 1 to 6 days after exposure to infection. It starts as an oral or round ulcer and spreads to contiguous surface by auto-inoculation. The soft sores are generally multiple, painful, soft and bleeding in contrast to the syphilitic chancre which is usually single, hard, indurated and painless. Dark ground examination of the scraping from the sore shows the spirochaeta pallida in a chancre or mixed infection, while B. Ducrey is found from the scraping of a soft sore. B. Ducrey is a Gram-negative short, thick and slightly dumb-bell shaped strepto bacillus, which is the causative organism of soft sore. It is often associated with a painful lymphangitis and lymphadenitis. The glands in the groin are enlarged, painful, tender and often suppurating, which may end as a chancroidal bubo, if untreated. Soft sore is a localised infection and never affects the general constitution like syphilis. It is never extra-genital.

Differential diagnosis.—Chancroid is to be diagnosed from (1) Chancre (2) Herpes (3) Follicular abscess (4) Erosions of Balanitis (5) Balanoposthitis (6) Moist papules (7) Scabies (8) Tertiary ulcerating gummata (9) Tubercular ulcers and (10) Epithelioma.

The soft sore is diagnosed from chancre and herpes thus—

	Soft sore.	Chancre.	Herpes
Etiology.	B. Ducrey.	Spirochaeta Pallida.	Due to mechanical irritation as in sexual intercourse or chemical irritation produced by acrid discharges or uncleanliness or neurosis.
Incubation.	2 days to 6 days.	10 days to 12 weeks. Average about 6 weeks.	None.
Site.	Rarely extragenital. Generally on the glans penis and the prepuce in the male. The labia and the Fourchette in the female.	Normally on the genitals. Sometimes extragenital as lips, tongue, elbow, nipples and fingers.	Generally on the genitals and also on the lips or tongue.
Number.	Frequently multiple due to auto-inoculation.	Usually single and occasionally multiple.	Multiple. Ultimately may be confluent.
Begins.	Starts as a pustule or an ulcer. Always ulcerates.	Begins as an erosion, papule or ulcer.	Starts as a group of vesicles which may coalesce or may ulcerate singly.
Cantour.	Round, oval or unsymmetrically irregular.	Round, oval or symmetrically irregular.	Irregular, circinate borders.
Depth.	Hollow, excavated or punched out.	Usually superficial, cup-shaped or may be raised.	Superficial.
Surface.	Rough, uneven, warty, pultaceous slough.	Smooth, shining, dusky red and glazed.	Bright red superficial granulations.
Secretion or discharge.	Profuse purulent secretion, bleeds readily.	Serous, no blood, rarely bleeds and scanty secretion except in cases of mixed infection.	Moderate discharge. On squeezing a drop of serum exudes.

	Soft Sore.	Chancre.	Herpes.
Auto-inoculation.	Auto-inoculable.	Not inoculable.	Auto-inoculable with difficulty.
Induration.	Rarely present. Boggy, inelastic shades off into surrounding parts.	Usually present firm cartilaginus India rubber consistency. The induration extends for some distance outwards. Sharply circumscribed.	No induration.
Sensibility.	Usually painful.	Painless.	Often painful.
Course.	Irregular, rapidly extends, acutely inflammatory, destructive and painful. Runs its course in 3 to 6 weeks. Relapses and phagadena common.	Extends slowly and usually painless and heals only with anti-syphilitic treatment. Relapses and phagadena uncommon.	Easily and quickly cured within a few days. Sometimes spreads as crops of vesicles. Usually recurs in syphilities and in unclean patients.
Histology.	An ulceration with more or less loss of substance. Scrapings show granulation tissue,	A new cell growth. Very little destruction of tissue. Scrapings show more or less epithelium.	Originally an elevation of the epidermis in spots by an effusion of serum.
Bubo.	Appears in one-third of the cases. Very painful inflammatory, single or bilateral.	Generally bilateral, indolent, painless, enlarged glands, hard and discrete. Rarely suppurate.	Rare. When it occurs painful, inflammatory, single or bilateral.
Prognosis.	More serious locally for there is tissue destruction. May become phagedenic. Never followed by syphilis unless mixed.	Good locally with little scarring. Followed by constitutional syphilis in many cases.	Always good.
Treatment.	Local anti-septics heal the sores slowly. Cauterisation hastens rapid healing.	Rapidly heals with anti-syphilitic treatment.	Heals rapidly with local treatment.

The lesions of Herpes, Follicular abscess, the erosions of Balanitis and Balano-phospitis or mechanical abrasions are easily mistaken for chancroids when they appear first. In a few days the superficial nature of the inflammation and the prompt yielding to cleansing applications indicate that chancroidal infection is absent.

Moist papules may simulate soft sores, but are slower in their course, less inflammatory in type. On dark ground examination of the serious discharge from the moist papules, the sprirochaeta pallida is found in abdundance.

Scabies round about the genitals may be mistaken for chancroids. They are distinguished as they are very itchy and are easily amenable to sulphur ointment.

Tertiary ulcerating gummata of the genitals may be diagnosed as the ulcer is punched out, sharply cut with raised walls covered with tough, yellow wash-leather like slough at the bottom. The slow progress of the lesion (weeks instead of days) the absence of the symptoms of acute inflammation and the effect of anti-syphilitic treatment clinch the diagnosis.

Tubercular ulcers are extremely rare. They are characterised by a very slow extension (weeks or months) and are usually associated with tuberculous lesions in other parts of the body. The ulcer may show sometimes grayish semi-transparent, military tubercles. Microscopic examination of the scrapings of the lesion often show Tubercle B. Inoculation into guinea-pigs will determine the diagnosis.

Epithelioma usually occurs in persons above 40 years and is an irregular, hard and ulcerative paplliated outgrowth and it is is easily diagnosed from soft sore. The infiltration of the base the appearance of the ulcer following infiltration and the microscopical examination help in eliminating epithelioma.

Treatment.—Usually anti-septic dressings as eusol or copper sulphate solution ½ per cent hasten healing of soft sores. If the sores persist in healing and have a tendency to spread, 2 per cent Mercurochrome dressing is applied. If the sores are small and multiple and resist ordinary local anti-septics, they are cauterised with fuming nitric acid or silver nitrate or pure carbolic acid. Most efficient is electric cautery.

Generally no injection is necessary if the chancroids heal under ordinary anti-septics without giving rise to complications. If it spreads, Dmelcos vaccine, preparation made from B. Ducrey is injected intravenously in graded doses with 1 or 2 injections. Soft sores heal very rapidly and the suppurating bubo which complicates chancroids also subsides rapidly. Dmelcos vaccine produces very high temperature as 105°F with the first injection and the patient is to be warned beforehand about it. Otherwise it does not give rise to any bad after effects. A course of 6 injections is given as a routine to resistent cases of chancroids.

Complications —(1) Phimosis and paraphimosis. (2) Excessive inflammation, phagedena and gangrene. (3) Lymphangitis and lymphadenitis or suppurating bubo.

Of all these complications, suppurating bubo is the most common.

Suppurating bubo or chancroidal bubo.—The groin glands are enlarged, tender and very painful in association with soft sores on the genitals. Usually it is unilateral. The predisposing cause for the formation of the bubo is the lack of proper drainage from the ulcer. B. Ducrey is the causative organism of chancroidal bubo. The lymph node reaction in chancroids is more than that of an acute painful adenitis, which softens and breaks down with one central area of necrosis, unlike in climatic bubo which has multiple areas of suppuration corresponding to the multiple abscesses in the nodes. In a

case of chancroid gone to the stage of adenitis, the patient will have a positive Ito-Recustierna reaction. This is a specific intradermal test corresponding to the tuberculin test, carried out by the injection of killed B. Ducrey organisms.

In early stage, absolute rest in bed, hot boric fomentation to the inflammed groin or sedative applications to the painful part of lead and Opium lotion or 20 per cent Icthyol in glycerine is indicated. It must be aborted by giving fomentation locally and injecting 5 to 10 c.c. of sterile milk intramuscularly every 3rd day. Bubo usually subsides with 2 or 3 injections of milk. If it does not abort with non-specific protein therapy as milk and if the bubo fluctuates and softens, daily aspirate it and wash out the cavity after aspiration, with 1 in 20 solution of Tincture of iodine. With 2 or 3 aspirations, the bubo aborts. If it bursts, then incise it from end to end and pack it with iodoform gauze after scraping out the cavity with a Volkmann's spoon. As far as possible avoid opening the bubo, as it takes a long period, say 2 to 3 months to heal when once it is incised.

Resistent cases of chancroidal bubo rapidly subside with 2 or 3 injections of Dmelcos vaccine, which acts both as a specific and a protein shock. Tonics and nourishing diet are given to brace up the patient.

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Some Reminiscences of Hospitals in Europe.*

By Mr. V. R. Kamath, M.B. & B.S., D.L.O. (Eng.).

I must begin with the admission that these reminiscences and reflections have to do mainly with the Ear, Nose and Throat hospitals of Great Britain, Austria and Germany; which being the case, the title of the lecture is perhaps a little misleading.

My first impression of an English hospital was a trifle disappointing. I had joined Guy's as a post-graduate, and with much anticipatory excitement I visited the Ear, Nose and Throat department which is under the direction of Mr. Mollison who has been more than once president of the Otological section of the Royal Society of Medicine. I found myself in a large room lined with rows of examining tables for the use of students; and at just one such table, with not even a nurse by his side to help him, was Mr. Mollison examining his out-patients. Inevitably, I compared the state of things with what obtains in our large hospitals where even a house-surgeon considers that a glass-topped table, an electric fan and a trained nurse are indispensable adjuncts for dealing with out-patients, and who thinks twice before filling an ear-syringe himself. I remember one case on that first day very well,—a man came with pain in his left ear. Mr. Mollison examined him and then asked me what I thought was the cause of the pain. I found nothing in the ears or nose or throat to account for the otalgia, and confessed my inability to discover the cause. Mr. Mollison then asked me to look at the patient's teeth. I had done that too, and had detected a carious molar on the *right* side,—consequently I had not connected it with the otalgia. When I explained this,

* Extracts from an address delivered before the District Medical Association Cuddalore. Published by kind permission.

Mr. Mollison related to me how he had seen two cases previously, in whom a carious tooth had been the proven cause of reflex pain in the contralateral ear.

The Central London Hospital for Ear, Nose and Throat, is the largest hospital in the speciality in Great Britain. Post-graduates are appointed Clinical Assistants and are afforded facilities for examining and treating patients. There are several Surgeons attached to this institution—all big names in the special field—and each attends on fixed days of the week. I once visited one of the senior surgeons in his consulting room at Wimpole Street, and he advised me to have my tonsils removed, offering to do so himself. I agreed, under the condition that he would do the operation under local anaesthesia. What was my unmitigated astonishment when he replied, "My dear young man, during the last thirty years I have done only two tonsil cases under local anaesthesia, and I have no wish. that you should be the third!" My tonsils are still with me.

Vienna is now a ghost of its pre-war self,—so they tell you, when you visit it. But if it *is* a ghost now, I truly cannot imagine what its real self could have been like. For it is one of the few cities in the world which do not let you down. You may envisage the most glamorous pictures of Vienna, "the City of Love and Laughter, heaven of hearts that seek Romance,"—and yet the reality which you find when you go there will always surpass the creation of your fancy. The Allgemaine krankenhans (General Hospital) contains six thousand beds, for Vienna attracts the sick and ailing from all Central Europe and even from Sweden and Spain. The American Medical Association of Vienna arranges regular courses of lecture and hospital work for English-speaking medical men, and most of the Professors and Surgeons can speak excellent English. Another feature of the teaching is cadaver surgery; as every case that dies in hospital is sent for post-mortem examination to the icy-cold uuderground vaults. where are always bodies available. One can join a hospital as Clinical Assistant to a

particular surgeon, and then one is given unlimited facilities for work. Professor Haslinger, the famous endoscopist, initiated me into the mysteries of that specialty within a specialty, and entrusted me with all the work that his own assistant would have done. I worked for some time under Professor Ruttin who has perhaps done more for modern otology than any man living. He is a genial, kindly man, indefatigable and inimitably humorous. "Many doctors come to me from foreign countries," he used to say, "who know a lot about otology; yet I have often to bring to their notice that all Austrian patients have *two* ears!"

Professor Ruttin has done a great deal to bring to the cognizance of the medical world the existence as a clinical entity, the comparative frequency, and the peculiar dangers of that special variety of acute otitis media which is caused by the streptococcus mucosus. Perhaps you will permit me to describe briefly what is meant by the term, and why it is specially distinguished from the inflammation caused by the pyogenic streptococcus or by the pneumococcus. The early stage of "mucosus otitis" is almost devoid of pain, and is diagnosable by inspecting the tympanic membrane which is lustre-less and greyish-red, by the diminution of hearing and by the presence of tinnitus; and is distinguished from ordinary catarrh by the non-improvement of hearing after inflation through the Eustachian tube. In doubtful cases, two smears are taken after paracentesis, one being stained with methylene blue (which colours the pyogenic streptococci) and the other with a fresh solution of thionin (which stains the mucosus only). After a latent stage of about five weeks or longer, during which the drum does *not* rupture, the condition is precipitated into the stage of complications—meningitis, cerebral abscess or sinus thrombosis. A young man was referred to Professor Ruttin from the venereal side, for slight discomfort in one ear. Ruttin diagnosed mucosus otitis and advised operation. "What!" cried the Young man, "I came here for my gonorrhoea, and

you want to operate on my ear?" But Professor Ruttin did operate, and had to take away a good bit of the man's skull and brain.

