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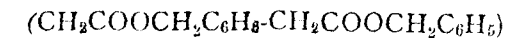
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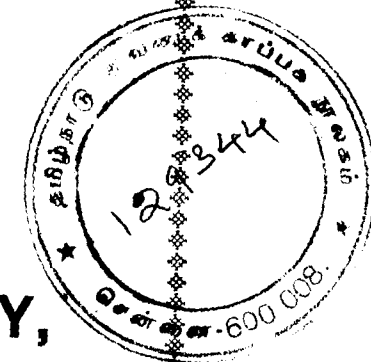
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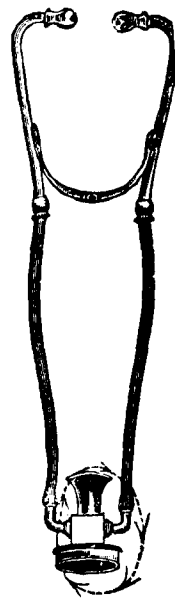
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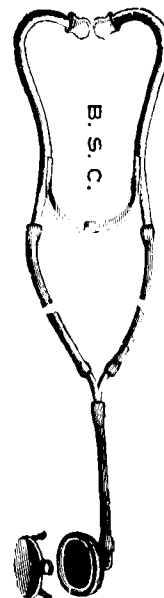


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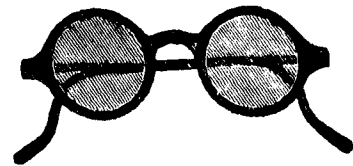
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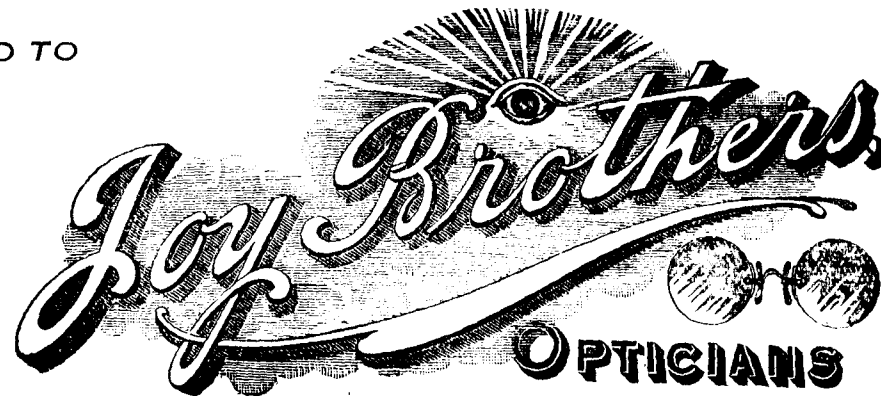
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Vol. XV

January 1936

No. 2

CONTENTS.

PAGE.

1. OBSTETRIC AND GYNAECOLOGICAL CONFERENCE ...	...	87
2. CONGESTIVE HEART FAILURE ...	...	93
By Clough Turrill Burnett, M.D.		
3. A CASE OF SYPHILITIC AORTITIS ...	...	108
By E. A. Shankar, Final Year M.B.		
4. A CASE REPORT ...	...	112
By V. S. Subramanian, V Year Student		
5. OUR MEN AND THINGS ...	...	121
By Arvy		
6. THE DOCTOR IN LITERATURE ...	...	125
7. COLLEGE CENTENARY 1935 ...	...	127
8. WHEN THE TABLES ARE TURNED ...	...	158
By N. Nellayappan		
9. GOOD-NIGHT ...	...	162
By "Boiler"		
10. OUR YOUNG CRICKETER ...	...	165
11. EDITORIAL NOTES ...	...	167
12. U. T. C. REPORT ...	...	168
13. THE MEDICOES U. T. C. MARCHING SONG ...	...	170
By M. San-Tosham		
14. MEDICAL COLLEGE ATHLETIC CLUB ...	...	173
15. THE PET OF MY BOSS ...	...	178
By A. W. Mathuram Santhosham		
16. OUT PATIENT STUDENTS' WORRIES ...	...	180
By "Dire Need"		
17. THE QUESTION OF EXAMINATIONS ...	...	182
18. IN LIGHTER VEIN ...	...	183
19. UNIVERSITY OF MADRAS ...	...	188

THE MADRAS
Medical College Magazine

VOL. XV

JANUARY 1936

No. 2

Opening Session of the First All-
India Obstetric and Gynaecological
Conference.

WELCOME ADDRESS.

Dr. A. Lakshmanaswami Mudaliar, Chairman of the Reception Committee, welcoming the delegates and visitors to the Congress said :

It is with feelings of profound thankfulness and sincere pleasure that I rise to extend to you all a most cordial welcome on behalf of the Reception Committee, to this, the first All-India Obstetric and Gynaecological Congress. We are happy to welcome to our City such a large and distinguished gathering of Obstetricians and Gynaecologists from different parts of India. We extend our fraternal greetings to the President and members of the Bombay Obstetric and Gynaecological Society, to representative delegates from Calcutta, Nagpur, Delhi and other parts of Northern India and to the distinguished members of our profession from the Indian States of Hyderabad, Mysore, Travancore, Cochin and Pudukottah. To that noble band of workers, for whose services to the women and children of our land we cannot feel too grateful, to the medical missionaries we desire to extend a particularly warm welcome. To the delegates who have so kindly responded to our invitation and come from different parts of Southern India and who from the real bulwark of the profession—I refer to the medical practitioners in the rural areas and in remote corners of the

Presidency—we are genuinely pleased to accord a welcome, for, they more than any one else, have to face occasionally obstetric problems of such difficulty and magnitude that will perhaps make the stoutest of us quail. We are convinced that this gathering would not have served its full purpose, its deliberations would not have the far-reaching effects that we desire them to have, if the general practitioners on whom the brunt of obstetric work in the mofussil parts necessarily falls, were not here to exchange views and to discuss the many problems of obstetric and gynæcological interest from their point of view. And lastly, may I, on behalf of the Reception Committee and on behalf of the delegates from British India, welcome most warmly the delegates from French India and Portuguese India, whose presence here to-day is a happy augury of the unity of the medical profession in Greater India and a symbol of the keen interest that the profession takes in the welfare of the women and children of the subcontinent.

Genesis of the Idea.

Your Excellency, for some time past, some of us have been dreaming of this day, when we can foregather on a common platform, the Obstetricians and Gynæcologists from different parts of this country. It was not till June last that the happy idea could materialise and its fruition is due entirely to the whole-hearted support extended by the members of the Obstetric and Gynæcological Societies of Bombay and Southern India. We desire to express our deep sense of gratitude to the members of the Bombay Society in particular, who have been most kind and considerate to us and have given us their fullest co-operation and encouragement in all our undertakings. We desire also to express our grateful thankfulness to Sir Frank Connor and to the present Surgeon-General, Colonel C. Newcomb, whose unfailing sympathy and support helped us in no small measure to organise this gathering. To Your Excellency's Government, we are particularly grateful for the facilities given to those employed in mofussil hospitals

to attend this Congress by extending to them the privilege of special casual leave.

It is perhaps not inappropriate that the first Congress of this kind should be held in the City of Madras. Madras may not stand comparison in many respects with the Gateway of India or with the City of Palaces—the second largest city in the British Empire. But Madras is proud and justly so, of the place it occupies in the Obstetric world of to-day and it is in no spirit of narrow provincialism that I venture to maintain that no other city in India could have claimed this honour with greater confidence and dignity. Madras claims the honour of having the oldest maternity institution in British India, nay, in the Far East—for, the Government Hospital for women and children next door was founded in 1844 and will be celebrating its centenary before the decade is over. Madras claims the honour of having instituted the first training school for midwives in India and for long the only training school of its kind in the whole of this country. Madras is happy to realise that it was the first city which extended through its University and Medical College, the portals of the profession to the women of the country. It is here that the first post-graduate school in obstetrics and gynæcology was established and to-day the Madras University is the only University which has established a Diploma through its affiliated hospitals in this speciality. It is, therefore, with pardonable pride that we welcome you to our historic city, but this very fact makes us all the more anxious about our future and the part Madras will play in the years to come. It is our hope and constant prayer that the people of this Presidency and the Government of the day, will feel a tithe of the pride we feel in our famous institutions and that they will do all they can to maintain its level of efficiency and extend its usefulness to the greatest possible extent.

Fellow-delegates, I am happy to announce to you that the idea of holding such a Congress has been widely welcomed by distinguished obstetricians all over the British Empire and

when a little later, I call upon the Secretary of the Congress to read to you some of the messages that have been received, you will yourself realise how much the idea of holding this Congress has been appreciated and what high hopes are entertained about its future and the part it will play in ameliorating the condition of the women and children of India. How far these hopes will be realised and to what extent our dreams would materialise, it is not for me to prophesy at present. We are encouraged in our task by the kindly sentiments expressed and the good wishes extended to us in such generous terms by the leading obstetricians of the day.

It is our hope that this Congress will enable us to know each other better and to appreciate the work that is being carried on in other parts of the Indian Empire. We hope that this assembly will act as a stimulus to every one of us not only to keep ourselves abreast of the times, but to take a genuine interest in tackling the many problems that await solution in a tropical country like ours. We feel sure that gatherings, such as these will foster the spirit of research and encourage some of us to increased activity in this direction, where a very fertile and virgin field awaits exploration. It is our hope that through such conferences there will be a dissemination of correct and up-to-date ideas of the subject and that the discussions here would tend to focus our minds on the larger problems that await solution. It would be fitting and proper that a gathering such as this would be in a better position to offer its considered opinion on the difficult, yet most important, questions of under-graduate and post-graduate training and what is equally important, on the proper training of midwives. We hope further that it will be possible from time to time to place our experience before the authorities of the land and to acquaint them with our view-point as to the measures needed for the care of the mothers and infants of this country. And lastly, we hope that this great gathering will serve as a stimulus for the spread of our ideals and that each one of us will be

enabled to carry with him the torch of knowledge to his own place and there spread the virus of enthusiasm to the medical profession and the general public.

Post-Graduate Study.

Your Excellency, it is hardly necessary for me to speak at length on the subject of obstetric aid to the people of this country or to dilate on the heavy mortality incident to childbirth or the great amount of morbidity and sickness that follows or the great amount of morbidity and sickness that follows childbirth. Some of us, who have had the sad privilege of attending on Indian mothers for the best part of our professional life, realise only too well, how much has been done in the past and only a little better, how much yet remains to be done. Two problems of transcendental importance which face us to-day are—the affording of facilities for post-graduate study and the encouragement of research in Obstetrics and Gynaecology. In no part of medical science is there greater need for post-graduate study than in the field of Obstetrics. Every one of us will easily realise that the time when one is in a position to understand and appreciate the practical side of Obstetrics is when one has finished his student's career and becomes an apprentice in a maternity institution. And when it is further realised that midwifery has to be practised as an emergency in many cases and in the remotest parts of the country, the need for adequate training will be more easily appreciated. May I take this opportunity of appealing to Your Excellency's Government, to provincial Governments in other places, and to those in charge of large maternity institutions, to keep open the doors of the institutions for post-graduate training, and subject to the facilities available, to impose no restrictions of any kind, territorial, provincial or otherwise. Every post-graduate adequately trained, is an asset to the nation and an instrument of relief to the mothers of this country.

Encouragement of Research.

Another great need of the hour is the encouragement of research. There are problems facing the obstetrician in India

which are peculiar to this country and which must be tackled and solved in this country. The deficiency diseases in relation to pregnancy, diseases like osteomalacia which are so widely prevalent in some parts of India, but which fortunately are rare in Southern India, the varying severity of the toxæmias of pregnancy in different parts of the country, the several tropical diseases and their effects on pregnancy—these and many other such problems are being tackled, but there is greater need for organised research to be undertaken. May we not hope that an appeal from this Congress and through Your Excellency to the generous public will not fail to evoke a sympathetic response? May we not also hope that various administrations in British India and Indian India will co-operate in a spirit of healthy rivalry to organise and support all such laudable enterprise?

Your Excellency, I must apologise for having spoken at some length. To-day is a red letter day in the annals of the obstetric history of this country and it is our hope and prayer that this Congress which is opened under your august auspices will grow from strength to strength and has years roll by, the tender seedling planted by Your Excellency to-day will grow to be a mighty tree spreading its sheltering branches throughout the length and breadth of India, such that under its shady bowers may gather together time and again the cream of the medical profession practising the twin specialities of Obstetrics and Gynæcology, such that its mighty breeze may waft to remotest corners of our land and bring comfort and solace to the rich and poor alike among the mothers of India. And may the Giver of all good help us in this noble cause, guide us along the path of wisdom and lead us to the promised land!

Your Excellency, on behalf of the Reception Committee and this Congress, may I now request you to be graciously pleased to declare this Congress and the Exhibition open.

Congestive Heart Failure.*

BY CLOUGH TURRILL BURNETT, M.D.,

Denver, Colorado, U. S. A.

Of functional disorders of the heart angina pectoris and congestive heart failure are of chief importance, the former more dramatic in its manifestations, the latter more certain as to the ultimate outcome. Both are due to functional insufficiency, the former of the coronary circulation, the latter of the myocardium.

Failure on the part of the heart to maintain an adequate circulation represents a potential congestive heart failure. This may be so slight as to pass unnoticed by the patient or may occur with the suddenness of an anginal attack. Between these two extremes lie the chronic progressive failure associated with valvular disease, hypertensive heart disease and luetic heart failure. While the causal factor of any of these cannot be removed, the early recognition of congestive failure will do much toward retarding downward progress through adequate management.

Three types of circulatory failure: I. Peripheral failure—failure of fluid to heart, shock, toxic states, etc., II. failure of rhythmic mechanism—Stokes-Adams, ventricular asystole, vagus effects, ventricular slowing and fainting auricular fibrillation and auricular flutter; III. failure of heart muscle: (a) Congestive, (b) anginal, and (c) paroxymal—cardiac asthma, acute pulmonary œdema, etc.

Clinically acute heart failure falls into three general groups: I. Those in which the auricles are primarily involved, as in chronic rheumatic mitral disease and thyrotoxicosis. In these cases total arrhythmia is associated with dyspnoea, cyanosis and

* Through Courtesy, Editor, "Medical Surgical Suggestion."

usually œdema; II. the cases in which the conduction system between the auricles and the ventricles is disturbed, leading to attacks of bradycardia and syncope; these are usually found to be cardiosclerotics; III. the cases in which the failure is primarily of the ventricles. These may be cases of valvular heart disease, either rheumatic or syphilitic, but frequently are associated with hypertension or coronary disease, or both. Pain, dyspnoea—often nocturnal—frequently pallor, lowered pulse pressure and collapse are the striking features; and in contradistinction to the rheumatic valvular cases, the rhythm is usually normal. Muscle failure occurs in acute infections and is nearly always ventricular in type. Diphtheria offers an example of this type of failure. The pulse pressure drops alarmingly, due in part to ventricular failure and in part to capillary paralysis. The effect of œdema on the utilization of oxygen by the tissues and the resultant metabolic disturbances are peripheral factors of importance in certain instances.

It is the group of cases associated with circulatory failure with which I am especially concerned at this moment. To these the term decompensation has been applied but congestive heart failure is a better descriptive term, for, according to Wenckebach, under certain circumstances the cardiac output of the failing heart—the heart showing evidence of congestive changes—may be normal or even increased for a time, yet coincident with this normal or increased output congestive changes occur, evidenced by slight breathlessness to profound engorgement of the venous system.