One *must* operate on cases of mucosus otitis, or refuse to treat the patient at all, but one need operate only in the fifth week, for the condition may subside by then, and will go on to complication's only later. Professor Ruttin told us of a man who did not flatly refuse operation but promised to report for observation every day. He used to put his head inside the doorway each morning and say, "Doctor, I feel wonderful!" One day the man's wife came to say that her husband wasn't doing quite so well. Ruttin exclaimed, "Jesus! Your husband is dead!" The man had meningitis, and his spinal fluid showed streptococcus mucosus in pure culture. Of course he died.

I found that the problem of deafness is not considered with the same hopelessness in the West as it is in this country. Every case of deafness is thoroughly investigated, and the wonderful new instrument called the Zund-Burguet Electrophonoide differentiates between the various types of deafness and accurately registers improvement or deterioration of the auditory function. One afternoon, at the Central London Hospital, a woman brought her sixteen-year old daughter for deafness. I asked the girl some simple questions and she answered them correctly even when I whispered them. I looked enquiringly at the mother, and she told me with pardonable pride that the girl had attended a lip-reading school and could read one's lips even from a side-view. She was a deaf-mute, but had been taught to hear with her eyes, and to speak though she could not hear the sound of her voice. A frequent cause of deafness is the existence of a large perforation of the drum. Perforations which are not very large are cauterised at their edges to make them heal by scar-tissue; while another device is to appose a piece of moistened cotton-wool against the promontory or in the region of the round

window. I have seen Prof. Ruttin and Dozent Brunner spend half an hour over a patient, trying to adjust the wisp of wool into the best position possible, as judged by the patient's hearing capacity after each manoeuvre. Prof. Ruttin told me of the case of a pretty girl who came for deafness and tinnitus; she had a dry ear with a perforated drum, which he succeeded in closing by cauterisation. The girl's symptoms, however, did not improve very much. One day, when he was just dressed to go to a theatre, she called to see him; and in order to placate her he inflated her ear in somewhat of a hurry. When he looked into the ear, the scar had ruptured! Nevertheless, a long time later, he got a letter from the girl saying that his wonderful treatment had cured all her symptoms and that she was now a famous actress. Such are the vagaries of otology!

When we come to consider the throat, the paramount question is course the tonsils. There is much controversy as regards the indications for, and the end-results of, tonsillectomy. There are those who hold extreme views on either side, but there can be no doubt that the evil reputation ascribed to the operation has been largely due to indiscriminate selection of cases by inexperienced medical men in the past two decades, and the belief that the operation is the sole therapeutic measure needed to restore the child to normal health. The surgery of malignant growths in the oral cavity has vanished almost completely, and has been replaced by Radium and X-Ray therapy. The scalpel has still to be used, however for the surgery of access and for exterpating the potentially infected tissues of the neck.

It was a thrill to listen to Sir St. Clair Thomson talking about the organ which he has made the object of his life-study, the larynx. He has estimated from world-statistics that one out of every three patients with active pulmonary tuberculosis suffers from the complication of a laryngeal lesion; furthermore, this laryngeal involvement is, next to meningitis, the most serious complication of tuberculosis, and its presence darkens

the prognosis at all stages. The routine periodical examination of all tuberculous patients by a laryngologist is the invariable rule in all European Sanatoria, for early recognition renders the outlook more hopeful than a diagnosis made when symptoms like hoarseness have made their appearance. I shall mention laryngeal carcinoma just to point out that it accounts for 1·8 per cent of all cancers, and when we are told that one man in every ten, above the age of forty, dies of cancer, we realise that the laryngeal condition is a potent factor in the mortality rate. Radium is the method of choice in cases of early cancer larynx, and I have seen many cases thus treated, alive and well after periods of seven years or more.

The most recent development in the diagnosis of affections of the paranasal sinuses is the so-called ' displacement method ' in which a solution of lipiodol is made to replace air in the sinuses, after which skiagrams are taken. I must not omit to put in a plea against the use of nasal douches in acute rhinitis. It has been shown that the mucous secretion in the nose which is the seat of an acute catarrh teems with protective substances, so that the replacement of such a secretion by saline or by an antiseptic can do no good, and possibly much harm. The tendency nowadays is to use, even for washing out the sinuses, liquid paraffin instead of watery solutions.

It has been demonstrated in recent literature that, quite apart from greater accuracy in diagnosis, the actual incidence of bronchial carcinoma is on the up grade. I do not think we can justifiably flatter ourselves that such tumours do not occur in this country. The symptoms are often-times akin to those of tuberculosis or bronchiectasis, and in not a few cases the diagnosis requires the aid of a bronchoscope. It is not difficult to imagine what a woeful number of lives are lost in this country for want of facilities in this respect,—a state of things which obtains, however, not in laryngology alone.

Of the many professional lessons I learnt in the West, not the least was the nature of the relationship between doctor and patient. I do not refer to private patients, for they receive preferential treatment all over the world. But in the hospitals of Great Britain and Europe it is a very pleasing experience to observe the personal and watchful care that the visiting physician or surgeon bestows on every individual case. In their turn, also, patients rarely flit from one surgeon to another, and if you ask a case to report in a year's time, he will knock at your door punctually at the correct hour. I was often reminded of the three functions which the medical man has to fulfil: sometimes, to cure ; often, to relieve ; always, to comfort.

Our Men and Things

OUR HOSPITAL HYPNOTISTS.

By Arvy.

The anaesthetist is a miserable being who is more sinned against than sinning. I can speak with a certain amount of authority on him as I had the misfortune to adorn the cap and apron of the hypnotist temporarily, when both our professionals sought welcome relief one after the other from their nerve racking and thankless jobs. Their anxiety to get away at the earliest possible opportunity can be judged from the fact that they literally scooted from the precincts of the hospital immediately after I relieved them of the burden of the mask and the bottle, just like public school boys on the eve of their anxiously awaited vacation. To one of them, I actually gave some sleepless moments when I lodged a diplomatic protest against my forced inactivity. But my subtle manoeuvers failed against the force of subtler brains and stronger hands. One man's poison is another man's food: to be more correct according to the Tamil proverb, what is feast to the fox is death rattle to the crab. While I was despondently brooding over my failures our hypnotiser was happy as he was assured of his longed for relief. I am dilating on these autobiographical touches, neither with the interested motive of grinding any proverbial axe nor with the idea of ventilating my grievances against the favouritism of Providence, but with the purely altruistic idea of upholding the anaesthetist's cause. It is no exaggeration to say that he is the most responsible person in the hospital, because he is held responsible for everything that happens be it the most silly or the most serious, things over which no human being can be expected to exercise any sort of control. If a patient dies on the table, whether the death be due to the shock of the operation particularly when the surgeon makes some clumsy and rough manipulation with the intestines or the spermatic cord or due to heart failure, the anaesthetist is held responsible. If a patient happens to consolidate his lung even a week after the operation, the poor anaesthetist is again held responsible. If a patient develops meningo or pneumo-coccal meningitits the poor anaesthetist has to shoulder the blame. If a surgeon perhaps through

hurry rather than through ignorance mistakes one case for another and operates on the left side for a right sided hernia, the poor anaesthetist will have to explain the mistake. Jumping from the sublime to the rediculous, if an irresponsible fly happens to flit into the operation theatre and shoot over the surgeon's head disturbing his equanimity and temper, the miserable worm of the anaesthetist has to rack his brains for an explanation. One can understand now what onerous responsibility the hypnotiser has to shoulder, from the ludicrous item of fly catching to the sublime termination of human life. And yet his existence and importance are unrecognised not only by the outside world but also by the surgeon who becomes aware of a being like the anaesthetist only when he wants to admonish him for the abdominal rigidity or the death of a patient on the table or for a literal fly in the ointment. The anaesthetist is really the person who is unwept, unhonoured and unsung, that is why I take up his cause now.

A small incident in my temporary career as a hypnotist would illustrate the amount of mental worry and nervous strain the poor anaesthetist is subjected to. The spinal failed to act in a case. The surgeon had already begun cutting. The patient was struggling. I was asked to push on with the mask and the bottle. Owing to an inscrutable dispensation of Providence the patient's heart stopped. I lost my head. But through the imperturbability of the operating surgeon who has the exceptional knack of becoming calmer and cooler as the situation becomes more and more critical and who is therefore best fitted to adopt proper measures to deal with such dangerous crises, the patient got another lease of life.

It is now time to consider the present incumbents of this unsought-for office. The chief hypnotist to the Goveinment of Madras is by his very personality and temperament eminently fitted for his responsible position. The cajolery of his words, the measured softness of his voice, the sublime imperturbability of his temper, his instinctive insight into the foibles of human nature, his exceedingly pleasant bedside manner and his adoption of a uniformly sympathetic attitude to every one enable him to subdue even the most rebellious of his victims who are drawn to him with the fascination of the rabbit for the snake. Thus hypnotised, the patient goes to the table with supreme confidence in the master to whom he has willingly entrusted his life. And he can rest

assured that our hypnotiser will fully justify the trust placed in him by the numerous individuals who pass through his hands.

He has a keen sense of humour and has a fund of funny stories which he releases on appropriate occasions. Someone remarked once "put him in the middle of the Sahara or on the snow clad-peaks of the Himalayas, and he would get patients there and will make money." There may be on element of exaggeration in these words but the observer was not far wrong.

His personality leaves nothing to be desired. Though short of stature he is sufficiently big to play the confidence trick on the patients who come under his hypnotic influence. The acquiline nose and the indrawn upper lip, though they may be suggestive of a grim determination in others, serve for him the purpose of an unfathomable mask behind which he laughs outright at human foibles. The scantiness of vegetation on his head is an unwelcome contrast to the abundance of common sense contained within his calivarium which holds within its concavity the pulvinous atoms that constitute his agile brain. But he makes tremendous efforts to cover up the rapidly increasing blot on the landscape of his shining scalp, by forcible manipulations of the remaining peripheral vegetation towards the centre of his head. He is quite satisfied with the modest success of his Herculian task of hiding an acreage of barren land by gingerily nurturing a few vines which have already given notice to quit his unfertile scalp. But others are of a different opinion. I am sure he entertains a wholsome horror for the careless barber whose solitary application of the relentless grasscutter over the periphery of his head would suffice to spoil the work of years in a second. The artist among the barbers would simply hate to have anything to do with such a polished head. But the cunning amongst them would welcome him with open arms as he can earn his full wages by the work of a few seconds unless our friend with his usual sagasity regulates the wages by the amount of forestry cleared. But our venerable head will have none of them anywhere near him.

I wonder if there is any occult relationship between baldness and anaesthesia; for our friend's comrade in arms at the other end of the hospital is strangely enough endowed with an equally polished convexity But unlike Punikulm he does not resort to any centripetal manipulations

to hide the all too conspicuous blot, not because of any neglect of his personal appearance hair being a sore point amongst all bald heads, but because of the physical impossiblity of adopting such a procedure. He too has a small peripheral undergrowth; but it is incapable of growing to any desirable length. Naturally therefore he is a devout follower of the sour-grape philosophy.

Their similarity ends with their baldness. The junior hynotist is not endowed with those natural gifts of personality, voice and adoptability, which qualify his senior colleague for the position of a born hypnotist. But their absence is fully compensated for by his extraordinary skill in anaesthesia, a skill acquired by years of perseverance and persistence, which, through its unwholsome strain on the nerves, is capable of driving less level headed individuals to the mad house.

He is a jolly old soul extremely sociable and sufficiently sporty to join the mad escapades and joy rides of his more youthful friends, equally anxious as they are to escape occasionally from the tedium of dead routine of hospital life. He enjoys himself thoroughly on such occasions in spite of the calls of the little Willies at home.

One can unhesitatingly say that both our anaesthetists are the right men for their jobs. I shall be particularly grateful if they go on sticking to their posts without taking any more leave so that I may be spared the painful necessity of having to step into their place from time to time, and get ill and hospitalised.

Destiny of the Medical College

By H. Sumitra Rao, Final Year.

When the Roman General Julius Caesar defeated Pharnassus, King of Pontus, he sent the triumphant message to Calpurnia, his wife, with the words 'Veni, Vidi, Vici,'—'I came, I saw, I conquered.' The conquest was so brilliant and meteoric. Even so, we believe, the springing up of the General Hospital and Medical College Extension buildings, with such astonishing rapidity, in the course of a few years, and in the teeth of the much lamented economic depression, sounds in our ears like the historic 'Veni, Vidi, Vici.' By the time we write this article, the Gods on High Olympus must be busy to move with bag and baggage to their new surroundings. The more we reflect upon the storied past of the Medical College and General Hospital, its chequered glories, its strange fortunes both in its staff and buildings, the more we are inclined to sing with Hamlet :—

"Ther's a Divinity that shapes our ends

Rough hew them, how we will."

Such kaleidescopic changes in the destinies of the Medical College, would bring home to the mind of the historian the days of the Moghul-Emperor Shah Jehan, when at the imperial commands, buildings of dazzling brilliance rose : to the sentimentalist, the unequalled vision which Mirza saw while traversing the Valley of Baghdad : and to the materialist thoughts for speculation as how Providence shows partiality in bestowing Her favours upon :—

'To one sole monarch Jove commits sway

His are the law : and let him all obey."

The 'Out-Patients' Block of the General Hospital was once occupying a humble position, lying in a snug corner as near to the Buckingham Canal as possible for the patients to sniff the '*hygienic*' 'Cooum' air, and at the portals of the General Hospital, the one wall of which serving as the boundary line between the 'inside' and the 'outside' of the Hospital. The hooting of horns, the shouting of bus

conductors, the creaking of trams, the vociferations of beggars, the hum of the public and the commotion of the traffic outside created a harmony, which *soothed* half the pain of the suffering patients inside. The building itself was like a dungeon, not unlike the Black Hole of Calcutta with its pigeon-hole windows, zig-zag paths and fencing palisades (so that the patients might not run away) and the 'sick' imbibing horizontally the dark and damp atmosphere.