Mechanism of congestive heart failure.—In heart disease one chamber or side of the heart is involved to a greater extent than the other with rare exceptions. For example, in the earliest form of heart disease—congenital heart disease—various types of developmental defects throw an unusual strain upon one side of the heart, right or left. This strain may be for a time entirely borne by one chamber the auricle or ventricle, but usually the effect is noted both proximal and distal to the lesion. If the

Congestive Heart Failure.

compensatory process is adequate the circulation is maintained in spite of the defect—a condition which occurs frequently in congenital hearts, and unless infection causes an added insult to the heart, through endocardial infections or myocardial damage, this compensatory stage may continue for many years—in fact, through the normal life span; but should there occur an excess load through any cause, as infection, strain or anything which furnishes a demand in excess of that of which the myocardium is capable, there at once appears a different picture—congestive heart failure.

The next group of cases in order of age occurrence is the large one of rheumatic valvular heart disease. Here mitral lesions occupy the place of prominence, with the stenotic factor the most important. Pure mitral stenosis is a rare pathological finding, but in the combined lesion of mitral stenosis and mitral insufficiency the former is by far of the greater importance in the production of myocardial strain and ultimate failure. For a time the left auricle carries the load, but sooner or later this overstrain is reflected to the pulmonary circulation, and we have the first manifestation of congestive heart failure. This stage may be long or short but always the right ventricle receives an added load. If the patient be spared physical strain and infection, especially pulmonary, the ventricle may undergo considerable hypertrophy so that the evidence of circulatory failure is limited to signs of pulmonary vessel stasis; but if the coronary circulation is inadequate hypertrophy fails to develop, or if it has developed it may prove inadequate to the needs of advancing stenosis and a general systemic stasis develops—the last stage in this progressive process. I have discussed only one example of rheumatic valvulitis. Should the aortic valve the seat of the disease the resulting insufficiency will produce its effect on the left ventricle; however, the course is the same as with initial disease. With complete compensatory increase in the size and efficiency of the affected chamber the heart carries on as though naught had occurred; but failing in this, somewhere

the circulation shows a deficiency. If distal to the lesion, the signs will be those of malnourishment of tissues; of proximal, those of blood stasis. This then is in general the mechanism of congestive heart failure. It may appear in the forties with no antecedent history of heart disease. A recognised or unrecognised early syphilis may solve the riddle. At this age, likewise, the effects of hypertension become manifest in the heart; first hypertrophy and compensation, but with continued overload a final stage of dilatation and failure.

A last group we have to consider—the cardiosclerotics. In these the earliest manifestations of cardiac insufficiency are usually those of coronary artery narrowing, either slow and progressive, or the spastic type so frequently associated with the anginal syndrome. In these, circulatory stasis is not a striking feature; in fact, it may not occur at all or late.

Failure of the auricle plays a limited role in congestive heart failure, although the usually associated auricular fibrillation furnishes an added source of embarrassment to the already overtaxed ventricles; likewise, failure of one ventricle taxes the functional capacity of the other ventricle. In hypertensive heart disease, following the initial stage of hypertrophy of the left ventricle when the increasing load becomes too great for this chamber, dilatation occurs and, with this, relative mitral insufficiency. The left ventricle fails to pump the blood onward which comes from a still competent right ventricle, and the left auricle dilates. In time pulmonary vessel engorgement becomes so great that the right ventricle in turn dilates, and the last stage of congestive heart failure appears. Common precipitating causes of congestive heart failure are any sort of strain—at times that of strenuous effort—the changing of an automobile tire, a sudden sprint in one not accustomed, a too strenuous golf game. Sometimes it may accompany a trivial physical strain, a slight respiratory infection, emotional strain or an unwise meal. These may appear to be sole causes in certain cases, but a careful analysis of all factors will usually show a heart already seriously

Congestive Heart Failure.

damaged by valvular heart disease, by long standing hypertension, or by coronary artery disease. Other common basic causes are chronic pulmonary disease and thyrotoxicosis. With the latter frequently are associated rapid heart action due to auricular fibrillation and flutter, and paroxysmal tachycardia in which fatigue is an important factor. While all of these more frequently cause the primary failure on the left side, recent studies show the importance of pulmonary tissue changes and pulmonary sclerosis on the integrity of the right ventricle and the not infrequent failure of this chamber before there is any appreciable change in the left heart. Continental writers, and recently Coombs, have called attention to the real danger of cardiac failure in angular deformities of the spine through aortic kinking, inadequate pulmonary air spaces, and diaphragmatic restriction.

Age plays an important part in this process. Failure occurs in childhood, though infrequently, and then usually due to an extensive pan-carditis. More often even in the badly damaged hearts this is postponed until the sixth decade when coronary artery changes limit the blood supply to the overtaxed ventricles. It is questionable whether the undamaged heart may ever fail due to strain alone, but long continued functional tachycardia may so fatigue the normal muscle that it finally fails.

Pathology.—White calls attention to the unfortunate trend of modern teaching to overemphasize the importance of the myocardium and to underestimate the importance of the valvular lesion. The essential factor, however, remains the diminution in the systolic power of the myocardium. There is no pathognomonic lesion in congestive heart failure. While enlargement, due to both hypertrophy and dilatation, is usually found, this is by no means the rule. According to Clawson "approximately half of the cases of myocardial failure show no anatomical changes in the heart muscle." These cases he explains as due to an exhaustion of the heart muscle. In this

group fall the cases of myxedema heart and the heart in beriberi, both functional myocardial disturbances and both reversible by simple treatment; the former by thyroid extract, the latter by vitamin B. Harrison and his co-workers state that the thickness of the muscle fibres and the associated heart rate are of importance; the subjects with enlarged hearts have rates much faster than optimal and fatigue may result therefrom. While these hearts show hypertrophy and dilatation, there may be no other evidence of myocardial abnormality sequential to congestive failure. Two years prior to the reports of Blumgart these authors suggested that a subnormal heart rate would be beneficial to "cardiac fatigue" and thus suggested the basis of total thyroidectomy in congestive failure. The remote effects of congestive heart failure on other organs are those of local circulatory insufficiency—oedema—which if transient may cause no permanent damage, but if long continued compression changes and fibrosis may follow.

Another factor not sufficiently recognized in congestive failure is the venopressure mechanism that pushes the blood back through the veins to the heart. It is this that often fails and precipitates congestive heart failure. Y. Henderson has shown that if in a rabbit the pulmonary artery is clamped and the vena cava opened, 50 per cent of the blood of the body will flow out, showing that there is some other pressure than the heart behind the venous return. Henderson after 25 years' search for the cause of this venous push concludes that it is the tonus of the skeletal muscles, particularly those of the abdomen and diaphragm, and that this tonus is especially influenced by the state of the respiration. If respiration is depressed, the diaphragm is relaxed, lung capacity is decreased, skeletal muscle tonus is reduced, and circulation volume is decreased. Strychnine was widely used by the past generation of doctors as a circulatory stimulant. It is probable that it increases muscle tonus and thus increases the efficiency of the venopressor mechanism.

Symptoms of Congestive Heart Failure.—The earliest and most lasting symptom is dyspnoea. This may develop so insidiously that the patient is not aware of it, and only after a severe break does he realize that accustomed effort has for a long time caused undue fatigue and some respiratory distress. It may occur suddenly, as in the acute cardiac asthma of advancing years, and may or may not be associated with precordial pain. As these attacks of cardiac asthma become more frequent, Cheyne-Stokes respiration appears. In extreme cases of complete failure of this type may recur the symptoms and signs of acute pulmonary oedema. In all of these the cause is oxygen want in the respiratory centre due to increased cerebral venous pressure which diminishes the blood flow, leading to anoxemia of the respiratory centre; oxygen therapy is beneficial.

These are the cases described by Allbutt as "ventricular defeat"—the cardiac asthmatic with hyperpiesis who suffers nocturnal attacks following exertion of the day before. Adrenalin (or ephedrine) often relieves these by dilating the coronaries—a fact not well recognized.

Acute pulmonary oedema, a less frequent syndrome, is likewise usually nocturnal and always of grave prognosis; death frequently occurs in the attack. In these cases the left ventricle suddenly fails while the right continues to function with a disproportionate force, the result being that since the left heart fails to force the blood onward, there is rapidly increasing engorgement of the pulmonary circuit. While pain is not a part of the picture, excepting when this is associated with coronary thrombosis, the seizure is no less dramatic than in coronary thrombosis or angina pectoris. Allbutt, describing such an attack wrote "...Someone exclaimed, 'Angina pectoris.' Thoracic agony it was indeed, but dyspnoea is not a character of angina pectoris."

Sudden or paroxysmal right heart failure is a rare event, one-fourth as frequent as left ventricular failure excepting, as a

sequel of thrombosis of the right coronary artery or of an acute pneumonia; but slow progressive failure of the right heart is a common event in rheumatic heart disease and is characterized by its chronicity and tendency to occur in bouts from which the patient makes a partial recovery and may even live for several years. Contrast this with the failure of the left heart in syphilitic or hypertensive heart disease. Congestive heart failure with leutic aortitis rarely clears because the narrowed coronary orifices reduce permanently the blood supply to the left ventricle. In either the sudden or slow progressive type of right heart failure cyanosis and other evidence of venous engorgement dominate the picture.

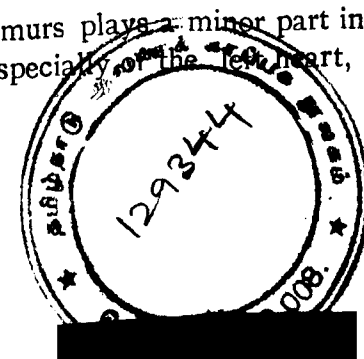
More commonly both the right and left ventricles are involved in congestive heart failure, though often disproportionately. Here signs and symptoms are due to the dual involvement. Dyspnoea becomes more constant and urgent, and orthopnoea supervenes. To slight cyanosis is added liver engorgement and dependent œdema, the former more readily noted in bed patients; in those up and about, œdema of the legs occurs first. A distended liver may be easily missed by placing the palpating hand too high on the abdomen. The "lumbar pad" may be the sole evidence of dependent œdema in the bed patient. In the ambulant patient there may be difficulty in the determination of the cause of the dependent œdema, especially in fat women with the present style shoe; but œdema due to peripheral causes, anæmia or debilitating disease rarely causes pitting except after exertion in hot weather. Slight puffiness of the feet and ankles is commonly encountered in those whose occupation requires standing without the massaging effect of muscular exercise of the legs. Pleural transudates may occur with any right heart failure. These are more frequent on the right, and should there be an old obliterating pleurisy, bizarre localization may be noted, as in one case recently reported by Steele of an interlobar pleural fluid in each of four attacks of heart failure.

Abnormal pulsation in the neck veins furnish accurate information of right heart failure and this increase in venous pressure, described as the positive venous pulse, usually precedes liver enlargement or they occur simultaneously. These patients are breathless, either at rest or with very slight exertion. In the presence of extensive lung changes, as in pneumoconiosis, pulmonary fibrosis or bronchiectasis, it is often difficult to determine to what extent dyspnoea may be due to associated cardiac insufficiency. Lewis has stated that "if it is established that a patient has no congestion of the venous system and is yet breathless in bed, then that breathlessness is not primarily cardiac in origin."

Vital capacity determinations may be of considerable assistance in determining the extent to which the pulmonary extensibility has been reduced by pulmonary vessel stasis. They do not add much in diagnosis after a careful physical examination, including inspection of the neck veins, has been made, but they may be of considerable value in the management of the patient and furnish some prognostic evidence.

Other signs of value may be mentioned: The protodiastolic gallop rhythm of ventricular dilatation and impending failure; pulsus alternans, the alternating strong and weak beat, recognizable oftentimes by palpation of the pulse—always by the sphygmograph and always a sign of left ventricular failure—in fact the only pathognomonic sign of pure left ventricular failure. This may not occur continuously but only for a few beats following a premature contraction; accentuation of the second sound at the pulmonary artery area, indicating an increased pulmonary vessel pressure, but not always of a failing heart; X-ray evidence of dilatation of one or all chambers of the heart; the fluoroscope offers much that is missed in the film, since the extent of systolic contraction may be estimated.

The study of murmurs plays a minor part in the determination of heart failure especially of the left heart, excepting that



murmurs frequently disappear with dilatation. Lewis has stressed the fact that in failure heart signs do not change much, but peripheral signs and symptoms change frequently. Demonstrable increase in heart size within a short period means dilatation or pericardial effusion; with this the sounds become more distant and less distinct; if effusion be excluded the picture is that of failure.

Blood pressure is usually diminished but not always; in fact, it may remain elevated, while the heart is dilating.

So far no mention of the *electrocardiogram*: What can it tell us of failure? Much can be told regarding hypertrophy of the right and left heart, practically all we need to know regarding myocardial degeneration, the arrhythmias, and conduction disturbances which so frequently initiate heart failure, but what of failure itself? In the absence of coronary artery disease low voltage is probably the sole evidence of the failing heart obtained from the electrocardiogram, and even this change has been noted in the absence of clinical evidence of failure.

Treatment: Since by the time congestive heart failure appears there is usually irreparable damage to the heart muscle, little can be expected from treatment but an amelioration of the distress resulting from functional failure. The average duration of life after the onset of symptoms of congestive heart failure is brief in all but the rheumatic and thyrotoxic cases and the small group occurring in the course of an acute infection. Romberg found this about six months in a group of poor patients; in those more fortunately situated it will be more. If the failure occurs in a bed patient little can be expected from treatment.

In spite of all of the advances made in other fields of medicine rest and digitalis remain our sheet-anchor.

Rest will vary from a simple elimination of the types of strain which precipitate the mild attacks to the complete and absolute bed rest required in the failure secondary to a coronary thrombosis.

Where absolute bed rest is necessary the physician too often errs in allowing a resumption of effort at too early a date. In the patient who requires a long continued bed regime attention should be paid to back rest, or, better still, an adjustable bed of the type of the Gatch bed, or one devised by Lewis in London and recently modified by White in Boston. I have seen patients perform more work in bed than they would have in being assisted once or twice a day into an easy chair, and more work in the use of the bed-pan than in being lifted to a commode. The old-fashioned rocker is a convenient substitute for a special bed since it can be adjusted to any position; if not so adjusted it should be blocked to prevent tendency to rock in such a chair, which entails no small amount of work in the course of an hour or so. Rest should also imply rest from disturbing factors. One who has passed through a personal hospital experience knows how frequently the kindly visitor saps the energy.

Digitalis: The most frequent error is that this drug is not given in sufficient doses. In urgent failure, when the drug has not been given in the preceding week or two, the massive method of Eggleston or some modification is desirable. Eggleston gives within twenty-four hours 1.5 gr. of the dried leaf or 1.0 c. c. of the fat-free tincture to 10 pounds body weight. Most doctors have their personal likes as to preparations. Mackenzie and Wenckebach stated that life was too short to learn all they needed to know about one form of this drug. If a dependable dried leaf is available, it is probably preferable, but for most of us a dependable fat-free tincture is preferable because there is less chance of deterioration. In the presence of nausea and vomiting the intramuscular injection of fat-free tincture is advisable because all of the gastro-intestinal tract is oedematous and non-absorptive. In case of generalized oedema it may be necessary to give a water soluble digitalis intravenously, although this method carries a greater degree of risk than does the intramuscular method; in the majority of cases the oral administration of digitalis is preferable. When large doses are given or the

drug is employed over long periods, the toxic effects of the drug should always be constantly looked for. In addition to the usual anorexia, nausea and vomiting at times diarrhoea, and the direct cardiac effects such as slowing irregularities due to premature contractions one may encounter visual disturbances of equal significance sometimes preceding any of the above mentioned symptoms of cumulative effect. Withering noted that under these circumstances all objects appear green and yellow, at times red and blue, or take on a snow or hoarfrost appearance. All of these are increased in the sunlight and to a less extent by artificial light. Dim, veiled, cloudy or cottony vision may likewise occur. In none of these is the mechanism clear. Delirium may occur rarely as an unusual toxic symptom.