The Clinical Laboratory was located on the top of the building in the so-called 'Honris'—the Seventh Heaven of Allah.

The way up to it was by a narrow stair case, so narrow, that if two persons meet from the opposite side, it was like the proverbial two goats meeting on a plank in the middle of the stream. Did not the Bible say :—'Strait is the path and narrow the gateway that leadeth unto Heaven'. Further, we have been repeatedly told that attentive observation is the *sine qua non* of a successful Doctor : and the Clinica' Laboratory stood as a unique example to illustrate this view : for standing at the window you could see the road, the River Cooum and also let 'observation with extensive view survey mankind from China to Peru.

A few years back there were two Tennis Courts adorning the 'front view' of the Medical College and a few gallants were seen occasionally playing there. But with the construction of that massive structure, popularly known as the 'Pathology' Block, the smiling Tennis Courts have also undergone a 'pathological' change. With the gradual encroachment of the pathology building, the Tennis Courts progressively underwent 'pressure atrophy.' It has been acknowledged from time immemorial as early as the days of Hippocrates, that systematic exercises are conducive to good health. But with our increasing Hygienic sense and swell-headedness due to too much learning we pooh-pooh the idea of systematic exercises. We cast away all the cranky old sayings as all shows of dross. Sometime back we remember to have been a Talkie Film of Imagination wherein all locomotion was done by aeroplanes and eating done in a trice by the swallowing of a tabloid of concentrated food-stuffs, thus dispensing with all the physical aids of legs, and without much ado about cooking or munching. Perhaps, we are endeavouring to approach a Utopian age. We are now

living in a Mechanical age and with our increasing sense of comfort and ease, even walking, much more so Tennis, is a superfluity. Congratulations to the authorities in thus endeavouring to keep abreast of the times.

The General Hospital and within its immediate vicinity, the Medical College, are little palace—worlds of their own, the former all in white giving it an air of dusky magnificence and the latter all in red stone, ominous of an insecure or perhaps a dangerous footing into the College, its central Library Hall standing like the Parthenow on the Acropolis at Athens, with its pillars of Doric architecture, and its interior adorned with the portraits of Deities who held the reigns of Government ever since the dim and distant past, students of the Medical College are merrier than crows in the first term and gloomier than owls in the last term—

'Larking in the sunlight
Loafing in the moonlight,
Slackening in the first term,
And sweating in the last term,
Having a lot of fun'—!!.

All work and no play make them as dull as the Jack in the saying. It is all one long drudgery. The Medical College is a jealous mistress in exacting a heavy toll from the students who unwarily happen to tread within its portal—!!.

Thus far we have written and here we stop. We have endeavoured to give our readers a picture representation of the Medical College and its environments through the medium of our articles from all points of vantage. We thank our numerous readers for the kind attitude they have shown towards its author.

'Thoughts in a Garden'

It was a beautiful summer evening. The delicate plants with the wild roses, mixed with the green foliage made the scenery enchanting. The air was filled with delicious perfumes and any one would have felt giddy with joy and excitement. The very atmosphere seemed to breathe heavenly bliss.

It was so fine that I could not think of sitting inside worrying my head over the sciences. So, I went out and sat down in an easy chair in the midst of the fairies, all in lovely hues. The music of the birds struck me as sweet and melodious. Everything was serene and beautiful as a charmed dream and it appeared as if Mother Nature was smiling as she had never smiled before.

I sat on. I do not know for how long. Twilight was creeping in and I could see groups of birds flying away to reach their respective nests. I saw all the students walking into their rooms with their hands full of books and downcast eyes. Probably, the matter that was in their brains was too heavy for their poor delicate heads. My conscience began to prick me. Yet, I could not make up my mind to go inside. So, I still sat, thinking and thinking about the long long voyage which I had undertaken to finish. Drifting against bitter winds for five and a half years in the Infinite Ocean is not a very tempting adventure after all. When I passed out my Inter, the problem 'What next' had attacked me, as it does every other. After consulting, considering, and reconsidering, I had hit upon the medical line. I felt that it would indeed be grand to be a doctor. Syringes, stethoscopes and thermometers all in a vanity bag, seemed to be the best ornaments one could possess. Alphabets like M.B.B.S., F.R.C. S. etc., seemed to add a new charm to any name. So, to be brief, I felt that there was nothing like being called a 'Doctor' every time you are spoken to.

But, an entry into the huge ship clearly proved that the voyage was not so easy as I thought at first. Five and a half years-long in itself no doubt, was indeed not so short as the figures imply. Abnormal people finish it in the time allotted but ordinary human beings usually

prolong it by several years. The obvious reason is that ship-wrecks are too many. When we enter it, we will be quite young, full of vibrant energy but alas, when we come out, our hair is no longer dark and curly —it is grey and sparse; our skin is no longer smooth—the long suffering has left, a deep mark on it, and once more, to be brief, we are old and ugly!

I had heard of several who had given up the voyage as hopeless. Some had felt the adverse wind in the beginning itself and others after they had gone through part of the journey.

Their remembrances were indeed heartrending. I thought of several other more patient creatures who were fighting against the cold current with 'Courage' and 'Hope' for their guardian Angels and 'Patience' and 'Hardwork' for their magic wands. The problem 'How will I fare' worried me again and again. Shall I give it up now alone? Is all the trouble worth its while? But, there was the other side of the question. The series of letters, the vanity bag with its contents, and being called 'Doctor' every minute—are not all these worth a few extra year's suffering? What a sigh of relief will escape us then and what a deep thanks-giving will reach the Almighty!

Such thoughts were crowding around me. Suddenly, I was awakened from my reverie by somebody calling out my name to go in for dinner. I was shocked and for the moment could not guess where I was. The whole garden was lighted up with a brilliant moonlight. The stars were shining as fearlessly and as silently as usual. The weather was fine. I looked at my watch. It was past eight. Off I ran, swallowed some dinner and began pouring over Osmotic pressure and Molecular weights!

'THE HOPEFUL MEDICO.'

Reflections of the Student Editor

BY A. NARAYANAN KUTTY MENON, STUDENT EDITOR.

A Welcome.

With open arms we welcome the "Freshers" into our fold singing our chorus 'Old Medicoes never die". Just emerging from the Arts College and with bubbling enthusiasm and splashing energy we are sure that our new friends will infuse an aroma of freshness into our "Association" and will extend a helping hand in the efficient production of our College Magazine.

F. R. C. S. Examination.

Our College is the centre for the primary F. R. C. S. Examination, for the first time in the history of Medical College in India. We hear that the finished products and old "prize boys" of this institution, nearing twenty in number are facing this ordeal. Our Anatomy museum, the scene of their labours and preparations, is teeming with activity and the students working there have become used to the act of saluting twenty times a day at the first sight of their Bosses or would be Bosses. Dame rumour has it that our beloved and revered Professor Koshi is making every effort to see that some of his old students appear for this examination. We hope and wish that the brilliant Johnstonians and Masters of Surgery who are appearing for this examination will hold aloft the banner of high standard of Madras degrees and impress the examiner (if impressions are wanting) of the grave and palpable injustice done to Indian Medical Colleges by the General Medical Council in not recognising their degrees.

College Hostel.

Petitions, appeals, representations and deputations for the last half a century have resulted in procuring for us the use of 'Jaya Mansions' (rented) as our College Hostel. With the roaring electric trains behind, busy public road and electric street-car in front, and carts-stand and liquor shops at the sides, this stately mansion is far from being a comfortable hostel (not to mention an ideal hostel). But we are

prepared to accept anything in the name of the sacred word "Hostel" and then fight constitutionally for more amenities. Our beloved Vice-President, Prof. Guruswami Mudaliar, has put forward a suggestion for organising, 'A collection day' to collect funds for erecting a hostel. Will not the Gods of Olympia who control the destenies of our College be awakened from their lethargy at the moving spectacle of the overworked Medicoes walking on the streets of Madras with begging bowls in their hands for a cause the justice and urgency of which is universally accepted? It not, it will at least teach us the wise lesson of 'Self Reliance'.

Old Students' Association.

My colleague Mr. Munuswamy Chetty has moved a resolution at the last General Body meeting for the formation of an "Old Students' Association". A properly formed 'Old Students' Association' will remain as a connecting link between the hoary traditions of the past and the living activities of the present, besides strengthening the bond of the Association. We hope that our energetic and enthusiastic Secretary Mr. Janardhanan will take steps to materialise this scheme.

A Trophy.

College Hockey team deserves our warmest congratulations for winning the much coveted M. U. C. gold cup and thus bringing honour to the whole college. We are sure that the sporting activities will reach its zenith this year under the able secretaryship of the veteran. Mr. Achuthan on whose worthy shoulders the mantle of sports secretary-ship has fallen. We hope that Mr. Achuthan and his co-workers will steer the ship of sports into calm and safe waters.

Heavy Toll.

Two flowers of our Institution Mr. Appa Nair and Vedachalam have been snatched away from us by the cruel and icy hand of death. Let their souls rest in peace.

Lt.-Col. Anderson.

Lt.-Col. Anderson, our Professor of Operative Surgery has left us to take up another appointment at Calcutta. An iron Deciplenarean, an efficient Surgeon and a painstaking teacher, he has left behind him

a tradition tall enough for others to admire and follow. He always took a keen interest in the welfare of our Association and never grudged to contribute valuable articles to the magazine. Under his rough exterior was a heart of gold. His departure has created a breach difficult to repair. We wish him a long, prosperous and useful career.

An Appeal.

We make an appeal, most sincere and earnest to the fair sense of our enlightened brothers and sisters of our Association to take more interest in the affairs of the magazine and to contribute articles and cartoons more liberally. Then and then only the fond dream of converting our magazine from that of a purely scientific journal to that of one of the students, by the students for the students and pulsating with the activities of our College, can be realised.

Letter to the Editor

THE WOMEN MEDICOS CLUB.

Mrs. Krishna Bai Nimbkar, Secretary, Women Medicos Club writes to us as:—

We are glad to announce formation of the above club, with head-quarters at present at Wallajah Bagh Hostel, Kilpauk. The object, among others, is to bring together women students, past and present, of the Medical College, Women House Surgeons, Post Graduates, and Women Doctors. The activities of the club at present, will be social. but occasional talks and lectures, medical and otherwise, may be held. The club provides two days in the month for sports in the Hostel grounds, for tennis, etc. The club, in course of time promises to develope an Information Bureau for answering to enquiries from old Students and render help and hospitality to Post Graduate Women Students and other Women Doctors who may be new to Madras and who are concerned with our hospitals. There is also a Dramatic Section to the club, which promises to get up entertainments once a year during the convocation week in August, and arrange for an Old Students week during the same season.

We hope that the publicity given by this announcement in our Magazine will reach all Women Medicos, and that we will be handling piles of letters of inquiries and requests to be enlisted as members.

The Principal has kindly consented to act as ex-officio Advisory Member and the Warden of the Wallajah Bagh Hostel as the President of the club. The Committee consists of representatives from the various classes with power to co-operate more members. Membership is as follows:—(1) Present Women Student Rs. 1-8-0 per term. (2) Old Students, Post Graduates and House Surgeons Rs. 2-0-0 per term or Rs. 5-8-0 annually. (3) Women Doctors in Service or in independant profession Rs. 7-0-0 annually or payable in two instalments of Rs. 3-8-0 each.

We are sure that with the encouragement and co-operation that the club hopes to receive, first, from the present women students, then from the old girls of the Medical College, and then from all women medicos, it will become a great factor and especially help to enrich our life in the college and outside.

Editorial Notes.

Lieut.-Col. R. E. Wright, C.I.E., I.M.S., is appointed acting Principal in the place of Lieut.-Col. C. Newcomb, I.M S., proceeded on leave to United Kingdom.

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We extend our hearty congratulations to Dr. A. Lakshmanaswamy Mudaliar, B.A., M.D., F.C.O.G., on his new appointment as Additional Professor of Midwifery.

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The need of a hostel for the students of the College has once more been brought to the forefront. This is a long felt want and the authorities do not as yet find a way to meet it. The Arts Colleges have their hostels, the Royapuram Medical School has an enviable and commodious building adjoining its teaching hospital and school premises, the Lady Willingdon Medical School has a hostel for the ladies, and our lady students have one at the Wallajah Bagh. The question arises, what about our gentlemen students ?

Dr. M. R. Guruswami Mudaliar, Vice-President of the Medical College Association, presiding at the General Body meeting of the Association to elect the office-bearers, remarked in passing that a "Collection Day for the Hostel" should be organized after the manner of the Royal Infirmary Day at Edinburgh. The Surgeon-General, in his address to the graduates of the year, referred to this question, perhaps being drawn out to do so by the number of placards stuck on the temporary stage for the occasion, was of opinion that the old students of the College should come forward and find funds for the building of a Hostel.

'Jaya Mansion', as a temporary abode, has many drawbacks to its being an ideal place for a Medical Hostel. Still the Principal, Col. Wright, has addressed the higher authorities to elicit their views and sanction.

The above is the present position. To most of our students, the time spent in Madras during their medical course connotes only a period of different examinations coming on frequently and still more so if one is unfortunate enough to hit off subject by subject. While a residential system is being advocated all the world over, the Madras Medical College students are scattered throughout the length and breadth of the City of Madras, not taking into account a few sporadic cases living in Saidapet and Pallavaram, with little supervision and control during the most impressionable part of their lives, and away from their parents and guardians. They have little opportunities to come together often as in a hostel or Residential University. The opportunity to have their angularities rounded off, prejudices forgotten, social life heightened, character moulded and better friendship made, is sadly lacking, and all of them leave their *Alma Mater* like Cyclops and with the adage in his mind "Everyman for himself, and God for all".

We are sure that at no distant date, private munificence from philanthropic gentlemen and flourishing old students will be forthcoming to help the Premier Institution, which will be entering on its Centenary next year, by solving this genuine want.

* * * *

The Surgeon-General, in his address to the new graduates, exhorted them to be humble as real knowledge can only be attained by slow degrees and it was only experience that counted. As appointments in the Government were fewer, he said, that most of them will enter

general practice; without crowding in big towns, they may try rural areas. Opportunities made a man, and quoted as instance that of Col. Smith of Jullundur. "House" appointments in hospitals were valuable in giving practical experience. He advised the young doctors to become members of such a powerful body as the British Medical Association.

Coming to the question of the Hostel, he opined that the past students may start a subscription list; he went a step further and said that there was room for a private medical college.

In conclusion he wished them all success in their future career.

* * * *

Reception to the new graduates, yearly, comes and goes. The students of the College showed more originality by writing special "Farces" and songs for the occasion. Every one of them who took part in the different items acquitted themselves admirably. We may be permitted to quote the remarks of the Principal, Col. Wright, "you have done very well. You have shown much originality. You really deserve all the *Kudos*".

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The Military students had a Ball arranged to celebrate our winning the Gold Cup at Hockey. The team deserves our hearty congratulations.

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Among the lengthy Association notes by the General Secretary, a few items now interesting the students of the College may be made out. Elsewhere in this issue we are publishing his report.

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Lt.-Col. Anderson, I.M.S. was transferred to Calcutta as Professor of Clinical Surgery during the summer vacation. This was an unexpected shift : all of our students are missing his popular clinics in the wards.

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College prize distribution was held on Wednesday the 29th August at 5 P.M. in the main hall of the old building. There was a large attendance. After the reading of the Annual Report by Col. R. E. Wright, I.M.S., the Principal, the Surgeon-General gave away the prizes. This was followed by a lengthy and very interesting address by the Surgeon-General, Sir Frank Connor, I.M.S.

The "At-Home" to The New Graduates.

The annual reception to the Graduates of the year by The Madras Medical College Association came off on the 13th of August 1934. It had been the practice hitherto to hold this function on the day following the convocation presided over by H. E. The Chancellor. The inevitable delay this time had materially contributed to the remarkable grandeur of the function which is a record achievement during the past decade. On this I have to congratulate the energetic Secretary of the Association, his untiring colleagues, the genial Treasurer of the Association, and all those who contributed to the grand success of the function.

The learned guests with the laurels of their degrees recently conferred on them were entertained at Tea in the College grounds. The golden rays of the evening Sun, the pleasant sea breeze, and the sweet melody of the Band music added much to the deliciousness of the dishes.

A group photograph was taken and after this the gathering adjourned to the great hall in the top floor of the New Buildings. The hall was tastefully decorated and in adding beauty to the already beautiful hall all the talents of the Secretary's lieutenants had probably been expended. Here I may mention that we have been spared this time, and for ever I believe, from the difficulty that was experienced every year in the matter of securing a suitable hall for occasions like this. A sweet welcome song heralded the proceeding. Mr Littlehailes, the Vice-Chancellor, presided over the function, and he recalled a few of his experiences with the Medicoes during the past. This was followed by the advice to the Graduates by the Surgeon-General, which was well thought out and fully significant of the abounding sympathy and concern the executive head of our department has for all those young Bloods who have been recently admitted into the profession. Quite opportunely he reminded them of the inadequacy of the knowledge that they have gained thus far and advised them to supplement the same by elaborate study and to keep in touch with current literature. He stressed on the futility of specialising in particular branches of Medicine from the very beginning. The advice inculcated the spirit and quest for research in

the young minds of the Graduates who had in them the traits of latent potentialities in this direction. I do not propose to go into those issues here suffice it to make a brief mention of them. Secondly the advice regarding a Hostel for the College is most disappointing and unfortunately is a virtual surrender of all responsibility and concern in the matter on the part of the Government. We hope and pray that the Surgeon-General would pursue the matter further and provide us with this long-felt and indispensable necessity ere long.

Replying on behalf of the Graduates Mr. Sarma thanked the Association for the splendid reception that was got up in their honour. Here I may observe that some of us at any rate who were eagerly awaiting to hear what might probably have been the maiden performance of the Johnstone medalist were disappointed. She is said to have very magnanimously resigned her most covetable prerogative in this matter in favour of her professional brother Mr. Sarma who was only too ready to accept the proffered hand of kindness.

The next item on the programme was the variety entertainment which presented indeed a most wonderful panorama. The tablaeux by the ladies depicting mother India in bondage was an excellent master-piece of ingenuity. It was realistic, well conceived, and a splendid feast to the mind and eyes.

I beg to be excused for a little bit of digression here. Even a day previous to the function gossips were rife in the air that certain disruptive elements among the ladies were sowing the seeds of non-co-operation in the matter of the reception on flimsy and untenable grounds and because of their strict adherance to certain formalities that unfortunately went wrong by inadvertence, and which might well have been tided over if those concerned had a little bit of humour. Thanks to the efforts of the Lady representative, wise counsel prevailed and the 'Apple of discord' was not picked up by these for whom it was conceived. The situation clarified when it was not too late and the ladies emerged out with the most interesting item of the entertainment—the Tablaeux —which made sufficient amends for their previous uncompromising demeanour.

The 'Bunkum song' excited the uproarious laughter of even those amongst us who are of a serious and sober minded disposition. The

melodious songs of Mr. Ramamurthy, Dr. Sudarsan on his Flute, and the musical performance of our Military students merited the heart-felt appreciation of the gathering. The up-country railway station scene which was the original conception of Mr. B. Varma was very enjoyable. Fun and hilarious laughter reached the climax when our talented master Comedian made his debut on the stage in the role of 'Ramu the idiot' which was another original farce. In the words of those amongst us to whom the names of the Hollywood Comedians Laurel and Hardy are as familiar as house-hold words, "Those professional comedians if they had seen the performance of our amateur comedian would have blushed with surprise nay strickem with horror lest their fame should wane into insignificance". Mr. Venkatachar kept the whole audience in sustained fits of uncontrollable laughter throughout his performance and I congratulate him on his splendid success. The South African Santho-sham who well deserves the name applied the finishing touches to the splendid entertainment by his inimitable mimicry.

One commendable feature of the whole function needs special mention and that is the spirit of harmonious co-operation that animated one and all of the members of the Association and which probably was the basic factor that made the function a grand success.

The function terminated with a vote of thanks proposed by the General Secretary.

The 'Cup' Dance.

By D. St. Louis-Little.

To celebrate the fine display given by our Hockey team in the recent M. U. C. Gold Cup Hockery Tournament, we, the Military Medical Students, held a 'Cup' Dance on the night of July the 27th at the V. P. Hall.

For the first time, after many years, the "Skull and Cross Bones" has come to the fore in the hockey field. We have always triumphed in almost every field of sport but the Blue Ribbon of South Indian Hockey had evaded us for quite a time. Every hockey enthusiast, in fact everybody, looks back with pride on the days when The Medicoes were invincible. The popularity that was ours exceeded that which any local team has ever enjoyed.

After the first few matches in the tournament were decided and our team evidenced glimpses of their former glory, people whispered: "Are the Medicoes going to win"? Are they taking us back to their all-conquering days"? And with one accord every stout heart of our *Alma Mater* responded in the affirmative. And the response was no vain boast. We defeated the finest teams in Madras—even the redoutable 'Telegraphs.' Thus it was our fame on the hockey field, like a melody lingering on, ascended the scales from 'pianissimo' to 'fortissimo,' to burst into a pæan that was expressed so adequately at the 'Cup' Dance.

The function was a huge success. There was little to choose between it and our Annual Medical Ball which, from time immemorial, has been the finest of its kind.

The Dance-Hall, decorated in pastel shades, presented an effect of a very high order. There was nothing formal about the occasion; it was this jovial atmosphere, pervaded with hundreds of happy faces and dancing feet (to say nothing of the refreshments!), on a background of decorative splendour that made the function the success it was. Amongst those present were Capt. Alexander, Dr. and Mrs. Goyle,

Dr. and Mrs. David and Dr. N. Pai. Capt. Alexander proposed the toast from the gold trophy. He congratulated the team on its success and excellent sportmanship, wishing it very many more successes in the future. Mr. Wilkins, the Secretary for Military Medical entertainments, responded with three hearty cheers for the team and its supporters.

"All good things end" and so did this Dance at 4 A.M. We were all so reluctant to even think it had an end. However, everybody can rest assured that Cullen, the Captain of the team, will cause us to have very many more victory celebrations! So good luck to him and his team!!

The Alembic Chemical Works.

Most of us may know that at present in India there are a good many companies manufacturing drugs; of which the Alembic Chemical Works is noteworthy.

It is situated in the quiet outskirts of Baroda city which is a night's journey from Bombay by the Delhi Express. Its factories cover an area of five acres and owns still a vast extent to meet future expansion.

Unlike other labour concerns like the tobacco factories where the uneducated hands form a majority, here they are strikingly few in proportion to the learned chemists; for only two hundred and fifty labourers are on the roll, whilst the chemists, druggists, etc., number a hundred.

A dozen of these are engaged in research work under the able guidance of three foreign qualified men. They have keenly felt the necessity for a laboratory for purposes of standardization of drugs and this is hoped to be ready soon.

Despite the drawback, the research branch has progessed well as will be seen from the records that their expenditure has shot up to Rs. 20,000 per year which but a few years ago was a meagre sum of Rs. 3,000 per annum.

The works possess all the up-to-date apparatus and appliances for preparing extracts, tinctures, salts, etc., and with the enormous quantities of raw material at hand it bid fair to supply a good many chemical needs of the country. Some of the many such that it has already in the market are totaquin sulphate, opium alkaloids, strychnine, tartaric acid and its salts from tamarind, etc.

The manufacture of drugs according to Ayurvedic Formulae has also been instituted, the famous Makaradhwaja being one of its kind.

Some of the scale preparations like ferri-et-ammonii citras, are also made here.

The outstanding feature of the works is the distillery where they are able to produce their own alcohol of 98-99 p. c. strength from "Avarampoo", our present day competitor with coffee powder.

The large quantities of carbon dioxide evolved as a by-product used to be sold in cylinders, maintained at high pressures; but now the chemists contemplate converting it into "dry ice." It is said that this latter may be obtainable at two annas an ounce.

Apart from chemicals the company has brought forth extract of sheeps' and goats' stomach.

Special medical advisers are employed in Bombay and elsewhere to give their opinion on the efficacy of these drugs.

The Alembic Chemical Works has its branches one at Madras and another at Bombay where tinctures alone and absorbent cotton respectively are made, the latter under the auspices of the National Textile Fibres Ltd.

A bright and prosperous future is ahead of the works and it is really a happy thing to observe that it has risen to the second place among its kind in India within a short period of its history.

SECRETARY,
M. M. C. A.

Notes from the Diary by a Tourist.

Just a few days after the medical results were unofficially out, the Secretary of our College Association came out with a proposal to some of his friends who were the only available then.

There was a trip to be made to the Alembic Chemical Works somewhere in Baroda, but most of us knew not its whereabouts, but we were given to understand that it was in close relation to the rich city of Bombay. We were also told that it would cost us no more than a single ticket fare to Bombay for an outing lasting not lsss than ten days. What with the idea of seeing every city enroute, whose geography still lingered in our brains it was really a tempting offer.

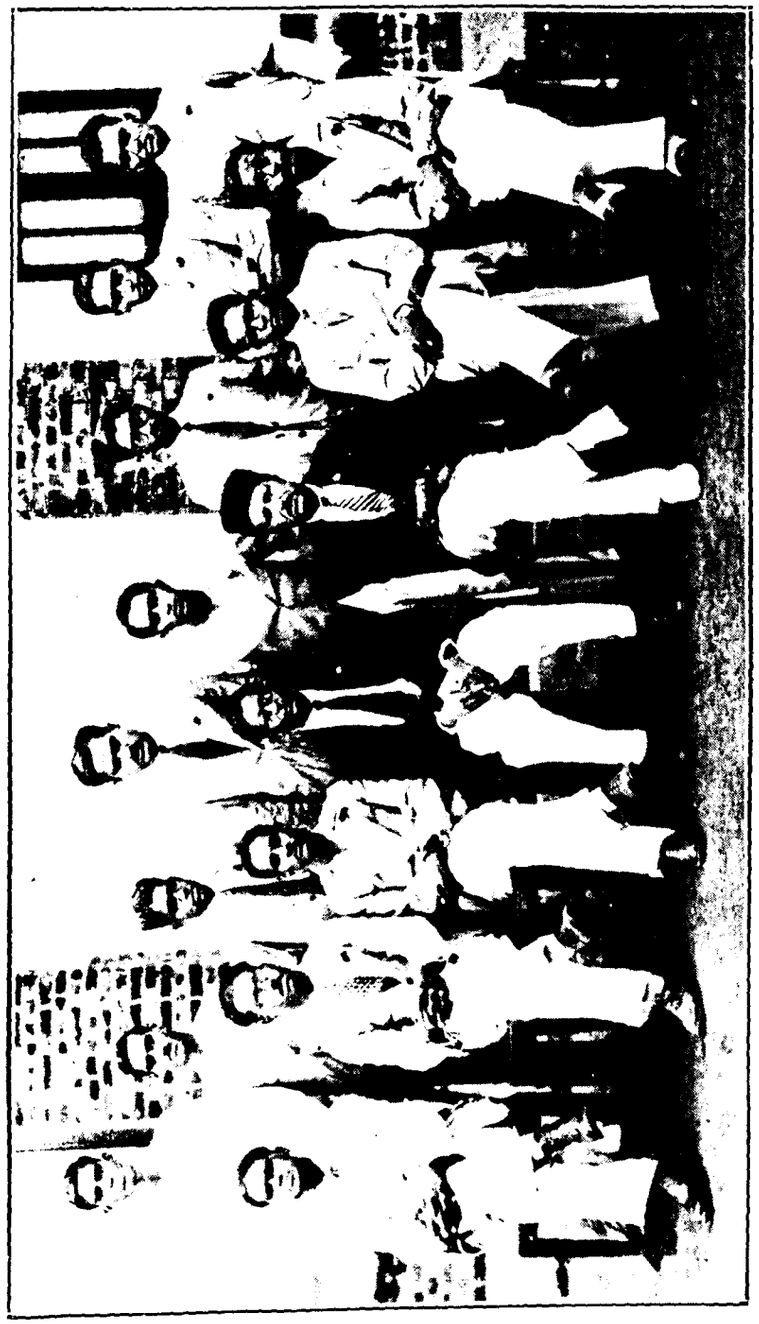
A few were easily won over: one gentleman was so happy at the proposal that he gave us all drinks and assured the secretary that he was a sure follower but it was a thousand pities that he did not turn up. The Secretary had no little difficulty over the rest of us. He gave us more weighty reasons than have been mentioned already, that it was an educational tour and that we should not miss the fund of Chemical knowledge offered by the Alembic Chemical Works, which after all was for nothing and that we should remember we were to appear for medicine next year, above all that our Principal had highly commended the idea and so it was a matter not to be slighted.