For the relief of cardiac oedema digitalis is ordinarily the best diuretic. If this is inadequate, one may employ mercury and for this purpose novasurol or salyrgan (1 or 2 c.c. intramuscularly) are often followed by significant diuresis. Because it is attended by less renal irritation, salyrgan is more frequently employed and best preceded a day or two by ammonium nitrate or chloride—in fact, often these latter drugs alone suffice. Recently urea has been administered in cardiac oedema. This acts as a diuretic without impairment of the kidneys and capable of use over long periods. The purin diuretics—caffeine, theobromine and theophylline—are less spectacular in their results and are more liable to cause nausea. Any of these is often more effective after tapping the pleura or abdomen. Likewise, a distended bladder in the male may seriously interfere with diuretics. Incision of the legs by multiple punctures or Southey tubes may be employed in oedema not responding to other methods. In the use of any diuretic the daily record of fluid intake and output and of weight loss is most important.

The method of venesection used by the earlier generation of doctors is too little used to-day. In the presence of urgent pulmonary congestion the removal of 300 to 600 c.c. of blood is usually followed by prompt improvement in symptoms.

Congestive Heart Failure.

Diet plays a minor part in cardiac therapy so long as a light diet is employed. One should prohibit a heavy evening meal for most cardiac patients. A light supper will often prevent the occurrence of pre-existing nocturnal dyspnoea. In cases where there is marked oedema the diet or Karell—800 c.c. of a milk a day for a few days—may act as an effective diuretic, to be followed later by a modification of the same by adding the usual light diet. In certain instances there appears to be a relationship between oedema and the sodium-potassium ratio in the diet. By substituting potassium for sodium, especially in non-valvular heart disease, a marked diuresis may be obtained. While the evidence is somewhat conflicting as to the role of salt in hypertension, it is probably wise in this condition, with or without oedema, to restrict the salt intake.

In any case of sudden failure associated with marked dyspnoea, with or without pain, morphine will be of equal value to digitalis. The relief is prompt and permits the rest so sorely needed. Codeine, pantopan, bromides, and barbitals may be used in less urgent situations. In acute pulmonary oedema atrophine may be advantageous.

In severe cases oxygen therapy by the open or by the closed (tent) method will be of great assistance. The cyanosis improves, the patient breathes without so much effort, rest is obtained and diuresis may continue one to several weeks after the withdrawal of oxygen. The effect of too sudden withdrawal will prove conclusively the advantage of the procedure.

Experimental evidence shows that glucose furnishes a temporary increase in the supply of carbohydrate, especially to the respiratory centre. Feeding appears to be preferable to the intravenous route because in the latter the increase is of short duration. It may act as a cardiac stimulant, but Smith and Luten claim that it is not effective in restoring and maintaining compensation. Yet there appears to be sufficient clinical evidence to justify a continuation of it in threatened or actual failure.

Coramine, a synthetic drug, pyridine-beta-carbonic acid-diethyl-amide, has recently been introduced as a substitute for digitalis. It is claimed that there is no cumulative effect, no nausea in full doses, and that it is especially effective in the control of cardiac asthma. My personal experience is that the same results may be usually be obtained with the proper use of digitalis.

Quinidine is not used in the presence of congestive heart failure because of the danger of embolism, but it is of distinct advantage in the prevention of failure since the re-establishment of a normal rhythm before failure sets in will remove an important factor (auricular fibrillation) which contributes to the onset of failure in these cases.

Thyroidectomy: In the past years several reports have appeared from Boston. Bulmgart and his co-workers have presented a group of 40 cases of congestive heart failure which had not responded to the usual methods of management. In about one-half of these there has been "economic rehabilitation" over a period of three to sixteen months following the total removal of the thyroid gland, in consequence of which there was a marked reduction in the basal metabolic rate. Time will not permit an extensive discussion of this new procedure. It is certainly radical but there is both theoretical and clinical evidence in support of the contentions of these workers.

There remains one more drug to mention, epinephrin, of chief value in vasomotor collapse, likewise in acute pulmonary oedema, although acute pulmonary oedema has been known to follow its use. It is of great value in certain cases of cardiac asthma, acting as a coronary dilator and cannot be considered as a means of differentiation between cardiac and bronchial asthma. Two recent personal experiences show that a similar effect may follow the use of ephedrine. Epinephrine is the only means for the relief of cardiac standstill, in which case it must be injected

Congestive Heart Failure.

into the heart muscle. Because of its pressor effect it is to be avoided in angina pectoris, coronary thrombosis and aneurism.

The picture is not alluring; save in the rheumatic cases the progress in downward following the first failure; we have barely scraped the surface in demonstrating what may be done in the preventive management of our cardiac patients. The real future of cardiology lies in that direction.

A Case of Syphilitic Aortitis.

(REPORTED WITH THE KIND PERMISSION
OF CAPT. M. GERARD KELLY, I.M.S.)

BY E. A. SHANKAR, FINAL YEAR M.B.

K. M.—A Hindu male bachelor aged 25 years was admitted into the General Hospital on the 27th of August 1935. There was nothing remarkable in his family history; the patient had a vague memory of a fever with swelling and tenderness of his joints two years ago and remembered having general anasarca a year prior to that.

Three years ago patient started having attacks of dyspnoea, palpitation and precordial pain once every two or three months; he also had attacks of syncope and exhaustion during then.

The usual attacks started towards evening with dyspnoea, precordial fluttering, and pain in the chest; the pain was substernal, radiated to the back, left side of the neck and left shoulder. There was a special liability for it to occur after food. He had tinnitus aurium and giddiness.

During attacks, he took alcohol to relieve it.

A fortnight before admission he had one of his usual attacks. There was orthopnoea, continuous pain disturbing sleep, and brick-coloured sputum after occasional coughing; the attack persisted.

The patient's general condition on admission was poor. He was wasted, with pale features, and cold moist extremities; a suggestion of cyanosis was present. There was moderate clubbing of his fingers; he looked anxious; there was visible throbbing of the patient's body and pulsation of his blood vessels. He had no oedema.

On physical examination, the pupils were equal, contracted and reacting well to light. There was precordial bulging; a diffuse heaving cardiac impulse; jugular and carotid pulsations were well marked and there was universal pulsation of the arteries. The veins were engorged.

A Case of Syphilitic Aortitis.

109

The apex beat was in the sixth interspace in the left midaxillary line. There was a palpable systolic thrill in the aortic area conducted upwards. Percussion revealed extension of dullness to the left midaxillary line, and slight enlargement to the right. There was definite impairment of the percussion note over the sternum at and above the level of the second interspace extending $\frac{1}{2}$ " to the left and 1" to the right beyond the sternal margin indicative of dilatation of the aorta.

There were double murmurs in all the areas, heard loudest at the aortic area.

In the aortic area the systolic was very loud, harsh and conducted upwards right up to the lobe of the right ear; it replaced the first sound. The diastolic murmur was softer and prolonged. It was conducted obliquely downwards and to the left.

In the mitral area there was no other evidence of organic mitral disease.

The pulse was of the Corrigan type; the rate between 80 and 90 per minute; rhythm regular; the force and tension normal; the pulse volume was normal and the artery empty between beats. The blood pressure was 135/25 mm. of mercury. The arterial wall showed no signs of sclerosis or degeneration.

The liver showed slight enlargement and tenderness. The lungs showed slight signs of basal compression and passive congestion. The urinary output was fairly good. There were no protein and no casts in the urine. The blood gave a strong positive Wasserman reaction. The skiagraph report was "Considerable enlargement of the left ventricle and the aortic area".

Discussion.—The two leading symptoms are Dyspnoea and Pain.

A longstanding paroxysmal dyspnoea specially prone to occur on exertion, after food, during the evenings, and definitely not asthmatic in a man aged 25, associated with variable cough is almost invariably due to cardiac disease. Since there are well marked physical signs of cardiac lesions and nothing in the lungs except slight signs of

compression and passive congestion, with the negative urinary findings it may be assumed to be of cardiac origin.

A well marked blowing diastolic murmur in the upper precordium, conducted downwards, with signs of left sided hypertrophy, the water hammer pulse, and the general pulsation and throbbing indicate fairly definitely aortic incompetence.

The aortic systolic murmur and thrill are very suggestive of an organic aortic stenosis; but the contradictory rheumatic history, the abnormal dulness over the Manubrium Sterni, and the strongly positive WR point to Syphilitic Aortitis. In the presence of syphilis of the aorta, stenosis is precluded, in as much as it is impossible for stenosis to occur, since the inflammatory changes in the wall lead to dilatation of the ring before stenosis could occur. The pulse is also water hammer in type without any modification due to concomitant stenosis. The systolic murmur and thrill must presumably be due to a relative aortic stenosis due to dilatation of the first part of the aorta. So organic aortic stenosis can definitely be ruled out.

From the point of view of pain, the pain is presumably anginal, due to strangulation of the coronary mouths by the syphilitic process and the dilation of the aorta. It is probably accentuated by the cardiac failure.

The absence of pressure symptoms like dysphagia, differential pulse, etc., signs like altered sizes of the pupils, etc., the negative physical signs of an aneurysm either of physical signs or symptoms and the skiagram definitely exclude aneurysm of the aorta.

The age, duration, the contradictory rheumatic history, the positive WR, the clinical and confirmatory X-ray findings naturally lead us to assume as the only solution, Syphilitic Aortitis, of the first part.

This has caused weakening of the aortic wall leading to diffuse dilatation and the aortitis has involved the coronary orifice leading to anginal pain, due to cardiac ischaemia. It has encroached upon the aortic valves leading to incompetence.

Diagnosis.—SYPHILITIC AORTITIS; Secondary congestive failure with normal rhythm.

A Case of Syphilitic Aortitis.

Prognosis.—Definitely grave.

Treatment.—Absolute rest in bed propped up high with pillows or backrests; continuous oxygen inhalation through a nasal catheter.

A Mixture Recipe

Pandigal	M 45
Glucose	Oz i
Tr. Nux Vomica	M 30
Spts. Amm. Arom.	} a a M 90
Spts. Etheris	
Aqua Chlorof. ad	Oz iii
F. Mist	i Oz. thrice daily.

Bromidia or Omnopon and Atropine at bed time for the relief of pain and procuring sleep.

Bowels regulated by mild aperients or enemata.

Diet.—Light nutritious fluid diet.

Outcome.—Patient went home much improved and the pain partially relieved, on 20th September 1935.

A Case Report

A Case Report.

(From Dr. S. Venkatasubba Rao's Ward.)

BY V. S. SUBRAMANIAN, V YEAR STUDENT.

**CHRONIC MYELOGENOUS ALEUKAEMIC LEUKAEMIA.
(OF EOSINOPHILIC TYPE.)**

Name.—Thammayya. Residence.—Govindapalayam—Vizag Dt.
Caste.—Hindu Admitted on—19.1.36.
Occupation.—Clerk. Duration.—16 months.

Complaint.—Weakness and inability to do hard work, due to a heavy tumour in the belly, and also indigestion with very poor appetite.

Previous History.—In 1927 he suffered for about a month and a half from fever of the intermittent type, coming on daily with rigor and followed by perspiration. Two months later he had swelling of legs followed by swelling of genitals and fluid collection in the abdomen. He took some Indian Medicine for the same (mercurial preparation as the patient says) and though he had some immediate relief for the swollen condition of the body, he developed swelling and bleeding from the gums, within a month, accompanied by vomiting and diarrhoea, with traces of blood in both. Subsequently, the patient says he was very much emaciated and also that he developed some dyspeptic complaints.

In 1934 September the patient came to Madras, and in October he suffered from fever with cold, which lasted for a week, and he was told by a doctor that it was influenza. Then he was also told by the doctor that he has got enlarged spleen. From that time the patient says that it has grown up very much.

On 20th December 1935, he got a severe attack of dysentery which lasted for 6 or 7 days and he was passing 20 to 30 motions per day with blood and mucus. He underwent treatment in an Ayurvedic dispensary.

General Condition on Admission.—Patient was fairly well nourished, not anæmic, eyes were sunken and skin wrinkled. Teeth were dirty, tongue clear and moist. He had no breathlessness, no jaundice and no dropsy in the legs or anywhere else except the abdomen.

Alimentary System.—Abdomen was swollen, better marked over the flanks. There were no prominent distended veins, and no eversion of the umbilicus. The swelling was more marked over the left hypochondrium, and there was no pain or tenderness anywhere. Small quantity of fluid was present as elicited by shifting dullness, though no fluid thrill was present. The fluid was once aspirated, (more for investigation purpose) and subsequently no increase in the ascitic fluid was noticed. He gave no history of hæmatemesis.

Measurements of the Abdomen:—

Round the umbilicus	30½	inches.
1" above the umbilicus	32	"
1" below the umbilicus	29	"
From umbilicus to Anterior Superior Iliac Spine	} right 6½" left 6½"	
From umbilicus to tip of the 9th Costal Cartilage	} right 6" left 7"	

Spleen was very much enlarged with slightly uneven surface, but was not tender. It was firm to feel, and the notch could be easily felt. It extended as far as the left parasternal line anteriorly, and 4 finger breaths below the umbilicus in the nipple line. Its boundaries were as follows:—

—	Nipple line.	Mid Axillary line.	Interior Scapular line.
Upper Boundary ...	6th rib.	7th rib.	11th rib.
Lower Boundary ...	3" below umbilicus.	Ant. Sup. Iliac Spine.	—

The total length of the spleen in its long axis was more than 14 inches.

Liver was not palpable. In fact it was slightly shrunk by about $\frac{1}{2}$ inch above the costal margin in the nipple line. The upper boundary was normal.

Other Systems.—Nil Abnormal.

Investigations done.—

- (1) Urine.—No sugar. No albumen.
- (2) Blood Picture.—No malarial parasites. Leucopenia with eosinophilic preponderance.
- (3) Gel and Chopra's tests.—Negative.
- (4) Van Den Bergh's Reaction.—Direct = Negative. Indirect = Positive.
- (5) Kahn's and Wasserman's reactions.—Negative.
- (6) Blood Pressure.—Systolic 90 and diastolic 55.
- (7) Levulose tolerance test.

Before Levulose	= 0.077 %	
$\frac{1}{2}$ hour after „	= 0.083 %	= Normal
1 hour after „	= 0.09 %	
2 hours after „	= 0.1 %	
- (8) Fragility of R. B. C.

Lysis of R. B. C. in	
0.3 % Saline	= + + +
0.35 % Saline	= + + = Normal.
0.4 % Saline	= +
- (9) Blood Cholesterol.—208.9 mgrms. % = Almost normal.
- (10) Biochemical Examination of Ascitic Fluid.—

Albumin	= 1.25 %
Globulin	= 0.5 %
Chlorides	= 300 mgrms.
Sugar	= 0.111 %
- (11) Fractional test meal.—Achlorhydria.

(12) Haematological Examination.—

(Done on 20-1-36.)

Total R. B. C. = 4.06 mills. per. c.m.m.

„ W. B. C. = 6875 per c.m.m.

Differential Count.

Polymorphs = 17 %

Lymphocytes = 12 %

Monocytes = 1 %

* Eosinophiles = 70 %

Total Platelets = 62500 per. c.m.m.

Reticulocytes = 0.4 %

Haemoglobin = 68 %

Halometric Reading = 7.64 microns.

Colour Index = 0.85.

(Done on 11-2-36.)

Total W. B. C. = 5616 per. c.m.m.

Differential Count.

Polymorphs = 25 %

Lymphocytes = 12 %

Mast Cells = 1 %

Eosinophiles = 62 %

[Of these 62 % Eosinophiles 45 were double lobed, 8 single lobed and 7 treble lobed.]