After much difficulty, involving speeches to the fathers or interviews with fathers-in-law, the secretary managed to have a quorum. Fifteen of us consented, but, friend or no, everyone had to substantiate his assent with ten rupees cash down. It was done.

The Madras and Southern Mahratta Railway very gladly granted us the necessary concessions, and were even so benevolent as to allow us to travel by mail even over other railways covered by the trip.

On the morning of the 21st April 1934 we gathered under the foliage of the Medical College for a sitting; so we were told.

The Press Photo Bureau man, another generous personage, offered to give publicity to our enterprise by lending our pictures to the dailies



The Party of Medical Students who went to visit Alembic Chemical Works, Baroda, with their General Secretary during the last summer recess.

Press Photo Bureau.

unlike other artists of his type, he took only one exposure and we dispersed.

We expected to see our pictures in the papers, the same evening hours before we left Madras, but we never did. Perhaps it was the failure of the Camera man, and it is human to err.

We all met at Madras Central just in time. Our luggage was not unwieldy, for the strict injunction was each man to carry his own burden but to get the sleeping accommodation in the Bombay mail was a job which no amount of medical study could tackle.

Two of our party posted themselves at the door of a compartment and started picketting as it were with the slogan. "Reserved for medicos." They did succeed a bit: only they could not convince an old gentleman who quietly got in pushed aside a bed from off the seat and stretched himself. We had many medicoes to see us off on the platform. A batch of affectionate fathers, anxious fathers-in-law and even brothers-in-law were seen giving instructions and advice. it seemed as though it was an occasion when every one was handed over to the meticulous care of the Secretary. One father-in-law requested him to write a letter everyday about the welfare of his son-in-law. No wonder every married comrade had to bow down his head to the bachelor-secretary, who quoted the adage, "A young man married is an young man marred".

The train steamed off at 8-40 p.m. for a time we were lost in reveries but soon collected ourselves. Our first attention was towards the old gentleman. We questioned him how dared he usurp our seat. He coolly shut us up saying "Alright sirs, I shall travel standing."

The secretary was fast asleep on the upper seat a well earned rest indeed while the rest of us either indulged in playing at cards or in looking through some old magazines which happened to be in our luggage. The night's journey was uneventful.

On Saturday morning he were entertained with sweets by a young member of the party. Our host was over zealous over serving us with laddues, jilabies, etc., from a basket and we were very glad that the trip had already borne fruit, that of laying bare the finest quality in a young man which all the while lay dormant when at College. Late in

the afternoon an other comrade put his hand into the self-same basket for something extra while the host was out strolling at a way side station. What was his astonishment when a fellow passenger caught him red-handed and claimed ownership of the very basket!

This was an incident which could have foiled the harmony of the whole trip in a moment. Fifteen of us apprised of having directly or indirectly, looted a fellow passenger's basket before his very eyes. The matter was talked over. It appears that there were three baskets in the compartment, resembling one another but containing different things. Two belonged to us and the other to the fellow-passenger. Our host did not suspect the triplets in existence, but he was all the while conscions that he was distributing somebody's sweets only, he least suspected it to be extraneous. The case was settled by our having to recompense the fellow-passenger from our General Fund. At the very next junction we bought for him an equal quantity. On Sunday night our carriage was detached and fixed to an electric train. The journey by this to Bombay was a much speedier one. It beats the Thambaram Electric service. We passed through a few tunnels.

We reached Victoria Terminus, Bombay, at 6-30 a.m. on Monday morning. We put our luggage on a trolley and with it we walked to Bombay Central, where we had to change for Baroda. We preferred to go on foot in order to break the monotony of the seventy hour journey by rail although the garroted train cars much attracted our attention. For the first time some of us passed through the beautifully kept roads of Bombay. The buildings to a Madras man look like skyscrapers. Apart from the gorgeous heights they reach to, they look picturesque. And there are places where seven roads meet.

We took a day's rest at the waiting Room, in Bombay Central, a veritable palace of a railway station. The interval was utilized by the Secretary in hunting for the Dean of the Grant Medical College, who received him kindly and offered us accommodation in his hostel for our stay in Bombay on our return journey. How we wish we had an hostel to repay their kindness!

An hour before 10 p.m. when the Delhi Express leaves for Baroda, we shifted opposite to the specified platform by a short cut but the authorities would not permit us to board the train unless we took all

our things back to the waiting room, climbed up a huge flight of steps, walked a bridge and descended to the platform. It was a Herculean task to perform but we had to do it. Leaving Bombay Central at 10 p.m. we reached Baroda City, early Tuesday morning. Our journey across many rivers which go to from the Sutlej was pleasant, especially as it happened to be a moonlit night.

An agent of the Alembic Chemical Works met us at the station and we were taken to the Guest house, the company's own. It was a spacious two-storyed building fitted with eleetric lights, and sanitary conveniences. We were provided with hot water for bathing, mattresses, luxuries in a strange land! As for our board we were guests of the Director, the Alembic Chemical Works, at his own residence, throughout our stay.

A word about our Central Indian diet. From start to finish it was nothing but sweets and rich food. What a contrast to our South Indian meal! No wonder gastric and duodenal ulcers are rare there. The Director kindly arranged a programme for us and we followed it up.

Tuesday, 24th Morning.—Visited General Hospital, Baroda, a small and cosy one containing thirty-two beds surgical and an equal number of medical. A maternity ward, an ophthalmic section, a gynaec section, and a dental department with its own bacteriological and biochemical laboratories make it a self contained unit. Male Nurses are employed in the male wards as an experimental measure. Each patient is provided with a tinkling hand bell to call the Nurses.

Evening.—Visited the zoo and the park—a pleasant place to go out in the evenings. The military band plays a few select items every Tuesday and we enjoyed the music.

Wednesday, 25th Morning.—Visited the Alembic Chemical Works—photo and articles appear elsewhere. Visited the museum, though small it contains a good number of exhibits of which chinaware forms a greater part. The Egyptian mummy two thousand years old seen there still hangs before our eyes. Even the skin of the dead man is well preserved to this day.

Spent a happy hour at the picture gallery. The pictures are most captivating and provide the artists good study. It is a glorious asset to the State.

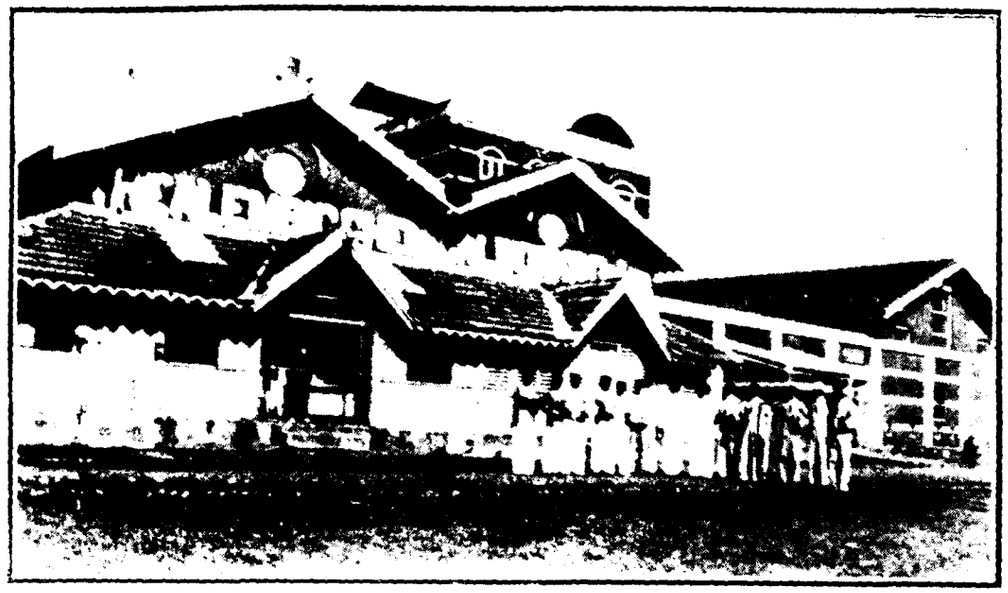
Thursday, 26th Morning.—Bussed to Laxmi Vilas palace, the home of the second richest Indian ruler. It was unoccupied just then, the royal family having sailed for England on a holiday. It was a specimen of Eastern splendour. Except for the building, all else was either of silver or gold. The sleeping chambers, the dining hall and the drawing room are beyond description. We had access to the ancient relics such as the nail that killed Shivaji and the weapons that were used against the enemy in ancient days when the Peshwas were a powerful dynasty.

Evening.—Witnessed that last day ceremony of Mohurrum. A grand procession, it was headed by the cavalry and the Diwan Mr. Krishnamachariar, seated on a howda, the Magistrates on another. The grandson of His Highness the Gaekwar in still another while on the last elephant were seated some men with sacks of copper and sweets which they freely aimed at the onlookers from the buildings or showered on the crowds following them, finally the tazia passed by; the assistant secretary (Mr. Syed Ali) unfortunately had to forgo the sights as he had to obtain the railway concession for our return journey from the District Transportation Superintendent, Ahmedabad. Our heartfelt thanks to him for the same. In spite of his enthusiasm, however, certain technical errors were made in the purchase of our tickets which compelled us to travel by passenger train, the whole way back.

Thursday, 26th Night.—Left Baroda City at 9-10 p.m, and arrived at Bombay Central early morning. During our three days stay at Bombay, we were comfortably lodged at The Grant Medical College Hostel, through the kindness of the Dean one spacious common room of the Hostel in the 3rd floor of the building was left entirely at our disposal. Two servants were at our disposal to keep strict vigil over our luggage during the hours we were out. Considering the number of bugs that lurk about in the cots of the hostel and the remarkable health the inmates of the hostel were enjoying, we were of unanimous opinion that there can never be any relation between bed bugs and Kala-azar.

At Bombay we visited the following places:—

The Medical College.—What struck us first was that the Anatomy dissection hall was partitioned off for women students, to work apart. There are a few specimens of interest there but the arteries seem to



The Party of Students with the Manager and the Chief Chemist.

Photo kindly supplied by S. A. Ahmed.

New Graduates "At Tea" on the College Midan.

take the red tinge better than those we are accustomed to see here. Of the three branches of the physiology department the histology hall is most suitably lighted for microscopic work. Complete ground glass provides the ceiling of the hall. A special pond for frogs is maintained there and giant toads performed acrobatic feats on seeing us. A separate coroners court forms part of the college premises.

The surgical theatre in the J. J. Hospital is so constructed that students have no direct access to it. They go up the stairs to an upper gallery which gives a fine view of the operations done below.

The Prince of Wales Museum.—Of a very high educational value to students of Hygiene, if not to those of Natural History.

The Prince Albert Museum.—The paintings of great Indians on such small back grounds as afforded by the tiny rice grains is enchanting.

Victoria Gardens.—Have a good collection of members of the Zoological Kingdom, and of course, they cannot be compared with the South Indian ones.

The gate way of India.—It is said that is was erected in commemoration of the landing at Bombay of their Majesties the King and Queen, who now reign over us. Though for want of time we could not go to the Elephanta caves, we had the proud privilege of having gone out of India by steam launches at least for a few hours. Most of us felt giddy at the thought of it and so we hurried back to the native soil.

The Regal Theatre.—A specimen of hygienic interest. The absence of ceiling fans is comopicuous. Air is conditioned and cooled before percolation.

The Choupati sands.—The sands cannot vie with our beautiful marina ; it is only a place of eating houses in the evenings. Parsi gentlemen may be seen here and there worshipping the sun God and Parsi ladies offering cocoanuts to the sea.

The Malabar Hill and the hanging Gardens.—A picturesque garden on the top of the water reservoir—it gives us a good view of Bombay but we could not escape the odour emanating from the Tower of Silence, unfortunately we could not go to this place, but we

saw a model of it, at the Museum. An hour's stay over the garden turns one philosophical, for on one side is seen the busy Bombay looking as though it is a miniature Chicago and on the other side the Calmback bay with the Tower of silence gently reminding every one of the day of judgment.