The 8 % single lobed Eosinophiles indicates the presence of immature cells. No other types of Myelocytes nor any abnormal R. B. C. were noted.

(13) Foeces examination.—No parasites. Nil abnormal.

Differential Diagnosis.—Before discussing the differential diagnosis of the case, the following are the important points from the investigations and clinical examination of the patient that has to be borne in mind. They are :—

(1) Marked Splenomegaly (2) Abnormal Eosinophilia and (3) No leucocytosis. (4) Slight anaemia, as the colour index was 0.85, though the R. B. C. count was 4.06 millions per c.m.m. (5) Presence of few immature eosinophiles as there were 8% single lobed ones. (6) Presence of small quantity of ascitic fluid more of the exudative type as albumin content was 1.25 %. (7) No cirrhosis of the liver worth mentioning. (8) No jaundice. (9) No increased fragility of R. B. C. (10) Normal Blood cholesterol. (11) History of dysentery 2 months back. (12) History of malaria-like fever 8 years back. (13) No relative mononuclear increase. (14) Achlorhydria and (15) Positive Indirect Van Den Bergh and, (16) During his stay in the hospital he had no fever at all.

The differential diagnosis can be divided into two main classes, viz., (I) those wherein eosinophilia is of pathological significance and (II) those wherein eosinophilia is not of pathological importance. I venture to mention the latter heading because the text book of Price describes a condition of hereditary eosinophilia, manifesting itself in different members of certain families, and where the eosinophiles

function in place of neutrophiles. Also Dr. Reddy, the ex-clinical pathologist of our hospital says, that he has met with at least 4 or 5 individuals in normal conditions of health with marked eosinophilic preponderance, i.e., above 50 per cent eosinophiles

I. *Condition where Eosinophilia is pathological.*—Eosinophilia is said to occur in the following conditions, viz., parasitic infections, skin diseases, asthma and hay fever, convalescence from acute fevers, Hodgkin's disease, etc. These conditions have been ruled out not only from examinations of (a) faeces for parasites, (b) absence of skin diseases, (c) absence of asthma and (d) examination of blood, but also from the fact that marked splenomegaly is not associated with any of these conditions except perhaps Hodgkin's disease. But in Hodgkin's one would expect one or other groups of glands to be markedly enlarged, with a history of characteristic fever, and also the duration of the disease with the present condition of the patient are all not in favour of Hodgkins.

The only other condition that we can think of where eosinophilia is pathological, is the leukaemia of eosinophilic type. But the total W.B.C. count shows no leucocytosis and therefore if we can still call it leukaemia, it can only be "chronic myelogenous aleukaemic leukaemia of the eosinophilic type." The splenomegaly and also the finding of 8 per cent of single lobed eosinophiles, (which clearly indicate the presence of immature eosinophiles in the blood stream) are in favour of this diagnosis. Of course the probability of such a case is remote but the possibility cannot be disputed. Moreover, the latest edition of Price's text book of medicine mentions under a separate heading of "Eosinophilia with Splenomegaly" (synonym *Eosinophilic Leukaemia*) "a syndrome in which enlargement of the spleen is associated with persistent eosinophilia. The course of this condition is described as benign, with absence of anaemia and presence of only small percentage of myelocytes, with eosinophilic percentage between 20 and 80. Perhaps the case we are discussing about is of this type of eosinophilic leukaemia. The book says that some of these are acquired on a basis of syphilis, malaria, hepatic cirrhosis, Hodgkin's disease and other known causes, while some others remain obscure. For such cases it is also mentioned that splenectomy is contraindicated, as it aggravates the eosinophilia.

A Case Report

2. Now with reference to the various differential diagnosis, where-in eosinophilia is considered as hereditary and not pathological, we can further subdivide these conditions into two main classes, viz., (a) those with the possibility of single disease and (b) these with the possibility of 2 or 3 diseases being present together.

II. (a) *Single diseases associated with Splenomegaly, where eosinophilia is not of pathological significance.*

(1) *Chronic Malaria.*—No doubt the patient gives a history of 45 days of malaria like fever eight years back. But his present condition with no relative mononuclear increase and no marked anaemia or emaciation, and with the presence of exudative fluid in the peritoneal cavity is not at all in favour of chronic malaria.

(2) *Chronic Kala-azar.*—The patient does not come from an endemic area. Moreover one would expect a patient with such a long duration to be more emaciated with a relative mononuclear increase. Also Chopra's test and Gel test are negative. Again there are no pigmentations of skin and mucous membranes and no history of fever as one would expect in chronic Kala-azar. So all these points conclusively exclude the possibility of Kala-azar.

(3) *Myeloid Leukæmia.*—Mere clinical examination of the patient must strongly suggest the possibility of Myeloid leukæmia, since the spleen is greatly enlarged, with no other enlargement of any other groups of glands. But the leucopenia with no increase in polymorphs, or any abnormal cells as myelocytes or abnormal red cells, and absence of anaemia are against the ordinary type of Myeloid leukæmia.

(4) *Banti's Syndrome.*—Even though splenomegaly and the suggestion of small liver with little fluid in the peritoneal cavity were present, the classical signs and symptoms, such as anaemia, cirrhosis with marked ascites and jaundice, tendency to hæmorrhages especially from the stomach, low colour index as '6 or so, the typical bronzing or pigmentation of the skin, and the associated symptoms of anaemia, like oedema, dyspnoea, hæmic bruit, albuminuria, etc., were absent in this patient. So the mere presence of splenomegaly is not sufficient to diagnose the case as Banti's Syndrome. Moreover the liver came up to the normal size when the patient was discharged.

(5) *Metabolic diseases as Gaucher's disease*—But Gaucher's disease is more in children, familial in character, and is said to be associated with secondary anaemia and hæmorrhages. Moreover there seems to be no evidence of metabolic disturbance in the patient, as the blood cholesterol and pulse rate were normal. Though the definite diagnosis is said to depend on the finding of Gaucher's cells in the splenic pulp, since none other factors were in favour of this condition, Gaucher's disease was excluded.

(6) *Cirrhosis of liver*.—Although such a huge spleen is said to be quite possible in cirrhosis of the liver, there was no marked cirrhosis (in fact the liver became palpable when the patient was discharged) which could give rise to such a huge spleen, nor was the ascitic fluid as large in amount as one would expect in cirrhosis of the liver. Further there were no prominent anastomotic veins seen over the abdominal wall, nor did the patient give any history of hæmatemesis or piles. So cirrhosis of liver is too far fetched to think off.

(7) *Pernicious Anæmia*.—No doubt the presence of achlorhydria and positive indirect Van Den Bergh are strongly in favour of P. A. Splenic enlargement, though not so big is quite possible too. But there were no marked reduction in R. B. C. total count as would be expected in P. A., and the blood film showed no megalocytosis poikilocytosis or anisocytosis which are the diagnostic features of P. A. Moreover the colour index was less than 1, viz, 0.85. The classical symptoms like pale, flabby countenance, soft pulse, breathlessness on exertion, etc., were absent in the patient. Therefore the possibility of P. A. with splenomegaly was ruled out. Also there were no signs and symptoms of sub-acute combined degeneration.

(8) *Perisplenitis*.—The presence of small quantity of exudative type of fluid in the abdominal cavity plus the enlarged spleen are expected in perisplenitis. But it is said to occur in association with diseases in which splenic enlargement is a feature as in septic endocarditis, leukæmia, acholuric jaundice and Vacquez's diseases. Moreover in perisplenitis pain is the chief symptom and friction both palpable and audible is the diagnostic sign. Since neither of these were present why think of Perisplenitis?

A Case Report

2. (b) Apart from the individual diseases associated with Splenomegaly, which were discussed above, the possibility of two or more diseases being present together should not be forgotten. They are as follows:—

(1) *Chronic Malaria and Post dysenteric Ascites*—This condition is quite possible as the patient gave a history of Malaria like fever 8 years back, and also a history of dysentery 2 months back. Post dysenteric ascites has been described by Major-General Megaw as one of the frequent causes of ascites, which he describes as due to mild peritonitis set up by the bacterial toxins, giving rise to fluid collection in the peritoneal cavity. Also the fluid was not so great in quantity as would be expected in cirrhosis of the liver. But as discussed above, the points for chronic malaria were not present in the patient.

(2) *Chronic Malaria and Cirrhosis of liver*.—The patient might have had some enlargement of the spleen from chronic malaria and cirrhosis of liver which might have set in recently (16 months back) might have further increased the size of the spleen. But as mentioned above, in discussing the separate conditions, points were not in favour of chronic malaria, and also there was not any appreciable fluid collection in the peritoneal cavity. Further, the liver increased in size during the stay of the patient in the hospital and the peritoneal fluid almost completely disappeared. So we are not justified in putting together two separate improbabilities as a possibility.

Diagnosis.—From all the conditions discussed above, the only two possibilities are, in the order of their importance.

(1) Chronic myelogenous aleukæmic leukæmia of the eosinophilic type, or otherwise described as "Eosinophilic leukæmia or Eosinophilia with Splenomegaly" in Price's text book of Medicine.

(2) Chronic malaria (?) + post dysenteric ascites + hereditary eosinophilia.

Of these the former is more likely than the latter.

Treatment and Progress.

Treatment given—(1) The patient was put under Arsenic, in the form of *Liquor Arsenicalis* in gradually increasing doses, starting with 3 minims dose.

(2) He was also given dil Hcl and pepsin for his achlorhydria and dyspeptic complaints. It is also proposed to give him liver therapy.

Progress noted—(1) The size of the spleen went down by about two finger breaths, and also it is not so hard.

(2) The liver slightly increased in size to about one finger breath below the costal margin.

(3) The patient improved in general health and also in digestion, and he became more energetic and cheerful.

He was discharged on 13th February 1936, for further treatment in the out-patient.

I have to thank Dr. S. Venkatasubba Rao and Dr. Govinda Reddy for having given me valuable suggestions and also permission to report this case.

Our Men and Things

BY ARVY.

(Vizag-Hospital-dogs-tennis and what)

There has been a sudden shifting of scenes in the drama of life. The zone of my innocently mischievous activities has been transported from the bustle and turmoil of the metropolis to the uninteresting quietitude of the Brighton of the East. Brighton of the East indeed! the person who is responsible for this undeserved hyperbole and perhaps grotesque comparison must have had an extraordinary sense of humour to indulge in such a rude joke at the expense of poor Vizag. I want to ask that witty individual what induced him to give Vizag that fantastic appellation. Is it because it has also an extensive beach desolate and deserted, bleak and barren, dark and gloomy at night owing to man's wholesome fear of marring nature's beauty by installation of electric lights and offensive and repellent to the olfactory sense through the perpetual stench emanating from human excreta and fishermen's nets? Or is it because he mistook the humble thatched abodes of the innocent fisherfolks for the summer huts found in hundreds in the beach at Brighton?

Of course Nature has been sufficiently generous in its offerings to Vizag not in the least step-motherly in its attitude. The belt of hills around, the over-hanging cliffs near the sea, the extensive marina, the beautiful uplands, and not to speak of the Dolphin's nose projecting into the sea, proud of its unique position as the daring sentinel for the foiled circuitous wanderer of the waves, are some of the aspects of Nature which any city can be proud of with sufficient justification. But unfortunately man has till now refused to co-operate with nature, to enhance the beauty of the city, by converting the sombre grandeur of the wilderness to a picturesque plot through artistic embellishments.

Our city no doubt is like the wild flower born to blush unseen and waste its fragrance in the desert air owing to man's inexcusable negligence born of reluctance to rouse himself from the stupor of

indolence and indifference, to round up its oddities and angularities and to cure it of its crudities by which process alone can any city entertain hopes to rank among the sublime and the beautiful. Brighton of the East indeed; with a third of its population lodged in those thatched abominations, insufferable blots on the landscape, the very antithesis of modern sanitation, and the breeding ground for all the epidemic diseases that never fail to make their annual visitations and claim their toll of customary devastation, and practically the rest of the inhabitants huddled together inside insanitary and totally inartistic masonries lining up narrow winding lanes which are used not only as public throughfare but also as abominable repositories of rubbish and as sewage channel; Vizag has as little claim for being called the Brighton of the East as the turkey has with all its vanity for the beauty of peacock's picturesque wings. Vizag can be proud of the bounties which Nature in a moment of generous weakness has supplied it. But Vizag will rise in rebellion against man for misusing and destroying its natural beauty and emphatically protest against those who are positively rude to it for making invidious comparisons and undeserved appallations.

No! I am not at all hard on the poor city; nor do I mean to assume an attitude of absolute pessimism as I am full of hopes for the future, hopes that spring eternal in the human breast, hopes not forlorn but fully justifiable. I anticipate for it a bright future when through its commercial prosperity consequent on its possession of an exceedingly beautiful and safe harbour which will form the only communication for central India to the outside world, when the unwilling hands of man will be forced to utilise and augment the resources of nature for the perfection of a 'vision beatific.' Then and only then will the rude joke about the Brighton of the East be no longer a joke but a stern reality.

But I am wandering. Brighton of the East took the wind off my sails and consequently my frail vessel was made to travel for a moment at a tangent. I am more concerned with the Hospital and its people where and amongst whom I want to find victims for my crude dissection. The atmosphere of excitement and unnecessary hustle which characterise the metropolitan hospitals is to totally absent here. There is no hurry about anything not even in the operation theatre.

Our Men and Things

Qualities of unperturbable calm and a stolid slowness are so ingrained in the bones of not only man but also beast that neither the tremors of a devastating earth-quake nor even the conflagration of a volcano will spur either of them to any kind of unusual activity. Their equanimity is enviable. Even the animal dragging the cart on the road will have its own slow and deliberate way, unperturbed by the persistent goadings and pullings by three bandimen who make ineffectual attempts to control its moorings. Neither love nor money will be a temptation to spur the ward attendant to any form of extra activity. Even the beastical inhabitants of the hospital, I mean the dogs whose numerical strength is any day greater than that of the human inmates of the institution (the hospital being **unique** in its hospitality both to man and beast are provokingly slow, perhaps disrespectfully slow, caring two hoots for their human comrades. No wonder therefore that the doctors are compelled to take things easy and assume an attitude of philosophic calm, living in the pious though not forlorn hope that things will be done one day or the other in their usual slow course. Jolly set of fellows they are, doing their work to their satisfaction in an atmosphere of co-operation, each finding pleasure in the company of others not only in the X-ray room through the kind courtesy of its present incumbent but also in the tennis court.

The staff tennis court is an institution by itself. Though new to the language of the court I am slowly imbibing it, the slowness of course being derived by infection and contagion. The language as I say is totally different from the common language of ordinary social intercourse. I presume it is due to the fact that you are made to conform to an artificial perhaps false sense of courtesy and etiquette. If politeness consist in giving expression to the opposite of what we feel, then the language of the tennis court is hyper-polite and hyper-refined. Your expression of profound sorrow when your opponent had the misfortune to commit double faults like me, or when he sends the ball sky-scraping or in search of new fields and fresh pastures beyond the screen or when he makes ineffectual bombardment of the net while you are all along chuckling within yourself at the effortless gain of a point is the hall mark of tennis court politeness. You have no place in the court unless you are familiar with such expressions as "dubs," "right," "fault," "no," "out," "excellent," "beauty," "marvellous," "wonderful," "sorry partner," "hard lines",

"service", "Oh! lovely", "kill", "murder", "Sultan", and last but not the least "shot". The uninitiated passer-by who is ignorant of the court language may sometimes jump with horror when you shout with wild excitement "shot partner!" thinking that somebody is actually giving up his ghost as a result of the shot.

These are things common to all tennis courts. But the staff court in K. G. H. is unique in that it is the only place where the members can meet and chat as there is no provision made for a common room within the walls of the Hospital. There is not a subject in the world which is not talked about by the members while they sit on those two rickety benches waiting for their turns to play, from the intricacies of high finance to the purchase of a gunny bag of rice including of course all the problems and scandals of departmental politics. There is however a healthy atmosphere of co-operation and comradeship, where the psychological complexes of superiority and inferiority are studiously eschewed and avoided by common consent of both high and low. That is the secret of its popularity. The tennis court helps to round up all individual angularities and to bring about a better understanding between the members of the staff. That is why I consider it an Institution by itself, a thing unheard of in the metropolitan hospitals.

Rest in my next.

The Doctor in Literature

The best Education for a man of letters.

In the course of a lecture recently delivered before the Royal Society of Literature, from which extracts are published in "John O'London's Weekly" Mr. Francis Brett Young, said:—

If ever a parent were to ask my advice—which is extremely improbable—as to what to do with a son who wanted to be a man of letters, my answer would be, give him a doctor's education, and I should justify it by an enormous list, full of some of the most remarkable names in English and foreign literature, of doctors who have turned authors to the great benefit of humanity.

It is a long list, I cannot do justice to it in this short hour. But ever since those dark days in which medicine was no more than a cult of superstitions, it runs without interruption through the story of literature. Let me mention a few names. Rabelais and Sir Thomas Browne, Lodge and Campion, the Elizabethan poets. Vaughan the Silurist:

FROM LOCKE TO TCHEKOV.

In the same century, Locke the philosopher. In the next, the poets, Garth and Akenside, and that great human writer. Crabbe: the gentle Goldsmith, the harsh, manly Smollett. Then, precious names for all of us, Keats and Shelley. I don't think it is generally known that Shelley walked the London Hospitals at the same time as Keats. In the 19th century, Francis Thompson, whose medical knowledge colours some of his finest images, as in that well-known anatomical description of the human heart: "Arrased in purple like a house of kings." And that wise essayist, Oliver Wendell Holmes. In our own, Robert Bridges, the greatest poetical influence of my own generation, and Anton Tchekov, to whom the modern novel owes so much and the modern short story almost everything.

RELIGIO MEDICI.

It is a bald list, of course, and yet, in the work of all these writers, different as they may seem, there are qualities which seem to owe some-

thing definitely to medical experience. What are those qualities? Let us look for them in the work of my first example—Sir Thomas Browne, the physician of Norwich, whose *Religio Medici* and *Urn-Burial* are among the most precious monuments of English prose. Browne makes a beginning fortunate to my subject; for he, my earliest English example, presents us with the typical doctor's point of view so markedly that one might almost say that every doctor who has written since has a little of Sir Thomas Browne in him—with the possible exception of M. Clemenceau! I suppose, to this day, his *Religio Medici* is read as an essay in style; but I venture to suggest to you that it has another kind of value. It represents, I think, the best and first expression in the English language of the type of mind that you will find in every age among the best physicians; an eager, inquiring mind, unwilling to take the greatest or the least of things for granted submitting every tenet of tradition to the scrutiny of acquired wisdom and commonsense, yet so deeply, so humbly aware of the manifold mysteries with which the practice of medicine brings it into contact, that even when it is most confident it is never arrogant or dogmatic. It contains a combination, in short, of those two cardinal virtues which the Romans admired—of piety and gravity; or, if you like to put it into English, of reverence and level-headedness. And those two qualities, in themselves, carrying in them the seeds of realism and romance, are, given the power of literary expression, I think, a sufficiently solid basis for the equipment of a man of letters, and, particularly, a novelist.

NOT BLOOMSBURY OR MONTMARTRE.

Now, the principal concern of the novel, I hope you will agree with me, is human nature, the bodies and minds of men and women; and that is why I advised that anxious parent to send his prospective novelist not to those centres where art is in the air—to Chelsea, or Montmartre, or even Bloomsbury—but to places where life and death, not art, are in the air: in other words, to the general hospitals of our great cities. If the young aspirant does not learn from them, it will be his fault, not ours.—(*The Hindu*).

College Centenary.

1935.

As early as March of 1935, the Principal, Lieut.-Col. Clive Newcomb, I.M.S., called together a few members of the staff and formed an advisory committee. After a few meetings of this Committee, it was decided to hold a meeting of all the old students of the College both in the City and throughout the Presidency. All the old students felt that the Centenary should be celebrated in a fitting manner, funds should be raised to found a permanent memorial and an Old Students' Association be formed. The Principal, Calcutta Medical College, in his reply gave a brief summary of their procedure in connection with their centenary celebration, which fell a year earlier, and this was of great help in planning out the later *modus operandi*. Later in July, a public meeting of the leading persons, heads of different departments, prominent members of the medical profession, etc., was held in the old library hall, and an influential General Committee formed with a small executive body. The latter was added to by two members from the present students of the College.

The Principal declared a whole week as holiday, from 4th November to 9th November for the celebration of the Centenary. Different departments of the College were asked to put up exhibits showing the progress in Medicine, and special rooms were allocated in the Pathology buildings for housing these exhibits. The Annual Prize Distribution and the Annual Sports which were held usually in August were shifted to fall during the Centenary Week. Special items of sports were thrown open to the different colleges by the monetary assistances given by the Centenary Committee.

FIRST DAY.

The forenoon of the opening day was utilized in selling Flags throughout the City and the City Hospitals in aid of the centenary funds. The Flag Day could not be kept open throughout the Day as His Excellency was expected to be present at the College premises to inaugurate the centenary celebrations. We may be permitted to quote

here at length the report published by the "*Madras Mail*" in this connection.

The celebrations were marked by scenes of great enthusiasm, and were attended by a large gathering of people representing all phases of public life in this Presidency. The College and its precincts were tastefully decorated for the occasion.

His Excellency the Governor and Lady Marjorie Erskine on arrival at the porch of the new Pathology Block of the Medical College Buildings were received by Lieut.-Col. Clive Newcomb, Principal of the College, and Sir Mahomed Usman, President of the General Committee of the centenary celebrations.

The Medical College detachment of the University Training Corps commanded by Lieut. K. S. Viswanathan provided a Guard of Honour, which the Governor inspected. Sir Mahomed Usman introduced to the Governor members of the Executive Committee of the celebrations.

His Excellency, Lady Marjorie Erskine and others then moved to the examination hall on the second storey of the building and took their seats on the dais which was specially decorated and the distinguished visitors were garlanded by representatives of the College students.

GOVERNOR WELCOMED.

Extending a hearty welcome to the Governor and Lady Marjorie Erskine Sir Mahomed Usman said :

"As President of the General Committee for the Centenary Celebrations of the Madras Medical College it is my privilege to offer Your Excellencies a most cordial welcome on this historic occasion. Your Excellencies presence in our midst to-day has greatly enhanced its value. On behalf of the Committee I beg to convey to Your Excellencies our most grateful thanks.

"The Madras Medical College, which was originally established as a school and later developed into a college, has earned a high reputation as one of the most efficient institutions imparting medical instruction in the Empire. It has supplied the country during these hundred years with thousands of trained and qualified medical practitioners who have been imbued with a high sense of professional honour and prestige.

MEDICAL COLLEGE GUARD OF HONOUR, AND A GOOD GUARD TOO.



College Centenary

"The relief, these successive generations of the alumni of the College have brought to the people of this Presidency and its adjoining Indian States, cannot be measured by mere figures, but is reflected in the general well being of the population and in scores of ways.

STANDARD OF ACCURACY.

"The College has always set a high standard of accuracy and thoroughness in the instruction imparted; in fact the Madras Medical College course and the Madras University examinations in Medicine have not been regarded as suitable for easy going students. The products of the College have held their own in coping with the obligations of any situations to which they were accredited.

"The College has a great future before it with the rapidly advancing march of Science in many directions and the rapid extension of these buildings is an evidence of the expansion in the curriculum of studies and the larger influx of students seeking admission. We cannot forget on this occasion the illustrious men of Science who held professorial chairs in this College from time to time, several of whom were experts of world wide reputation in their departments of study and added to the sum total of medical knowledge.

REWARD FOR LABOURS.

"It is very gratifying that this celebration has not been confined to medical men alone but has been extended to obtain the valuable support of the general public also. After all it is the public for whom institutions of this kind exist; and to the extent to which they meet with the approbation of the public the institutions will feel rewarded for their labour.

"I am not therefore hoping in vain that the public will pronounce their verdict of appreciation by making a generous response to the call for funds for the advancement of post-graduate research in the College as a fitting memento of this unique event. We are confident that our appeal will not fail to secure us a lakh of rupees, a very modest aspiration. It has been decided by the general committee to keep the fund open for a period of one year from to-day and I venture to say that the value of a fund is rightly judged by the promptitude of the response it receives from the public.

"Before concluding, I should like to take this opportunity of thanking Lieut.-Col. Newcomb and his Executive Committee for the valuable services they are rendering in making the Centenary Celebrations a striking success."

HISTORY OF COLLEGE.

Lieut.-Col. Clive Newcomb, Principal of the Madras Medical College, who has been appointed Surgeon-General for this Presidency, gave an account of the history and progress of the Madras Medical College during the past hundred years. He said :—

"The Madras Medical College whose Centenary we are met here to celebrate to-day, was founded as a medical school by the Rt. Hon'ble Sir Frederick Adam, under an order of Government dated 13th February 1835 and the school began its first session on July 1 of that year. The object of the school in the words of this order was "to afford better means of instruction in Medicine and Surgery to Indo-British and Indian youths entering the medical branch of the service in this Presidency." The curriculum of studies extend over two years and the staff consisted of four members—a Superintendent, an Assistant Superintendent and two Assistants.

"The activities of the school were soon extended and on October 1, 1850, the school was raised to the status of a college. The School Council now became a more formal College Council with a nominated president and rules of procedure laid down for its guidance. In 1852 the College was for the first time granted the privilege of issuing diplomas to its students who passed out successfully, and enjoyed this privilege for about 15 years when its diploma became merged into the degree of the University of Madras.

VESTED IN PRINCIPAL.

"In 1858 the Government of the College was for the first time vested in a Principal and the College Council was reorganised into a body to advise the Principal. At this time the College was responsible for several grades of medical instruction. There was a senior department for the training of candidates for University degree in Medicine, a junior department for the training of Apothecaries and a third

College Centenary

department for the instruction of candidates for the grade of Hospital Assistants.

"In the sixties of the last century Universities were first established in India and claimed the exclusive privilege of granting Degrees and Diplomas. In consequence in 1863 the privilege of granting a diploma to the highest class of medical students was transferred from the College to the University. After this the senior department of the College was limited to those seeking a University Degree, but the College for many years continued to grant diplomas to Apothecary and other students.

REPUTATION ENHANCED

"This affiliation of the College to the University of Madras far from being to its detriment enhanced its reputation and prestige. Shortly after this the College began to be heard of abroad and was recognised by the Royal College of Surgeons and by the Faculty of Medicine of the University of Edinburgh and it is on record that many of its past students who proceeded to England for further studies were particularly successful in gaining higher qualifications in the Universities there.

"An important step was taken in 1875 largely through the exertions of Surgeon-General Balfour, of admitting lady students to the College to qualify for degrees in the Madras University.

The Madras Medical College was the first College in India to open its doors to women students and one of the earliest Colleges in the world to adopt this course at a time when there was considerable controversy as to the desirability of women becoming doctors.

FAMOUS WOMAN

"The first batch of lady students to pass out of the College included Mrs. Scharlieb who afterwards as Dame Marie Scharlieb became famous amongst the women practitioners in Medicine.

"Another change for which the same Surgeon-General Balfour was largely responsible was the inception in 1875 of the Degree of Licentiate of Medicine and Surgery. This degree after many changes was finally abolished by the University in 1924. In 1902 the third department of

the College for the training of the grade of Hospital Assistants, now known as Sub-Assistant Surgeons was transferred to the Royapuram Medical School.

"During all these years since its foundation the number of students of the College has tended steadily to increase, the curriculum of studies has tended to become more and more elaborate and the staff and accommodation have been increased to meet these needs. The school started with a staff of 4 which increased in 1867 to 8 departments with 5 Professors and various Assistants and in 1901 to 17 Professors and Lecturers besides 8 qualified Assistants.

THE STAFF TO-DAY

"To-day the qualified teachers of the College, Professors, Lecturers, Assistant Lecturers and Demonstrators, Tutors and others make a total of 90. The increase in the accommodation has more or less kept pace with the growth of the College.

"The Medical School was originally constructed in 1836 at a cost of less than Rs. 10,000 and consisted of 4 rooms. It was enlarged from time to time but it is not till 1870 that extensive alterations were undertaken and the centre block of the College buildings was fashioned substantially into the form it now has. The block now occupied by the Anatomy and Physiology departments was completed in 1911 at a cost of 2½ lakhs and the handsome block in which this meeting is being held and which houses the Departments of Pathology, Bacteriology, Bio-Chemistry and Chemistry together with the Library, the Examination Hall and various lecture rooms and class rooms was only occupied in July this year. This building was erected at a cost of about 12 lakhs and was built as part of a large scheme of reconstruction of the General Hospital and College.

AFFILIATED INSTITUTIONS

"In addition to improvements to the College itself we are fortunate in having very excellent affiliated institutions in which the students are trained in the clinical part of their studies. I refer to the General Hospital, the Women and Children Hospital, the Ophthalmic Hospital and the Mental Hospital.

College Centenary

"When the reorganisation of the General Hospital has reached completion it will be found that it has materially contributed not only to the comfort of the patients but also to the facilities for clinical studies of the students. The Ophthalmic Hospital due to the enthusiasm and ability of a succession of Superintendents is world famous for the quality of the teaching and the research that is done there. The Maternity Hospital largely due to the efforts of the late Major General Giffard is as well equipped a hospital as you could find.

"The students of our College are very fortunate in having three such institutions to pursue their clinical studies.

"Thanks to the trained and experienced staff that the College possess to-day, we expect our students who proceed to high academic qualifications in other countries to meet with more than average success and in this we are proud to say that they do not fail us. The staff are proud of the remarks expressed by Government in reviewing the last annual report :

SUSTAINED EFFORTS.

In reviewing this report, Government wish to place on record their appreciation of the very useful work done by this pioneer institution during the one hundred years of its existence.

'The period was a century of sustained effort and marked progress, and the appreciable advancement of medical knowledge in South India generally, was mainly due to the efficiency maintained by this institution during its long period of existence.'

"It is our hope that the progress which has been made in the past may be continued into the future and that the College will continue to advance from strength to strength so that it may be said of its Alumni that there are no better products of Medical Education in India or elsewhere."

GOVERNOR'S ADDRESS.

His Excellency the Governor then delivered his address, inaugurating the centenary celebrations. He said :

"Sir Muhammad, Mr. Principal, Ladies and Gentlemen,—Speaking on behalf of Lady Marjorie Erskine and myself. I should like first to thank you for the kind welcome which you have given us this afternoon, and to tell you how much we appreciate this opportunity of sharing in so happy an occasion as the centenary of this College. We deem ourselves fortunate that so memorable a date should have fallen within a year of our coming to Madras, and have been looking forward to it with very pleasurable anticipation.

"Everyone knows that medical colleges, no less in this country than in my own, are homes of good cheer, and the medical student an hilarious fellow who up-lifts a merry voice in our streets and displays himself to great advantage on the fields of sport. I confess I find the reason for this hard to understand. It passes my comprehension why to spend a major portion of one's time dabbling in the insides of very dead frogs should be conducive to hilarity; or how eyes accustomed to spend long hours searching for unmentionable things through microscopes can be equally skilled at watching the flight of hockey balls.