The Crawford Market.—Living appears to be very cheap. After a crowded programme, we left Bombay at 10 p.m. by the Poona Passenger.

Monday 30th:—Reached Poona at daybreak. We hurriedly threw our luggage on the platform but one of us appeared to have lost his wrist watch. He ran hither and thither, saw the station-master, the Railway police, etc., for his watch. A search of the Railway porters proved futile. In despair he came back to us but we had it in our possession for we found it tied np to the train! After a few hours' stay we left Poona by the Bangalore Passenger at 3 p m. The scenery over the Ghat section was pleasant.

Meanwhile the members of the party were already feeling the approach of their daily routine of life in Madras. So many liked to extend the excursion by some days more. Suggestions freely poured out. Shimoga said one, Mormugao said another, Gerosappa said yet another and Nasik, Pandarpur and a dozen more were also cited. 'What about boarding and lodging' quietly said the secretary. 'No previous arrangement has been made.' There was an end to the discussion. But an irresponsible and irrepressible young man of the party was all along tempting the secretary, saying that he had a cousin in every one of these places and in fact wherever the train stopped. A lucky devil he is! He would not keep quiet until the secretary began to tell his comrades in measured tone 'Every important place in India has got a Railway station, a post office, a police station and Mr. . . so and so's cousin.

Reached Bangalore on Tuesday evening, after a tiresome journey. One of our members left us here for Trivandrum. The rest of us found our way to the Empire hostel, at Bangalore City, spent the night there. The next day we visited the Lalbagh, the Hospital, Basuvangudi and its temple markets and the Cantonment.

At 5 p. m. the same day we left by the Bangalore Passenger for Madras, amidst a shower of rain which began synchromously as the train started.

On our way yet another friend left us at Jalarpet for Coimbatore. We arrived at Madras on Thursday the 4th May 1934 at 5-45 a.m. once more to enter into the humdrum of life.

A little about the members in conclusion representatives of all the leading languages were among us: Tamils, Telugus, Urdus and Malayalams in proper proportions too. Despite the rash differences in outlook and a few rales and rhouchi occasionally indicating that consolidation was passing on to resolution, through our secretary's impartial endeavours and studied treatment of symptoms we accomplished what perhaps is unprecedented in the annals of the Medical College.

Three Cheers to the Secretary !!!

In Lighter Vein.

Stiff Examiner.

In a Pharmacology examination a student was asked to mention all the diaphoretics. He gave a long list of names. Examiner not being satisfied "Anything more?" Student—hesitating a while—"A stiff examiner like you, Sir."

An enthusiastic House Surgeon "Sir, patient No X is dying, can I give him an injection of camphor in oil?

Physician:—"Is he a Hindu."

House Surgeon (curiously)—"Yes, Sir."

Physician:—"Well you can. It will help him in cremation."

Thick Skin.

Medical Student Mr. Bore:—"Sir, Veins of my fore arm give a thickened feel.

Surgeon:—"It is not the veins that are thick my boy, but your skin."

A stingy Scotchman, an Irish man and a few others went to visit the London Zoo. At last they came near a Skunk house. (Skunk is an animal which emits a very foul odour). They made a bet that the person who can remain for the longest time inside the Skunk house will get a shilling. The Scotchman went inside the Skunk house and with great difficulty managed to remain for 10 minutes and then came out. The greedy Irishman remained inside for 20 minutes and came out. Then the few went inside. After half an hour.....the Skunk came out.

Taking Life Easily.

Student in Toxicology class to his neighbour "Henceforward I mean to take life easily". *Neighbour*—"Well! take potassium cyanide."

During out-patient. work, an enthusiastic Lady Student examined case and took it to the physician and said "Sir, the patient has a spleen."

Physician.—"Palpating added coolly" Yes you are right, the patient has got a spleen. He has also got a Liver. But both are not palpable, that is all."

Surgeon shaving a case of Leprosy "Is Leprosy cantageous"

Lady Studcnt.—"Yes, Sir."

Surgeon touching the affected limb "Now, can I get it?"

Lady Student.—'No Sir, Surgeons are immune."

I. M. S. Officer's Young hopeful—"Papa, What did you do in the last great War."

I. M. S. Officer "Hurt.....Your Mamma is in the next room."

Surgeon was operating on one table and his assistant was aspirating a foul abscess on another. The Surgeon in the midst of operation asked. Halls, my assistant Mr. X. Does that smell come from you." The assistant replied humbly "yes, Sir."

A Grammar master wrote "kiss" on the board and asked a girl student whether it was a proper or a common Noun. The girl answerd "Sir it is both, proper and common."

Grammar teacher: Mr. Jack, can you tell me the past tense of 'live'

Jack smartly: 'Dead.'

Leela "Dad. Teacher taught me that two negatives make one affirmative. How can it be Dad?

Father goes on explaining but Leela interrupted in the middle and said "Now I understand, Mummy tells me that cousin in the Medical College failed once and he is called irregular, whereas the sister failed twice and she is called a regular student.

Association Notes.

A meeting of the College Association was held at 12-15 P.M. on 7th July 1934 in the Hygiene Lecture Hall to express sorrow at the untimely and premature deaths of Mr. Appa Nair and Mr. V. R. Vedachalam both final year students of our college.

Lt.-Col. R. E. Wright, C.I.E., I.M.S., presided Mr. Narayana Kutti Menon spoke a few words about the qualities of late Mr. Appa Nair after which the following resolution was read by him all members standing :—

'That this meeting of the Madras Medical College Association places on record its deep sense of grief at the untimely death of Mr. Appa Nair.'

Mr. M. Munuswamy read a short note about the genial temperament of late Mr. V. R. Vedachalam after which he moved the following resolution which was passed all members standing :—

'That this meeting of the Madras Medical College Association places on record its deep sense of grief at the premature and untimely death of Mr. V. R. Vedachalam.'

Mr. P. N. Rangiah then moved the following resolution :—

'This meeting of the College Association authorises its Secretary to convey the above resolutions to the respective members of the bereaved family.

This was duly seconded.

The General Secretary of the College Association then moved the following proposition for the acceptance of the General Body :—

'That it shall be made a custom among the students of this college, to pay at least a minimum subscription of one anna each which shall be collected by the respective class representatives whenever a student of our college dies, so that a suitable memorial in the shape of an enlarged photo of our departed colleague could be kept in the students common

room.' It was duly seconded and the proposition was passed unanimously.

The chairman informed the audience, that he was not aware of the proposal to give a common room for the students, but relied on the Secretary's statement that Lt.-Col. Newcomb, I.M.S., the principal on leave has promised to allot a common room for the students as soon as certain departments shift to the new Pathology building.

The meeting was then dissolved. The college was closed for the rest of the day.

Annual General Body Meeding of the Association was held in the College Library Hall at 12-30 P.M., on 16th July 1934 when Dr. M. R. Guruswami Mudaliar presided. The hall was crowded and many members were left standing.

The Chairman called upon the Secretary to read the minutes of the last general body meeting which was read and passed. The Chairman then welcoming the new members of our Association said that 'the cream of all colleges come in to enrich the medical college'. He appealed to the outgoing students of the college and said that it is they who can really contribute their intellect and money for the improvement of the Association. He pointed out that unity amongst all the outgoing students is a necessity at this period when 'philonthrophy and self-sacrifice has reached a collosal height especially in the personnel of the medical profession.' The result, he pointed out, is that medical men suffer in all departments of life with a few more preliminary remarks the Chairman proceeded with the business to elect the office-bearers of the Association for 1934-35.

Mr. Syed Ali Ahmad proposed 'that the same vice-presidents do continue for this year also.' This was seconded and carried.

Dr. M. R. Guruswami Mudaliar, B.A., M.D., and Dr. A. Lakshmanaswami Mudaliar were duly declared vice-presidents of the Association.

The Chairman pointed out the undesirability of changing the Honorary Treasurer often. Thereupon Mr. Santhanam moved 'That the same treasurer he elected for this year.' This was unanimously carried. Dr. K. S. Viswanathan, B.A., M.B.B.S., B.S.Sc., was duly declared honarary treasurer.

Mr. Raghavachari proposed the name of Lt.-Col. Pandalai to be the president of the magazine committee which was seconded and carried unanimously.

The Chairman pointed out to the audience the undesirability of changing the editors of our college magazine often. He said that the policy of the magazine should be maintained at all cost. Dr. Thambiah our last year's Editor was declared general editor for 1934-35.

Mr. Ramakrishnan moved that 'the same Associate Editor continues.' This was seconded and carried.

Dr. N. S. Narasimham, F.R.C.S., was declared elected.

Student Editors.—Three names were proposed and seconded for the places of two student editors, on putting the names to vote

Mr. M. Munuswamy (final year) got 100 votes } Declared
Mr. Narayanakutti Menon (final year) got 75 votes } elected.

Mr. Maduram Santhosham (IV year) got 31 votes

The Chairman then called for the nomination for the following office-bearers.

Assistant Secretary for the Association.—Mr. V. S. Subramaniam (III year) was proposed by Mr. R. Narasimhachari, seconded by Mr. Rajagopal.

The names of Mr. Syed Ali and Mr. N. A. Rangachari were also proposed and seconded but the candidates withdrew in favour of Mr. V. S. Subramaniam, who was declared elected.

Sports Secretary.—Two names were proposed and seconded that of

Mr. M. Natarajan } on Wednesday 18th July the election was
Mr. T. Achuthan } held by closed ballot and Mr. Achuthan got 337, votes as against 225, got by Mr. Natarajan, Mr. Achuthan was declared elected.

Captains for the College Teams.

Hockey.—Mr. Cullen was proposed and seconded and was declared elected unanimously.

Football.—3 names were proposed and seconded that of

Mr. P. O. Oommen } Mr. Hull was declared elected as the other
„ L. G. Hull } two withdrew later.
„ Haridoss }

Cricket.—3 names were proposed.

Mr. Thiruvenkatachari } Mr. Thiruvenkatachari was declared
Mr. A. V. Rajagopal } elected as the other two withdrew
Mr. D'Costa } later.

The last item in the agenda was 'Any other business brought before the meeting'.

Hastel for Our College.—Mr. Nagappa Alva moved that our college should have an hostel at an early date and suggested that the 'Jaya Mansions' a newly erected building at No. 1, Poonamallee High Road be temporarily converted into an hostel for our college students.

The Chairman said that it is really inconceivable how our college managed to exist without an hostel for nearly 100 years. He said that he knew that it causes not a little inconvenience to the mofussil students who are to wander about in the city for proper lodging shifting from place to place for nearly 6 years. As a result he said 'that in the best part of their lives they fall a pray to the ravages of many a disease'. He said that it is a pity that the Government fails to understand that 'if at all any college requires an hostel as an immediate necessity it is the medical college which attracts students from all over the Presidency—nay from all over India? He commended the idea of Mr. N. Alva and said that he will certainly do his best to see that student get 'Jaya Mansions' provided at least 30 students are willing to take rooms. 'True' he said 'that the building is wedged between the railway line on one side and the tram on the other', but let us be satisfied with a footing to start with and fight for a real hostel'. 'If the Government is not willing to agree to our proposal then certainly' he said 'the remedy is with you'.

The Chairman graphically described how years back late Mr. Surendranath Bannerjee the talented orator of Bengal came with his begging bowl for the sake of the Congress, when Surendranath became an household name and every one gave what he could for the Congress

cause. 'Many of his admirers called out from the road side 'surrender not, and Surendra Nath never surrendered'. The Chairman warned the audience that he is not talking on behalf of the Congress, but what he wanted to impress was that no diginity is lost by the students if they go about with a 'begging bowl' to collect money from house to house. 'Even in England' he said 'the students and nurses go about begging in the streets on what they call a 'hospital day'.

U. T. C.—The Chairman next referring to the U. T. C. in our college said that as early as 1922 Dr. Luther who was then in charge of the E. N. T. department was the man who worked heart and soul for its inception. He said that arrangements are being made to have the examinations earlier so that the students may attend the camp care free. He appealed all of them to join the U. T. C. [Since this appeal, I learn that the strength of our contingent has doubled and we are seriously thinking of whether the authorities would permit us to recruit more students than the allotted number for our college -Secretary].

Old Students Association.—Mr. M. Munuswamy said that this is the only college where there is no old students association. He argued vehemently for the establishment of an old students association. He hoped that the present General Secretary at least will try to get in as many old members as possible. Mr. Narayana Kutti Menon seconded the proposition

Special ward for students.—Mr. B. Narasimham then suggested that our college students should be given beds in the special wards in the General Hospital instead of the existing practice of providing beds in the general wards along with the other patients.

The Chairman said that this matter should be sent to the Superintendent of the General Hospital for consideration. He said that Lt. Col. Pandalai will certainly oblige the students only if he could help them in any way. He thought that there may creep in certain audit objections.

Question of removal of the present vendor of refreshments in our college. Mr. Aga Mohamed Shirazi said that it is a pity that the students of Medical College should tolerate having a refreshment man who, inspite of warnings and complaints, would never improve the quality of

the refreshments. He pointed out certain examples to show how the vendor is making huge profits. He complained that the secretary has not done anything to remove the present vendor in spite of a written memorandum which was submitted to him during the summer recess requesting the secretary to get in a new-man to run the cafe. 'However' he said 'the college opened with the same man but with more vehement complaints against him.'

The Chairman at this time finding the time to be 2 P. M. was obliged to leave the meeting as he had some urgent affairs to attend to. He asked Dr. K. S. Viawanadhan to occupy the chair.