"But such is the reputed effect of medical schooling, and if ever there were an occasion for cheerfulness, it should be this.

STRENGTH AND VIGOUR.

"It is the custom the world over to shower congratulations upon the centenarian, but all too often the recipient of those congratulations is some mere decrepit mortal who can at best anticipate the dragging out of a few more years of useless and unhappy existence.

"Not so this College. Here we have a centenarian not only in full possession of his faculties, but actually showing every sign of increasing strength and vigour and with every right to look forward confidently to many a hundred years yet of healthy life and growth. Surely this is nothing less than another of those miracles of modern medical science.

"I must confess, ladies and gentlemen, that in matters of medicine and surgery I am the merest layman. I am aware that there are certain portions of the human anatomy which, for reasons partly known to the medical profession but best known to themselves, are accustomed from time to time to go wrong and to have to be removed.

"I believe, too, that the human body is a mass of tiny organisms, so extraordinarily small as to be quite beneath one's notice, if it were not for the fact that they frequently make their presence felt in sundry unpleasant ways.

NO FINER SCHOOL.

"I am afraid that you will not consider the extent of my knowledge very great, but this I do know, that man, being the unreasonably frail and complicated animal that he is, is in constant need of skilled medical attention, and that for the training of his skilled attendants there is no finer school than the Medical College, Madras.

"At the time of the foundation of this College medical science can scarcely be said to have been in existence. There was practically no certain knowledge of the causation of disease and the results obtained by the methods of treatment at that time in vogue were not unnaturally equally uncertain. Medicine was then an art, not a science, and was learnt as an art by apprenticeship. I think I may say that there is still quite a lot of art in it, but it is now much more a science and the method of its acquisition very different. Then the would-be physician picked his knowledge from washing his master's medicine bottles, and the budding surgeon sharpened the kitchen chopper which was about to hack off a limb.

VALUABLE RESEARCH.

"In the absence of anaesthetics and antiseptics none but the most rudimentary operations were possible, and those apart from being too horrible to contemplate, were very often fatal.

"The very existence of bacteria as the cause of disease was unsuspected. Indeed it was not until some years after the foundation of this College that the great discoveries in these fields were made which gave to medical science an impetus which it has never since lost. The College cannot, I fear, take credit to itself for those discoveries, but it was not slow to take advantage of them, and much valuable research work has been done here in addition to the practical instruction which has been imparted.

"We may point with pride to the discovery in 1903 by Donovan, a Professor of this College, of the parasite of one of the then most deadly

diseases prevalent in South India—kala azar—paving the way for the subsequent introduction of a treatment which has reduced the death rate of that disease from 100 per cent. to almost nil.

"The progress of medical science in the second half of the last century was indeed rapid, and no less rapid since 1900. When every step forward its complexity has increased, and parallel to it has been the growth of this College.

DEVOTED SERVICE.

"The history of the College is in fact the history of medicine in South India, until to-day it stands a noble monument to one hundred years of steady and devoted service in the interests of humanity. Attached to it are a wide range of clinical institutions as up-to-date and efficient as any in India, and amongst those in charge of them are men whose reputations are worldwide.

"At the recent F.R.C.S. examination, held for the first time in India at this College, Madras candidates secured better results than their fellows from all parts of India, and I may fairly claim that the reputation of our medical profession is second to none.

"A word, too, of congratulation to our lady students. For is it not the fact, and justly so, that they who first stormed the citadel of male prejudice here in Madras are still able to hold their own in competition with the so-called sterner sex?

"Ladies and gentlemen, we are met to-day in an institution of which any city in the world might well be proud. It is an ever-growing institution and this fine building in which we now find ourselves is the latest addition to its requirements.

NEEDS YET MANY.

"But its needs are many yet. I think I am entitled to say that my Government have in the past dealt generously by the College, and I would now urge that College deserves generously at the hands of the public. That the Madras public can be generous is shown by the example of a lady who has within the last few days offered an endowment of fifty thousand rupees for the institution of scholarships tenable in this College.

College Centenary

"I refer to Mrs. Kamala Rangachary, and it gives me great pleasure to take this opportunity of expressing to her the gratitude of my Government for her munificent gift.

"The President of the Centenary Celebrations Committee has informed you that a centenary Fund has been opened and will be kept open for a year from this day. I understand that subscriptions to it already total Rs. 14,000 apart from Mrs. Rangachary's gift. I warmly sympathise with this undertaking and I confidently appeal to you and to the public at large to give it your generous support, for no worthier object for your charity could be found.

"In conclusion, ladies and gentlemen, I would like to assure you that the interest taken by Lady Marjorie Erskine and myself in this College is deep and abiding. This afternoon will long remain amongst our happiest memories of Madras. We wish the College and its Centenary Celebrations all possible success."

Lieut.-Col. R. E. Wright on behalf of the Centenary Celebrations Committee and the large number of graduates of the Madras Medical College expressed his gratitude to His Excellency the Governor and Lady Marjorie Erskine for gracing the occasion with their presence. He then presented the Governor with a copy of the centenary volume, an attractively got up book containing the history and achievements of the Madras Medical College during the past century.

The party then adjourned to tea in the spacious lawns of the Medical College, which were decorated.

SECOND DAY.

OPENING OF THE CENTENARY EXHIBITION.

Lieut.-Col. Clive Newcomb, Principal of the Madras Medical College, who has been appointed Surgeon-General for this presidency opened this morning the exhibition organised in connection with the Madras Medical College Centenary celebrations at the college halls.

A large gathering of persons, including students of the Medical College, past and present, and representatives of the medical profession and members of the public assembled at the examination hall of the college in the second floor of the new Pathology Block this morning.

Col. Newcomb, before formally opening the exhibition, unveiled the portraits of Dr. C. B. Rama Rao, Major H. Kirkpatrick, Lieut.-Col. R. E. Wright (Superintendent of the Ophthalmic Hospital, Madras), Major A. C. Ingram, Dr. K. Vasudeva Rao, Lieut. Col. A. J. H. Russell (Public Health Commissioner of the Government of India), and Dr. P. S. Chandrasekhara Ayyar, who were professors in the Medical College and who rendered meritorious service to the institution.

Dr. S. Ramakrishna read a statement dealing with the lives of those professors.

Dr. R. Audishesha Ayyar, Professor of Hygiene in the Medical College, said that the Public Health Authorities in Madras had asked him to present on their behalf to the College the portraits of Dr. Chandrasekhara Ayyar (a former professor of Hygiene in the Madras Medical College) and that of Lieut.-Col. A. J. H. Russell (who was the Director of Public Health for this presidency before he was appointed Public Health Commissioner to the Government of India). For a time Col. Russell was also Professor of Hygiene in the Madras Medical College.

To Col. Russell should go the credit of having introduced practical demonstration courses and field experiments in hygiene. Dr. Chandrasekhara Ayyar was the first director of the tuberculosis institute in Madras.

Col. Newcomb, on behalf of the students and staff of the Madras Medical College, accepted the portraits and thanked the donors. The portraits would adorn the College walls and serve as a reminder of the distinguished services rendered to the cause of medical science and the college by those former professors. By honouring those men the College was honouring itself.

He then unveiled the portraits, which were placed in a row on the dais.

EXHIBITION OPENED.

Col. Newcomb then declared the exhibition open. It was organised, he said, by the various professors of the College for the edification and amusement of not only medical students but of the general public as well.

College Centenary

Col. Newcomb accompanied by Sir Mahomed Usman (President of the General Committee of the Centenary Celebrations) then walked down to the first floor of the building, where the exhibition is being held.

The cinema show on health and hygiene and other medical subjects shown at the exhibition to-day was largely attended.

The first room in the second storey of the building contains the section dealing with hygiene and public health, where are displayed charts showing the progress made in preventive medicine especially in relation to water, nutrition, air, cleansing and the spread of disease by germs. Posters are also displayed giving instruction on the essentials of diet, food grains, vegetables, dairy products and other foods showing the purposes served by them in nutrition; the right type of cooking appliances, which contribute to comfort and cleanliness in the kitchen; and models of filters for purifying water suited to large communities.

There are other posters showing what citizens are expected to do to notify the authorities about births, deaths and infectious diseases.

Visual instruction to laymen of the comparative health conditions in Madras compared to other countries through coloured rods and tubes provided in the section attracted considerable attention. There are also charts of deadly insects, and showing the transmission of insect-borne diseases—the malarial mosquitoes, fly and other insects.

Small-pox, vaccination, damages caused by rats, infections caused by worms and their control, were subjects of other posters. There was also a cinema show on health and hygiene.

From here the visitors proceeded to the exhibits displayed by the King Institute of Preventive Medicine at Guindy, where they inspected the manufacture of vaccine lymph, experiments that are being conducted to produce the lymph from eggs, the preparation of cholera vaccine, researches into Kala Azar and specimens of Food adulteration.

A MECHANICAL BRAIN

On entering the physiology section the visitors were shown a mechanical brain controlled by electricity. At another place they were shown an instrument to which the sound of the beating of a heart forty

feet away was transmitted by radio. Tests for respiratory efficiency and the mysteries of circulation were also explained here.

Model showing the different stages of development of the human body, sections of the brain and other parts of the human system, skeletons and portraits of leading anatomists during the last three centuries were displayed in the anatomy section.

Going a little further on they were shown charts and instruments regarding the utility of X-rays and the use of X-ray photography in the identification of persons.

The Ophthalmology section was particularly attractive with charts and instruments. A coloured picture showed how eye operations were conducted in India in years gone by.

Radio-therapy formed a section by itself. A small radiographic picture showing the inside of a man with a push-bicycle in his chest excited curiosity. The mystery was solved when Captain T. W. Barnard explained that the bicycle was a toy which the man had swallowed. That was one of the first radiographic photographs taken at the London Radiological Institute. There were many other pictures showing the uses of radio-therapy.

In the Pathology section were several wax models explaining the effect of diseases, and in the Biology section were various specimens of poisonous reptiles. In an adjoining section were charts dealing with the ravages of tuberculosis and the measures adopted to fight the disease.

A Radium clock in the Physics section was particularly attractive, while in the Chemistry section crowds gathered to witness dyeing and silvering work.

THIRD DAY.

His Excellency the Governor presided over the annual distribution of prizes to students of the Madras Medical College on November 6.

On arrival at the porch of the new Pathology Block he was received by Lieut.-Col. Clive Newcomb, Principal of the College, and was introduced to the members of the staff.

College Centenary

The party then moved to the examination hall, in the second storcy of the building, where were assembled leading members of the medical profession in Madras, members of the public, students of the college, and prominent citizens.

Lieut. Col. Clive Newcomb, presented the annual report of the college. He said that the hundredth session began on July 2 last year and terminated on March 31st this year.

There were 890 students in the college during the year including 226 who were newly admitted. The new admission included 107 regular M. B. B. S. and 90 Sanitary Inspectors class students.

BETTER DOCTORS.

Col. Clive Newcomb then dealt with passes during the past three years and said that in 1932-33 the percentage of passes was 28.21, in the next year it was 25.9 while during the year under review it rose to 38.4.

The regulation by which L. M. Ps. were afforded a chance to qualify for the University Degree in Medicine carried out the directions of the Committee on Medical Education, who had emphasised that what was needed in this country was not more doctors but better doctors.

Although preference was given to Madras L. M. Ps. in the matter of admission the course was not confined to Madras, but was thrown open to all who held the necessary preliminary qualification for admission as required by the rules. As only very few seats were allotted by Government for L. M. Ps., numerous applicants with good qualifications, not only from Madras but from all over India, had had to be refused admission.

MADRASIS SUCCESS.

The principal said that it appeared that Calcutta University had now provided the necessary regulation to enable L. M. Ps. to qualify for their medical degree. Col. Clive Newcomb next referred to the success attained by Madras students in the last F. R. C. S. preliminary examination held in Madras, where out of the 21 who passed 13 were Madrasis.

The military medical pupils class of the college consisted of 74 students, of whom 35 were reading for the M. B. B. S., and the remain-

der for the Board Examination. The new regulations for military medical pupils required them all to take the M.B.B.S. degree.

For the Sanitary Inspectors' Class 90 students were admitted during the year under review and at the two examinations held during the year 67 passed. Owing to financial stringency the postponement of the quinquennial training of Health and Sanitary Inspectors for a period of two years from 1932 had been extended for a further period of two years.

WOMEN STUDENTS.

Referring to women students the principal said that there were 89 women students. Fifteen took the final M. B. B. S. examination in April, 1935 and twelve were successful. The women students' hostel was very useful to the women students, but it required improvement and expansion to give more accommodation and greater amenities for the residents, who had now organised a women medicoes' club for extending their activities in games, etc.

The new Pathology Block of the college named the Goschen Institute of Pathology was handed over, for the most part, at the end of June and the beginning of July and occupied by the departments concerned. Two important works which had not yet been taken up though their necessity was becoming more and more urgent were the construction of a hostel for male students, and the construction of a block. The former was abandoned as a measure of retrenchment and its construction postponed year after year.

HOSTEL NEEDED.

The principal said, "It is a pity that a premier college, whose centenary is now being celebrated has not yet been provided with a hostel for its male students and it is hoped that it will not be postponed a day longer than is absolutely necessary."

In spite of the increasing amount of routine work done at the college, said the principal, the various departments managed to do some amount of research. Altogether 21 papers had been published and many other investigations were in progress.

The principal also recounted the achievements of the Medical College students in the field of sport, and recounted the trophies they had won at tournaments.

During the year the strength of the University Training Corps of the college had risen to 67. Five more enrolment forms were approved by the Government at the end of the year and therefore the present strength of the corps was 72. The present progress had shown the popularity of the institution.

Then Col. Clive Newcomb requested His Excellency the Governor to distribute the prizes, with which request he complied.

PORTRAIT UNVEILED.

LIEUT.-COL. DONAVAN.

H. E. the Governor after distributing the prizes unveiled the portrait of Lieut.-Col. Charles Donavan, a former professor of the Madras Medical College, who discovered the parasite responsible for Kala azar. His discovery in 1903 proved to be of considerable value in fighting the disease. After a distinguished career in the Indian Medical Service Lieut.-Col. Donavan retired in 1916.

His Excellency said: "It gives me great pleasure to be able to come here this afternoon and give away the prizes, and especially to be able to unveil the portrait of Lieut.-Col. Charles Donavan. You have all heard of the immense progress made in certain forms of medicine which were due to him. I think it is a great honour to this Medical College that his great services should have been at the disposal of this institution so long.

"I am quite sure that on this occasion you do not want me to make another long speech. But, I should like to say that in reading your annual report I was struck by the great success which has attended the students of this college. I was also pleased to find that this college has done so well in athletics this year. As I said in my speech the other day it is a remarkable thing the world over how medical students are exceedingly good at games. The school in which I studied has the motto, 'A healthy mind in a healthy body.' Who should better realise than the budding doctors that one cannot work with brains unless at the same time one's body is also thoroughly fit?"

"I am very pleased indeed to be able to be here this afternoon. I congratulate all those to whom I had the honour of presenting the prizes and I am quite certain that in the coming years the College will do just as well as it has done in the past, if not better."

Lieut.-Col. R. E. Wright proposed a hearty vote of thanks to the Governor, and the meeting ended.

We are indebted to Rao Bahadur R. Krishna Rao Bhonslay, I. S. O., for the following; which shows in contrast the change that can occur in 50 years.

H. E. Lord Erskine, in his address inaugurating the centenary celebration of the Madras Medical College, made two statements, which struck me most:

(1) At the time of the foundation of this college, Medical Science can scarcely be said to have been in existence.

What the status of the Medical man then was, might be examined.

(2) Mrs. Kamala Rangachari, the wife of a Brahmin doctor, offered an endowment of Rs. 50,000 to this college.

What the attitude of caste Hindus joining the Medical College then was might also be examined.

SURGEON MAJOR FURNELL.

A graphic picture of the two aspects was drawn in 1878 in the Madras University Convocation address delivered by the then Principal of the Madras Medical College—Surgeon-Major M. C. Furnell, M.D., F.R.C.S. Here it is.

Each year sees an ever-increasing number of candidates for matriculation and graduation in Arts, but I fail to notice any increase for degrees in Medicine—a matter, I see, on which our gallant and respected Director of Public Instruction (Lieut.-Col. R. M. Macdonald) touched upon in his address last year. In twenty years, the Faculty of Medicine, has produced three doctors, half a dozen bachelors, and one licentiate, in a population numbering some 50,000,000 of people! As the Principal of the Medical College, this fact is of singular interest to me, and it has often been present in my mind, not only that the number of

College Centenary

Indian students who presented themselves to study Medicine, apart from those entering the service of Government, was singularly small, but that the Brahmins practically held altogether aloof.

If we turn to the Ancient History of India, we find that Medicine, far from being a despised Science, was one of the most honoured. Next to the vocation of the Priest, that of the Doctor seems to have been the most respected. Nay, I am not sure it was, in the most ancient times, second even to that of the Priest: for I find in your ancient books that one of the fourteen "Ratnas" or precious objects which the gods produced by churning the ocean after the deluge, was a "Learned Physician":

"And lastly from the troubled waves,
Amidst the glorious cheering,
Uprose Dhanwantri, the sage,
The lost Ambrosia bearing."

I may add here that this Dhanwantri became King of Benares.
Dr. Furnell adds:

Susruta, a disciple of the King-Doctor, in his book, which was an abridgement of the Ayurveda, stated 'Those men who in ignorance of the human frame, venture to make it the subject of their experiments, are the murderers of their species.' What says Manu, the great Lawgiver: "Should a Brahmin touch a fresh human bone, he is purified by bathing, and if it be dry, by stroking a cow, or looking at the sun, having sprinkled his mouth duly with water." It is evident the great Lawgiver passed no prohibition on the matter. I find also that, in Bengal, the opinion of learned Pandits was given on this point in Lord William Bentinck's time, and the Shastras made to declare that dissection was permissible to a Brahmin seeking Medical knowledge. My own opinion had always been that this was the insuperable bar to the study of our Western Science of Medicine by good Caste Hindus.

Dr. Furnell, in his own inimitable way, summed up as follows:—

I have said enough, I think, to convince you that Medicine is not a science, which the people of India, of all people, should despise or neglect. But is there not something else which keeps the bold intellects amongst you from choosing Medicine as a career? I am afraid there is

and here, as a servant of Government, it behoves me to be careful in what I say, but I take courage from the Viceroy's witty figure of speech on a late occasion, and feel sure that no English Government would wish to be treated as the Parsis treat their dead: "to be surrounded by a Tower of Silence." Medicine is not an honoured calling amongst Englishmen. There is no use blinking the fact. It is the Cinderella amongst professions. It wears the poor clothing and does the drudgery whilst its sisters, Law and Divinity, and in this country, Arms and the Civil Service, are clad in purple and fine linen and obtain all the honours. You hear it called an 'honourable profession,' a 'noble profession,' but this alludes to its work, not to its rewards. "No English Physician, ever so famous, was ever ennobled." In this country, no English Physician has ever been deemed worthy of a seat in the Legislative Council. If the English gods churned the ocean for lost treasures, I am afraid, it is not a "Learned Physician" they would bring up; or if by any chance they did, they would not make him King of Benares; they would most probably pop him in again, and go on churning, until a lawyer or a clergyman came up to fill the place and be made a Chancellor or an Archbishop. It would be a waste of time on this occasion, my offering any speculations as to why this is so. I must content myself with simply mentioning the fact and pointing out how, in my opinion—open, I feel acutely, to the misconception of professional jaundice—this state of things is injurious to the commonwealth.

May I add that the Caste Hindus moved with the times and overcame their prejudices, and that the status of the Medical man rose in geometrical progression? Thus to-day's picture is happily quite different from that drawn by Dr. Furnell, more than half a century ago? I wish he were alive!

REUNION OF MEDICAL MEN.

Madras College Old Boys' Association Dinner.

Tributes to Alma Mater and the Profession.

The largest Medical dinner ever held in the annals of the medical profession in this country was held at the Madras Medical College night of Nov. 6 in connection with the centenary celebration.

Conducted under the auspices of the Medical College Old Boys' Association the dinner was attended by about five hundred persons including professors of the College, leading doctors in the city, representatives of the present students of the college, Government officials and prominent residents of Madras.

The guests on arrival were received by Rao Bahadur Dr. A. Lakshmanaswami Mudaliar and Dr. N. Venkataswami Chettiar and conducted to the second floor of the new Pathology block.

The dinner was held in the examination hall and consisted both of European and Indian courses. Dewan Bahadur Dr. C. Natesa Mudaliar an old boy of the College presided.

Dr. Natesa Mudaliar proposed the toast of H. M. the King-Emperor, which was enthusiastically drunk.

Rao Saheb N. Ramaswami Nayudu, the oldest student of the College, proposed the toast of the *alma mater*. His family have been connected with the institution for nearly a century. His father entered the College in 1836, a year after it had been formally opened. As Mr. Nayudu could not stand the glare in his eyes he requested Captain S. Thambiah to read his speech in the course of which he said:

THE GIANTS OF OLD.

"The central life-size picture adorning the main hall (which is now, I understand, used as a students' common room) among the many Surgeons-General, Principals and Professors, is that of my Principal, Surgeon-General George Smith. There were also James Shaw, William Mackenzie, Balfour, Robert Cole, George Biddie and Furnell. I had the honour to attend their lectures in the College and later to serve under some of them.

The anniversaries in those days were quasi-military functions and generally were presided over by the Governors. The Commander-in-Chief, the Generals of the Divisions, the Judges of the High Court, the Secretaries and Members of the Legislative Council, the Sheriff of Madras, and the *elite* in Madras, attended these in large numbers.

"The first two that graduated through Madras University were Doctors Rockwood and Dhanakoti Raju. Both of them subsequently

were conferred the degree of M.D. The first alumnus of this College who went to England and competed successfully for the Indian Medical Service was Dr. Shortt, an Anglo-Indian. He was followed by Dr. Kees who was my Professor of Anatomy. Among the Dressers, Dr. Palaniandi (failed to secure a pass in England, returned and) served in the Travincore Durbar as Superintendent-General of Vaccinations.

"These were all incidents that took place before many of you were born. I served H.M. Queen Victoria, her son King Edward VII and our beloved Emperor, King George V for forty years, both in India and abroad; both during peace and war; and retired thirty years ago Assistant Professor of the College

"It is a great privilege to me to participate in this Centenary—a reunion of the old students and the present students and staff of the College; and may I conclude with a prayer for the prosperity and progress of my *alma mater* and for the success, happiness contentment; peace and honour of its alumni and of the staff of this wonderful institution."

PRINCIPAL'S SPEECH.

Replying to the toast Lieut-Col. Clive Newcomb, Principal of the College, said: "Mr. Chairman and gentlemen: I am deeply grateful to you for having asked me to reply to this toast. I feel perhaps it would have been more fitting that one of the real sons of this College should have responded to this toast rather than an adopted son, as I hope I may consider myself. Whatever other defects I may have, in one respect I can yield to no one, I yield to no one in my pride in the college.

"To many people the College means the buildings and, indeed I often feel that it means more buildings than anything else to the inspectors who come from time to time to have a look at us. My pride in the buildings is mixed. We are all proud of this handsome new block. We regard with complacency the anatomy and physiology block and with affection on account of its antiquity, the old centre block of the buildings. There are, however, other parts of the buildings discreetly hidden from casual visitors which are the objects of anything but pride.

"The buildings are merely the outer husk. The College, properly understood, is the company of men and women who work here. In

them we can all take a legitimate pride. We have now a very highly qualified staff and what are commonly called the 'bad old days' are gone; when men were put in to teach largely on account of suitable seniority and other considerations and with little thought to their knowledge of the subject they had to teach. It is remarkable how successful the teachers were in those 'bad old days' and this serves to confirm my idea that the personality and general culture of a teacher is of as much or more importance than his specialist knowledge."

"THE PROFESSION".

The toast of the medical profession was proposed by Dr. U. Rama Rao. Something went wrong with the loud speaker and his speech was inaudible for the most part.

He paid a handsome tribute to the services rendered to the progress of medical science in this country by members of the Indian Medical Service, who were, he said, the makers of modern medicine in India. They had done much for medical education, researches into various diseases and other fields of the science.

The demand for the reversion of the members of the Indian Medical Service to the military, leaving the civil posts to the sons of the soil, he observed should not be misconstrued as an act of ingratitude, but was to be taken merely as a part of the programme of autonomy, which Indians claimed for themselves.

Continuing Dr. Rama Rao said that forty years ago the period of training in the Medical College was not fixed. It used to be two, four or five years. Now things had changed, the period was fixed at five and in certain other cases at five and half years. In those days the professors of the College were members of the Indian Medical Service. He compared that state of affairs to the conditions prevailing to-day, when the professors were mostly Indians, holding high medical degrees. Thanks to the efforts of the late Dr. T. M. Nayar the appointment of honorary medical men had come into existence. And the Indian School of Medicine and the Medical School for Women which were doing such immense work, were largely brought into being by the efforts of the late Raja of Panagal.

He observed that medical men becoming ministers to the Government would be a great blessing to the country, and he advised medical

men to take up politics. "At any rate one thing is certain, that we are proud we belong to this noble profession and have the opportunity to serve and relieve human suffering. Let us pray God that this institution may gain strength and influence and become more and more useful in the days to come."

LIEUT.-COL. WRIGHT'S REPLY.

Replying to the toast Lieut.-Col. R. E. Wright said: "When I was asked to speak in support of the toast of 'the profession' it seemed to me that there surely must be a lot to say about the great calling which unites doctors the world over under the three words.—*The Medical Profession*. On thinking it over I realised that to me the profession was most naturally subdivisible into two groups the profession as exists for me in the world at large, and the profession as it exists for me in the country, or more particularly in the presidency and city of my adoption.

"With regard to the latter it is an impressive mental process to review in my mind's eye the position as I saw it over twenty years ago and to-day. At that time with a very few notable exceptions, the Madras members of the profession constituted a great group which struggled hard in the routine of dependent positions in trying to meet the more urgent medical needs, both curative, preventive and educational. I am not drawing a distinction between the official and the non-official members of the profession at all. Gradually the picture changed, and although to me the intervening years have seemed to fly, I can look back on the springing up of individuals of various talents, some in the political sphere, others in purely professional or academic spheres, until one realised that a veritable forest of independent growths was steadily taking shape. I can remember the progress of many of these individuals, growing older contemporaneously with me in the service of medicine and assuming larger responsibility with the years. I am glad to say that in the case of many. I have been enabled not only to watch their progress with interest but also to maintain a valuable intimacy. Some slightly junior to me have gone—like my old friend the late Dr. Krishna Menon, others of a later period have with astonishing rapidity grown to win not only my respect but that of us all. To-day one realises that the profession here has a core of dignified and progressive scientists. For me then the profession as it exists in

College Centenary

Madras, has attained an independence, an individuality, a style of its own, moulded of Western medicine through Indian influences. But it has been very largely preoccupied with local affairs and has a distinctly local atmosphere.

A DIFFERENT PICTURE

"What of the profession in the world at large, my other subdivision?"

"This is an entirely different picture. One sees the various groups of the profession in different parts of the world as one might see one's relations when on a visit, rather on their best behaviour, as their domestic troubles are kept in the background. Some of them are rich, some poor; some young, some old. Whether we like it or not we belong to that family and the dignity of any particular group and the esteem in which it is held by its neighbours is determined by the progressive scientific achievement of its individuals. It is the magnitude of the purely scientific attainments of any particular school which attracts the attention of the profession in the world at large. The profession as a whole is not really concerned with the parochial struggles of its various schools, but it is vastly concerned with the advancement of medical knowledge. Let us hope that the profession in Madras will not be content until early in the second century of its career it attains further dignity of attracting the universal attention of the world to its capacity for scientific progress, and produces Madras qualified scientific, the mention of whose names will be a password into any other school in the civilized world.

"I have just had an opportunity of looking from the outside, as it were, at the profession in Australia. Although nearly all the visitors from overseas were struck with the excellence of medicine in that country and the flourishing condition of its schools, it was the fact that Australia had produced some master minds whose names are household words and whose work is of unsurpassed excellence in the realm of medical science, that made the greatest impression.

"At the great Annual British Medical Association dinner to which over a thousand sat down, there were of course numerous speeches. Like the school in Madras, the Australian schools are relatively young—just over a hundred years old—and apparently young schools are rather

apt to let politics vie with science. We had therefore several doctor-politicians before the microphone. One such started hopefully by telling of a certain important speech which he had made. He asked his wife how he had got on. She said: "Well, you missed several good opportunities." He said, "What of?" She replied, "Of sitting down." We trusted this had made a lasting impression on him, but alas! he treated us to Australian politics till the more noisy elements ended the matter by shouting him down at the end of 35 minutes.

"Gentlemen, I have very nearly made a similar mistake, but will now take my opportunity, and in doing so thank you, Mr. President, for giving me the privilege of attending one of the first big dinner parties of the Madras Old Students."

A RED LETTER DAY.

The toast of the guests was proposed by Rao Bahadur Dr. Lakshmanaswami Mudaliar, who said yesterday was a red letter day in the annals of the medical profession in South India, since that was the first occasion when an old students' rally, as it were, had taken place. The rejoicing was all the greater because there were present some distinguished guests representing different walks of life. The Old Boys of the college were pleased to find that the Hon. Minister for Education was present at the dinner. It was in 1918, that for the first time, a member of the Government attended a medical dinner in Madras. He was Sir Alexander Cardew who took a deep interest in the progress of the medical profession and it was largely due to his efforts that the professorial chairs of the Medical College were thrown open to students of the College. The name of the Late Raja of Panagal would ever be remembered with feelings of gratitude by people of this presidency for his remodelling the medical administration in this province and improving the health department.

Dr. Mudaliar paid a handsome tribute to the services rendered to the cause of medical education in this presidency by such eminent professors of the College as Lieut.-Col. Charles Donovan. Nothing pleased him more than to see representatives of the present students of the Medical College. They were the real representatives of students elected on a system of adult franchise.

College Centenary

The scheme for the construction of a hostel for the men students of the College was discussed and rediscussed, but nothing came out of it. With the aid of his fellow students Mr. Alwa, a student of the College, had opened a hostel at Periamet, which was the envy of students of many other colleges. He said that Old Boys were proud of the fact that there were present women representatives of students, one of whom was a Muslim, Miss Abusha Maricair, which gave sufficient indication of the great changes in the country during the past few years.

TRIBUTES ENDORSED.

Replying to the toast, the Hon. Dewan Bahadur S. Kumaraswami Reddiar, Minister in charge of the medical portfolio, endorsed the tributes paid to the services of the late Raja of Panagal, and other distinguished men. No member of the Government, he said, had done more for the medical profession in this country than Sir Alexander Cardew and the Raja of Panagal. Perhaps if example was required of the deep interest taken by the Government in the medical profession it could be found in the fact that in spite of the financial depression the Government had assisted considerably in the progress of the medical department. In fact it was during the past decade that the department had made the greatest progress. Concluding he wished the institution and the Old Boys' Association all success.

The toasts and replies were enthusiastically drunk.

FOURTH DAY.

The annual athletic sports of the Madras Medical College were held on 7th November afternoon on the Medical College ground before a large gathering, which included Dewan Bahadur S. Kumaraaswami Reddiar, Sir Mahomed Usman, Lt.-Col. C. M. Plumptre, Lt.-Col. C. Newcomb and members of the college staff.