Then the newly elected Assistant Secretary Mr. V. S. Subramanian proposed a vote of thanks to Dr. M. R. Guruswami Mudaliar. Three cheers were called for which was lustily responded when the Chairman left the hall. Continuing Mr. Shirazi moved the following resolution. 'As the present vendor in the Macgrath cafe is unsatisfactory the president of the association be requested to take necessary action for his removal.' This was duly seconded. The Secretary then asked the audience whether anybody had any objections for the resolution. The whole audience with one voice said 'No' and the resolution was carried unanimously.

With a vote of thanks to the chair the meeting was dissolved.

The executive committee meeting of the College Association was held on 25th July 1934 at 12 noon at the principal's office when the following members were present:—

President.—Lt.-Col. R. E. Wright, C.I.E., I.M.S.

Vice-President.—Dr. A. Lakshmanaswami Mudaliar M.D., F.C.O.G.

Honorary Treasurer.—Dr. K. S. Viswanadhan, B.A., M.B.B.S., B.S.Sc.

General Secretary.—Mr. T. Janardhanan.

Assistant Secretary.—Mr. V. S. Subramanian.

Representative for Lady Students.—Miss Gladys Connor.

B. S. Sc. and Health Officers representative.—Mr. A. B. Srinivasa Mudaliar.

Final Year representative.—Mr. S. R. Vaidyanathan.
Fourth „ „ —Mr. Subramania Chetty.
Third „ „ —Mr. N. R. Subramaniam.
Second „ „ —Mr. Paul Devadoss.
First „ „ —Mr. R. Arunachalam.

Pre-registration.—Mr. Shirazi (Jr.)

After passing the minutes of the last meeting, the accounts for the last year was also passed. A Sub-committee was elected to arrange for the reception to the new graduates.

The Secretary then moved a resolution that this meeting shall arrange for the opening of a medical college exhibition on the lines of those that are being conducted in other colleges? It was contended by the mover that the Association should try to help the public as well as itself by arranging such exhibitions. He said that this may not be much instructive to the students of the medical college but it will be a boon to the student population at large and the public in as much as it will explain certain fundamentals regarding every branch of medical science. He pointed out that it will be highly educative to the students of the primary and high schools where they have at present to read a bit of elementary physiology, anatomy, hygiene and public health. In conclusion it was pointed out that the finances of the Association can be materially improved only by conducting such Annual exhibitions.

Dr. A. Lakshmanaswami Mudaliar speaking on the subject said that he knew that most of the colleges are conducting exhibitions which is certainly educative and very popular also. He said that in Presidency College there used to be many exhibitions every year conducted by different departments in the college. He said that it is better to have a separate committee consisting of heads of departments in the college as the exhibition committee.

Thereupon the meeting elected the following committee to draft a programme for the proposed exhibition.

Rao Bahadur Dr. A. Lakshmanaswami Mudaliar Avl., B.A., M.D., *President of the Commttiee.*
Dr. S. R. Pandit.
Dr. R. Adiseshan, *Prof. of Hygiene.*

Dr. S. Ramakrishnan, L.M.S., L.R.C.P. & S.
Dr. A. N. Goyle, M.B.B.S., Ph.D., *Prof. of Pathology.*
Dr. B. T. Krishnan, B.A., M.B.B.S., M. SC. *Prof. of Physiology.*
Dr. K. Koman Nayar, D.O.M.S.
Dr. K. S. Viswanadhan, B.A., M.B.B.S., (*Treasurer.*)
T. Janardhanan (*Secretary.*)

In the end the President gave his approval of the resolution passed in the general body meeting concerning the removal of the present vendor of refreshments in our college. He asked the secretary to suggest a substitute. Thereupon the secretary said that it is not difficult to get in a substitute, but that he was afraid that the same difficulty will arise after some time. He suggested that a committee should be formed with some Assistant Professors and students to enquire into the question of running a co-operative hotel by the association itself as is done in certain Government Offices and Colleges, so that the profits may go to the Association funds. The president said that he will arrange to give three months' notice to the vendor first and then consider the question at leisure.

The meeting was then dissolved.

GENERAL SECRETARY.

Antiphlogistine.

READER.

In the management of the ordinary accident and wound cases local treatment generally requires a surgical dressing which, also, is an efficient antiseptic. To be an ideal antiseptic, however, it must be one which, while inhibiting the bacteria in vivo, will not destroy the tissues and break down their natural resistance. It must be one which will nourish, support and promote the cells in their rehabilitating process while exercising their antiseptic powers.

There are, of course, countless antiseptics and surgical dressings for the practitioner to select from, but as an application, fulfilling the requirements of an ideal antiseptic surgical dressing, few preparations are better adapted for the purpose than is Antiphlogistine. A glance at its formula 45 per cent c. p. glycerine, boric acid, a minute quantity of salicylic acid, iodine, oils of peppermint, gaultheria and eucalyptus, blended in a base of the finest dehydrated silicate of aluminium—will easily explain the reason for its efficacy in the treatment of injuries and accidents.

When applied direct to a punched, contused, or incised wound, Antiphlogistine lessens the chances of infection. In suppurative wounds it aids in diminishing the amount of wound exudate. A spreading lymphangitis may be inhibited or diminished through its use. In cases of dislocations, sprains and synovitis it helps to relieve inflammation, swelling and pain. In burns it should be applied cold, when it favours healing, promotes growth of epithelium with minimum of scar tissue. It is not a dressing that causes pain on application and removal, nor is there the least danger of its bleaching or macerating the skin. Soothing, decongesting and healing, it lends protection to a wound.

"A" Company: University Training Corps, Medical College.

U. T. C. Notes.

It is gratifying to note that our college contingent of the U. T. C. has shown a remarkable improvement in strength. From a strength of about 35 at the end of last year, it has exceeded 70 at present. This turn in the tides is mainly due to the change of the University Examination date to the 3rd week of November and the Annual Camp to the 2nd week of December after the Examinations are over. The present rush for enrolment shows that the Medicoes welcome this change.

University of Madras.

Pre-Registration Examination, 1934

INORGANIC CHEMISTRY

WEDNESDAY, 4TH APRIL. 10 A.M. to 1 P.M.

Candidates must use separate books for PARTS I *and* II.

PART I

1. The dissociation constant of a monobasic acid is 0·0003. Calculate the *p*H of a decinormal solution of it. [20]

2. Explain how one could determine if the decomposition of hydrogen peroxide into water and oxygen is a mono-or a bimolecular reaction. [15]

3. How can emulsoids and suspensoids be distinguished ? [15[

PART II

1. Explain fully the statement that the osmotic pressure exerted by substances in solution is analogous to their gaseous pressure. Compare the osmotic pressure exerted by electrolytes and non-electrolytes. [15]

2. What do you understand by the terms—(*a*) normal solution, (*b*) anion, (*c*) equivalent weight of an element, (*d*) supersatured solution, and (*e*) catalysis ? Give an example of each. [20]

3. What are isotonic solutions ? How is the osmotic pressure of solutions compared ? Describe in detail one of the methods. [15]

Pre-Registration Examination, 1934

PHYSICS

WEDNESDAY, 4TH APRIL. 2 P.M. to 5 P.M.

Candidates must use separate books for PARTS I *and* II.

PART I

1. Explain how you would measure—

(*a*) a small interval of time correct to the hundredth part of a second ;

(*b*) the specific gravity or a liquid correct to four places of decimals. [16]

2. Explain the difference between—

(*a*) saturated and unsaturated vapours ;
(*b*) the isothermal and adiabatic elasticities of air. [16]

3. Give an experimental and quantitative account of Joule's determination of the mechanical equivalent of heat.

A man of mass 15 stone walks at the rate of 3 miles an hour up a slope of 1 in 120 and covers a distance of 2 miles. Find the heat equivalent of the work he does. [18]

PART II

1. Describe, with a diagram, the construction of a compound microscope fitted with an oil immersion objective and condenser.

Explain the physical principle governing the function of each part. [17]

2. Enunciate the law governing the production of energy in an electrical circuit.

A current of 0·5 ampere passes through an electric lamp with a fall of potential of 110 volts. Find the resistance of the lamp, the power consumed by it, and the heat developed in it per second. [17]

3. Write short notes on :—

(*a*) A Nicol's prism.
(*b*) The neutral point in the magnetic field around a bar magnet.
(*c*) Fleming's left hand rule.
(*d*) Positive rays. [16]

Pre-Registration Examination, 1934

GENERAL BIOLOGY

THURSDAY, 5TH APRIL. 10 A.M. to 1 P.M.

Candidates must use separate books for PARTS I *and* II.

PART I

1. Describe a typical flower. Explain the use of the various parts, and show how they are adapted to fulfil their functions. [16]

2. Is it possible to grow a mould and a flowering plant in artficially prepared aqueous solution ? State what should be the ingredients of such solutions, and explain in what important respect they must differ. [17]

3. Give an account of the occurrence of root-nodules on the roots of some plants. How are these nodules caused, and how do they affect the life of the plant ? [17]

PART II

1. Describe the different types of reproduction met with among the animals you have studied. [19]

2. State briefly how the following parasites are transmitted to new hosts : —liver-fluke, round-worm (ascaris), tapeworm, guinea-worm trypanosoma. [15]

3. In what important respects do the invertebrates differ from the vertebrates ? [16]

First M.B. and B.S. Examination, 1934

ORGANIC CHEMISTRY

WEDNESDAY, 4TH APRIL. 10 A.M. to 1 P.M.

Candidates must use separate books for PARTS I *and* II.

PART I

1. What are the general characteristics of the acids found in combination in the natural facts ? [10]

2. What reactions would you expect of the substance having the formula CH_2 =CH. COOH ? [8]

3. By what methods might the phthalic acids be distinguished ? [7]

PART II

1. Devise a scheme for synthesizing each of the folllowing substances :—

(*a*) $CH_3.CH(CH_3).CH_2.CO.CH_3$,
(*b*) $COOH.(CH_2)_4.COOH$,
(*c*) $CH_3.CH_2.CH_2(CH_2.CH_3).COOH$. [8]

2. What is meant by the term 'saponification value'? Given ethyl acetate and methyl propionate, which are isomeric, describe how you would experimentally distinguish between the two. [8]

3. Compare and contrast the properties if (*a*) the hydroxyl, and (*b*) the aldehyde group when present in the nucleus and in the side-chain of aromatic compounds. [9]

First M.B. and B.S. Examination, 1934

ANATOMY, INCLUDING THE ELEMENTS OF HUMAN EMBRYOLOGY

WEDNESDAY, 4TH APRIL. 2 P.M. to 5 P.M.

Candidates must use separate books for PARTS I *and* II.

PART I

1. Give a detailed account of the oculomotor nerve. [17]

2. Describe the pulmonary artery and its primary branches. [16]

3. Descrbe the male urethra. State briefly how it is developed. [17]

PART II

1. Give a detailed description of the thyroid glant, including an account of its development. [17]

2. Describe the position, extent, and relation of the omental bursa. [16]

3. Describe the arches of the foot, and mention the structures concerned in the maintenance of each arch. [17]

First M.B. and B.S. Examination, 1934

PHYSIOLOGY INCLUDING BIO-CHEMISTRY

THURSDAY, 5TH APRIL. 10 A.M. to I P.M.

Candidates must use separate books for PARTS I *and* II.

PART I

1. Name the products of digestion expected to be found in a healthy stomach one hour after a meal of bread and milk. How would you demonstrate their presence ? [17]

2. Describe briefly the origin and mode of transport of *carbon dioxide* in the living body. [16]

3. How do sound waves give rise to *auditory sensations*? Trace, with the help of a diagram, the nervy-path involved. [17]

PART II

1. Describe the part played by the *carotid sinus* in the reflex regulation of the heart-rate and the arterial blood-pressure. [17]

2. What is the physiological significance of the variations in the amount of *urea* and *ammonia* in the urine? [16]

3. What is meant by (*a*) reciprocal innervation of muscles, and (*b*) axon reflex? Describe the physiological importance of each. [17]

Second M.B. and B.S. Examination, 1934

PHARMACOLOGY

WEDNESDAY, 4TH APRIL. 10 A.M. to 1 P.M.

PART I

1. ***Insulinum***. What is its action? How is it administered? Give its dose. What dangerous effects may it produce, and how may these be combated? [15]

2. Give the chemical composition and mode of action of ***Arsphenamine*** and ***Neoarsphenamine***. Give their doses, and state the undesirable effects that may follow their use. [20]

3. What are *Oculenta*? Mention those Official in the B.P. Give the strength of the medicament in each, and describe its action. [15]

PART II

1. Describe the action of adrenaline, and compare it with that of pituitary extract (B.P.). [16]

2. Detail the means by which a rubefacient and a vesicant action may each be obtained. Explain the mode of action of '*counter-irritants*'. [16]

3. Define the term *antipyretic*. How do the following act as such :—phenazonum, ice, quinine, potassium acetate? [18]

Second M.B. and B.S. Examination, 1934

HYGIENE

WEDNESDAY, 4TH APRIL. 2 P.M. to 5 P.M.

Parts I and II to be answered in separate books.

PART I

1. Mention the diseases that are transmitted by mosquitoes. Indicate briefly the preventive measures to be adopted in the case of the mosquito-borne disease which causes considerable morbidity and mortality in the population of this Presidency. [18]

2. Discuss the significance on health of the changes brought about in the air by respiration [16]

3. Write short notes on :—(*a*) Schick test, (*b*) septic tank, (*c*) balanced diet, (*d*) bacteriophage. [16]

PART II

1. What should be the minimum average supply of water in an ordinary municipal town in this Presidency ? Show how you arrive at this estimate. Describe briefly how you would render the water supply safe for drinking purposes. [16]

2. What is disinfection ? Mention the various methods of disinfection indicating their practical application. [18]

3. What is ' infant mortality rate' ? What is the average infant mortality rate in Madras Presidency and in Madras city ? What are the chief cause of infant mortality ? [16]

Second M.B. and B.S. Examination 1934

GENERAL PATHOLOGY WITH BACTERIOLOGY

THURSDAY, 5TH APRIL. 10 A.M. to 1 P.M.

PART I

1. What are the principal causes of enlargement of lymphatic glands ? Describe the pathological changes which occur in the lymphatic glands in Hodgkin's disease [18]

2. Describe the characters of stools in amoebic and bacillary dysentery. How would you obtain a pure culture of *B. dysenteriae* from a sample of faces ? [18]

3. Describe the phenomena of repair as seen in a granulating ulcer. [14]

PART II

1. Under what pathological conditions does fatty degeneration occur ? How would you demonstrate the presence of fat in an organ ? [18]

2. Give an account of the changes in the lung in a case of mitral stenosis. [14]

3. Describe the parasite of quartan malaria, and give an account of its life-history. Indicate the lesions produced by this parasite in man. [18]

Second M.B. and B.S. Degree Examination, 1934

OPHTHALMOLOGY

THURSDAY, 5TH APRIL. 2 P.M. to 5 P.M.

PART I

1. What do you mean by cataract ? Mention some of the cause of this condition. [8]

2. Describe briefly how you would treat a case of ulcus serpens. [8]

3. In what strengths are solutions of the following drugs used in the treatment of eye disease :—atropine, eserine, cocaine, argyrol, silver nitrate, zinc sulphate ? [9]

PART II

1. Describe briefly the ophthalmoscopic appearances in a case of optic neuritis. [8]

2. How would you treat a case of acute congestive glaucoma ? [8]

3. What are the chief causes of iridocyclitis ? Describe the signs and symptoms in a case of chronic iridocyclitis. [9]

Final M. B. and B. S. Degree Examination, 1934

FORENSIC MEDICINE

MONDAY, 9TH APRIL. 10 A.M. to 1 P.M.

PART I

1. Describe a case of poisoning by oxalic acid. Give the post mortem signs. [17]

2. Detail how you would conduct the Hydrostatic Test. What is its value as an evidence of respiration ? [17]

3. What evidence may be obtained by examination of the woman (*a*) during life, (*b*) after death, in a case of alleged abortion ? [16]

PART II

1. Describe the procedure adopted to determine the age of an adolescent girl produced for examination by the police for alleged kidnapping. [16]

2. Mention in detail the characteristics of homicidal cut wounds. Distinguish them from self-inflicted wounds. [17]

3. Distinguish the post-mortem signs of a case of hanging. How would you determine if it was not homicidal ? [17]

Final M.B. and B.S. Degree Examination, 1934

MEDICINE

MONDAY, 9TH APRIL. 2 P.M. to 5 P.M.

PART I

1. Discuss the diagnosis of pyaemia. [17]

2. Discuss the etiology and treatment of rickets. [17]

3. Describe the naked-eye and microscopical changes which occur in acute scarlatinal nephritis in the kidney. [16]

PART II

1. How would you recognize and treat the complications that may arise in the third week of typhoid fever ? [16]

2. How would you distinguish between a case of angina pectoris and coronary thrombosis? Give the treatment appropriate to each. [17]

3. Discuss the treatment of a case of sprue. [17]

Final M.B. and B.S. Degree Examination, 1934

SURGERY

TUESDAY, 10TH APRIL. 10 A.M. to 1 P.M.

PART I

1 Describe the course and distribution of the musculospiral nerve and the treatment required consequent to division of the nerve in the middle of the upper arm. [16]

2. Describe the causes, symptoms, signs, and treatment of hydronephrosis. [17]

3. What are the complications which may arise from chronic suppuration of the middle ear? [17]

PART II

1. Discuss the differential diagnosis and treatment of a small painless lump in the breast of a woman 45 years old. [17]

2. Describe the anatomy of the internal semilunar cartilage of the knee-joint. What traumatic lesions of this structure are met with? Explain the mechanism by which they are produced. [16]

3. Enumerate the causes of acute intestinal obstruction, and discuss the factors which produce regurgitant vomiting. [17]

Final M.B. and B.S. Degree Examination, 1934

OBSTETRICS AND GYNAECOLOGY

WEDNESDAY, 11TH APRIL. 10 A.M. to 1 P.M.

PART I

1. Discuss the principles of treatment to be adopted for a primipara in labour at term with a generally contracted pelvis of the first degree. [17]

2. Name the main varieties of toxaemia of pregnancy. Deacribe the pathology, symptoms, diagnosis, prognosis, and treatment of acute yellow atrophy. [17]

3. Discuss the causes, diagnosis. course, and treatment of transverse presentation. [16]

PART II

1. Discuss the course of gonorrhœa in the female. [17]

2. Describe the causes of chronic inversion of the uterus, signs and symptoms, and treatment of the condition. [16]

3. Discuss the causes of sterility in woman, and briefly indicate in each case the treatment that may be carried out. [17]

M. D. Degree Examination, 1934

(COMMON TO ALL BRANCHES)

Medicine.

WEDNESDAY, 4TH APRIL—10 A.M. TO 1 P. M.

PART I

I. Mention the various protein substances which may be found in the urine, with their tests; give their clinical significance.

II. Give the symptoms and pathology of *Acromagaly* and mention the treatment you would adopt.

III. Give in detail the general and differential diagnosis of a case of Empyema.

PART II

I. Give a clinical description and the treatment of Bronchial Asthma in infancy and childhood.

II. Discuss the pathology and prognosis of *Angina Pectoris*.

M. D. Degree Examination, 1934

BRANCH I

Medicine, including Mental Diseases and Pathology I

WEDNESDAY, 4TH APRIL. 2 P.M. TO 5 P.M.

FIRST PAPER

I. Discuss the pathology of cirrhosis of the Liver.

II. Discuss the prognosis of Pulmonary Tuberculosis.

III. Give clinical description of the Epileptic variants that you know. Give the treatment of Epilepsy.

M. D. Degree Examination, 1934

BRANCH I

Medicine, including Mental Diseases and Pathology II

THURSDAY, 5TH APRIL. 10 A.M. TO 1 P.M.

SECOND PAPER

I. Discuss the diagnosis and treatment of chronic Splenomegaly in childhood.

II. Discuss the symptoms and pathogenesis of the hæmorrhagic diathesis.

III. Describe the congenital defects that may be present in the aorta and state how you would detect them clinically.

IV. What do you understand by the term maniac depressive psychosis ? Discuss its ætiology, prognosis, diagnosis and treatment.

M. D. Degree Examination, 1934

BRANCH II

Midwifery and Diseases of Women and Children, including Pathology I.

WEDNESDAY, 4TH APRIL. 2 P.M. TO 5 P.M.

I. Discuss the etiology, pathology and treatment of "contraction ring of the uterus."

II. Describe the changes that the Foetal pelvis undergoes in its transformation to the adult form and discuss the effects of rickets on the growing female pelvis.

III. Classify 'Double Monsters.' Discuss the diagnosis, prognosis and treatment of this complication in labour.

IV. Discuss the etiology, pathology and diagnosis of Pyelitis in Pregnancy.

M. D. Degree Examination, 1934

BRANCH II

Midwifery and Diseases of Women and Children including Pathology II

THURSDAY, 5TH APRIL. 10 A.M. TO 1 P.M.

I. Discuss the etiology, pathology, diagnosis and treatment of Krukenberg tumours.

II. Describe the various anomalies of congenital origin of the uterus and state how they occur. What complications may arise in pregnancy and labour ?

III. Discuss the various operative measures that may be employed in the treatment of downward displacement of the uterus.

IV. Discuss the uses of Radium in Gynæcology and state the contra indications and adverse effects that may arise from its use.

M. D. Degree Examination, 1934

BRANCH IV

Tropical Medicine, including the Pathology of Tropical Diseases I

WEDNESDAY, 4TH APRIL, 2 P.M. TO 5 P.M.

FIRST PAPER.

I. Discuss the ætiology, symptomatology and pathology of *Yaws.*

II. Discuss the symptomatology, pathology, prophylaxis and treatment of *Endemic Hæmaturia.*

III. Classify and discuss the *short fevers of Madras.*

IV. Briefly describe the myocardial changes in *Malaria, Ankylostomiasis, Beriberi* and *Bacillary Dysentery.*

M. D. Degree Examination, 1934

BRANCH IV

Tropical Medicine, including Pathology of Tropical Diseases II

THURSDAY 5TH APRIL. 10 A.M. TO 1 P.M.

SECOND PAPER.

I. Describe the P. M. appearances in a case of Sprue. How would you correlate these with the changes in the blood and central nervous system found in the various stages of the disease ?

II. Discuss the pathology and P. M. findings in a case of Blackwater fever. Describe its treatment.

III. Describe the life history of the Entamæba hystolytica. What are its local and distant complications and how will you treat a case of chronic intestinal infection by the parasite ?

IV. Discuss the ætiology and differential diagnosis of Beriberi.

M. S. Degree Examination, 1934

SURGERY 1.

WEDNESDAY, 4TH APRIL. 10 A.M. TO 1 P.M.

I. What fractures occur around the hip joint ? Give the diagnosis and treatment.

II. Describe the diagnosis, pathology and treatment of spinal tumours.

III. Give the signs, symptoms, pathology and treatment of carcinoma of the rectum.

M.S. Degree Examination, 1934

SURGERY II.

WEDNESDAY, 4TH APRIL. 2 P.M. TO 5 P.M.

I. Describe in detail your treatment of a case of primary sarcoma of the lower end of the femur.

II. Discuss the causation, diagnosis and treatment of malignant disease of the upper oesophagus.

III. What surgical measures may be required in cases of pulmonary tuberculosis ?

Describe briefly the indications for their use, and the technique of their performance.

IV. Discuss fully the treatment of a case of intussusception of 4 days' duration with a pulse of 120 and faecal vomiting.

M. S. Degree Examination, 1934

SURGICAL ANATOMY AND PATHOLOGY.

THURSDAY, 5TH APRIL. 10 A.M. TO 1 P.M.

I. Describe the internal jugular vein giving its relation in detail.

II. Discuss the pathology of swellings of the thyroid gland.

III. Discuss the recent advances in the surgery of the Sympathetic Nervous System.

M.S. Degree Examination, 1934

SPECIAL SUBJECT VENEREAL AND GENITO-URINARY SURGERY.

THURSDAY, 5TH APRIL. 2 P.M. TO 5 P.M.

I. Discuss the causation, differential diagnosis and treatment of Retention of Urine.

II. Describe the new growths of the testis, their differential diagnosis and treatment.

III. What is Hypospadias ? Describe its pathology and treatment.

Examination for the Diploma in Midwifery, 1934

MIDWIFERY.

MONDAY, 9TH APRIL. 10 A.M. TO 1 P.M.

I. Discuss the causes of antenatal, natal and neonatal mortality of infants. State briefly the measures you would adopt to reduce the mortality.

II. Discuss the causes of Hæmorrhage during the last trimester of pregnancy and indicate the lines of the treatment for any one of them.

III. Discuss the indications for artificial termination of pregnancy. Enumerate the different methods that may be adopted and describe the method you consider best in detail.

IV. Enumerate the indications, contra indications and choice of method in Cæsarean section.

V. A primipara is admitted in labour for 16 hours, membranes ruptured two hours before. F.H. 136 M.P. 92 T^{E} 99·2°. Os is $\frac{3}{5}$th dilated. Head presenting and occiput posterior. Discuss the further management of this case.

Examination for the Diploma in Midwifery, 1934

GYNÆCOLOGY AND DISEASES OF A NEW BORN-CHILD.

MONDAY, 9TH APRIL. 2 P.M. TO 5 P.M.

I. Discuss the causes of sterility in the female and modern methods of diagnosis and treatment.

II. A woman aged 45 comes to you with a history of bleeding of a few months duration. Discuss the causes of this condition and how you would investigate and treat such a case.

III. Classify ovarian tumours and describe the complications which may result therefrom.

IV. Discuss the causes of dysmenorrhœa and the treatment for this condition.

V. What are the causes of pelvic infection in the female and discuss the pathology of tubal infection therefrom ?

Review of Books.

A Hand-book of Laboratory Technique By Dr. D. Govinda Reddy M.D., with a foreword by Dr. M. R. Guruswamy Mudaliar B.A., M.D., Professor of Medicine, Medical College. Publishers—Antiseptic Press, Price Re. 1.

The author has well managed to compress within the compass of one hundred and ten pages very many valuable information, which one is usually driven to consult various books. The first part dealing with "Urine" is now out, and is written in a simple style, free from ambiquity. The general get-up of the book is commendable. We consider it a very good performance for a first edition; both the students and doctors will find much to interest them.

EDITOR.

Acknowledgments.

The following Journals were received :—

Medical Bulletin, Bombay.
Medical Digest, Bombay.
Bombay Medical Journal.
Burma Medical Times, Rangoon.
The Vizagapatam Medical College Magazine.
The Journal of the Stanley Medical School, Madras.
Medico-Surgical Seggestion.
Medical Practitioner, Madras.
Marriage Hygiene Vol. I, No. I, Bombay.
Health, Madras.
The Antiseptic, Madras.
Indian Medical Record, Calcutta.
Bulletin, South Indian Medical Union, Madras.
King George Medical College, Clinical Society Journal, Lucknow.
Sind Medical Journal, Karachi.