There was keen competition in all the events, the inter-class relay proving the most interesting.

Balavantha Singh of the Y. M. C. A. College ran a clever race to win the open mile, for which Jansen was most fancied, having won the college mile from Nicholas the previous day. A good start saw the field take the first bend close together, Jansen lying third with Balavantha

Singh a few yards behind. After the completion of a round, Jansen moved up to second place with Singh close on his heels. Going into the third round Jansen closed in on Natarajan, who was leading, and drew level before they came round to open the final lap. At the first bend on the final round, the order was Jansen, Singh and Natarajan. Down the far straight Singh strided into the lead, leaving Jansen trailing behind, the latter being eclipsed by Natarajan, who finished strongly.

After repeated false starts, a small field went away well together for the 440 yards race. Toomy setting the pace till the far straight, McInnes then drew up and took the lead to finish by a narrow margin. in 54 2/5 secs. Pereira beat Toomy for second place.

D'Costa, who was awarded the individual Championship, was in fine form, breaking two Madras Presidency records (120 yards hurdles and hop, step and jump) and giving a fine exhibition in the 120 yards shuttle hurdle relay when he turned a three-hurdle lead into a six-hurdle victory. He also gave a remarkable performance in the inter-class relay.

At the conclusion of the sports. Sir Mahomed Usman congratulated the winners.

The prizes were distributed by Dewan Bahadur S. Kumaraswami Reddiar.

THE RESULTS.

Following are the results :

100 Yards.—S. D'Costa, 1; McInnes, 2; Ralston, 3. Time : 10 2/5 secs.

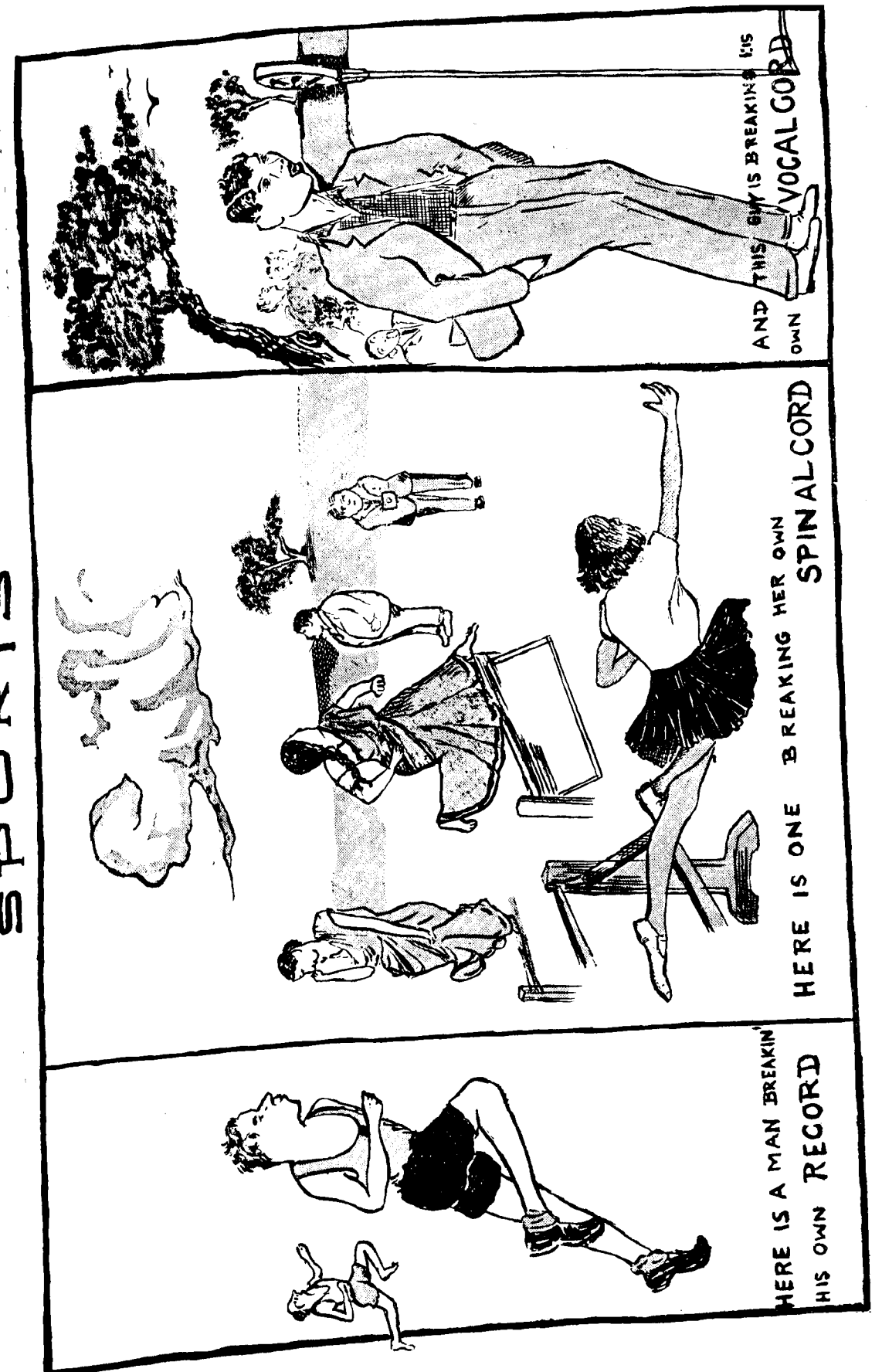
440 Yards.—McInnes, 1; B. Pereira, 2; Toomey, 3. Time : 54 2/5 secs.

880 Yards.—R. Jansen, 1; B. Pereira 2; Nicholas, 3.

120 Yards Hurdles.—S. D'Costa, 1; McInne, 2; Toomey, 3. Time : 16 secs.

440 Yards Hurdles.—McInnes, 1; Pereira, 2; Toomey 3. Time : 1 min. 3 1/5 secs.

SPORTS



One Mile (College).—Jansen, 1; Nicholas, 2; Vincent de Bayles, 3. (Open).—Balavantha Singh, 1; Natarajan, 2; Jansen, 3. Time: 4 mins. 45 1/5 secs.

Throwing the Cricket Ball.—Hogg, 1; Chacko, 2; Hughes, 3. Distance: 98 yards.

Putting the Shot.—Hog, 1; Bird, 2; Hull, 3. Distance: 35 ft. 7 1/2 ins.

Discus Throw.—Toomey, 1; Bird, 2; Pushong, 3. Distance: 94 ft.

Long Jump.—D'Costa, 1; Cullen, 2; Toomey, 3. Distance: 21 ft. 1 inch.

High Jump.—D'Costa, 1; Toomey, 2; Hogg, 3. Height: 5 ft. 7 ins.

Hop, Step and Jump.—D'Costa, 1; Mahadevan, 2; Hull, 3. Distance: 43 ft. 11 ins.

Fast Cycle Race.—Hart, 1; Pinharo, 2; Briganza, 3.

Slow Cycle Race.—Balarama Varma, 1; Kalyanam, 2; Natarajan, 3.

U. T. C. Race.—Cadet Joshi, 1; Cadet Radhakrishnan, 2.

Ladies' Obstacle Race.—Miss Asirvadam, 1; Miss Thorasingham, 2.

Inter-Class Relay Race.—Final Year, 1; First Year, 2. 2 min. 32 secs.

Old Students' Race.—Dr. Ghani, 1; Dr. Raghavachari, 2.

Tug-of-War.—Staff beat House Surgeons.

120 Yards Hurdles Shuttle Relay.—Medical College, 1; Christian College, 2.

Ladies' 100 Yards (Open).—Miss Hughes, 1; Miss Mahadevan, 2; Miss Asirvadam, 3.

Nursing Staff Race.—Miss E. Court, 1; Miss Rowlands, 2.

FIFTH DAY.

The exhibition was kept open on this day as usual and large numbers of students from various colleges and the public pressed for admission and the place was practically full up with very little moving

pace even along the passages. No special programme was fixed up for the day as most of the students were already tired with their lot in demonstrating and showing round the visitors to the exhibition. In the fitness of things, some of the enthusiastic students got up a nice dinner both European and Indian, and one may add a Mohomedan too.

STUDENTS IN FANCY COSTUME.

The spacious lawn in front of the Pathology Block where the dinner was held was brilliantly illuminated with multi-coloured electric lights. Covers were laid for over 600 persons.

Some students were dressed as nursing sisters, others as Gypsies, Burmese, Arabs, Parsis, Red Indians and Cossacks. In flowing robes of velvet and lace and with a large turban. Mr. Alva, Secretary of the Medical College Students' Association, was a striking picture.

After dinner which was lively and mirthful a variety entertainment was given in the centre of the lawn. The programme included Indian and European songs, gypsy dances, and recitations.

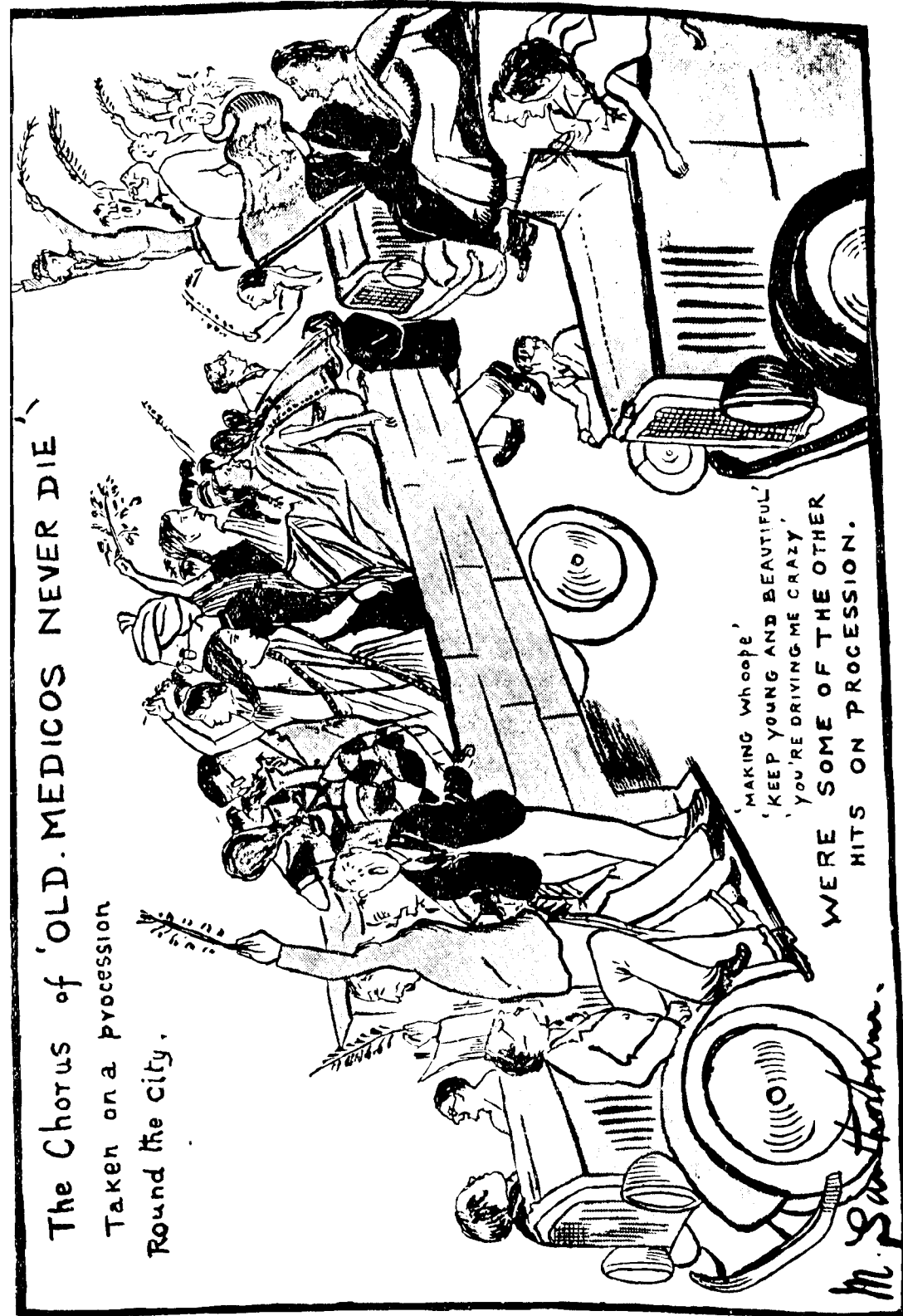
Rao Bahadur Dr. A. Lakshmanaswami Mudaliyar was voted to the chair and a committee of professors judged the best among the various costumes.

Dr. Lakshmanaswami Mudaliyar thanked the students for their co-operation with the Centenary Celebrations Committee.

After the party had broken up those in fancy costumes and others mounted decorated motor lorries and drove round the city, singing songs specially composed in honour of the college.

SIXTH DAY.

At the request of the public the exhibition was kept open on Saturday though the students and staff were looking weary after the strain of the previous five days. Anyway the College authorities ordered the College exhibition should be closed at least by 2-30 p.m. The members of the Executive Committee of the Centenary Celebrations were 'At home' to the students and staff of the College, about 5 p.m. on this day. Once again the specious lawn in front of the College was



College Centenary

157

utilized for the occasion. The Modern Cafe ran the show so well that every one present acknowledged that the tea was an unqualified success, and Mr. Seetharama Rao, the Manager of the Modern Cafe deserves every congratulation.

In conclusion the Principal thanked everybody for their hearty co operation and wound up by a few words of encouragement. The Principal was cheered enthusiastically, "Chaired" and carried all round the lawn. "The boys and girls" of the College rode in lorries through the different parts of the City shouting and singing, waving flags and carrying branches of trees. This was kept up till the small hours of the morning and they visited the houses of the staff and hostels. A good many had to be admitted into the Hospital for fever, pharngitis, laryngitis, etc., in addition to two or three who sought admission due to gastro-enteritis directly attributable to a generous helping of the tea, not to speak of the large potation of tap water and soda water drunk, in their rounds through the city.

(Collected and adapted.)

EDITOR.

When the Tables are turned

BY N. NELLAYAPPAN.

It is a miserable state of affairs when the tables are turned — when the prospective physician becomes a patient. No one would better appreciate the contrast than the healer when he has to be healed.

The breezy call of incense breathing morn greeted me when somebody woke me up. It was cold and dewy for it was November then. I was sleeping the sleep of the tired. My thoughts were in the strain of

“Weary the oar, weary the wandering fields of barren foam,
Our island home is far beyond the waves
We will no longer roam.”

I was lost in dreams like these when I felt something cold on my shoulders. It gave me a start and the next minute I was in unison with the surroundings. The cold thing was a piece of cloth dipped in pseudo warm water, with which a patient is sponged on a morning like this. There is no use of complaining for the ready reply is ‘Hospital regulations.’

Lights on at five. Rather tough on those pious guys who have made twelve noon the dawn of day. Half sleepy men swallow the bitterest of mixtures. After the last drop has been swallowed then and then only the bitterness or unpleasantness is felt.

“Theirs not to reason why,
Theirs not to question why,
Theirs but to do and die. (If they have to)”

Whichever way you turn you meet with only wry faces. Next come the ‘cups that cheer but not inebriate.’ Blankets off at six and help the nurse to tidy up the bed.

If you are bed ridden further trials await you. From all corners of the ward cries of ‘urine bottle’ are heard and the impatient Rama

When the Tables are turned

159

frowns. You do not get the urine bottle until your bladder reaches the bursting point. If you are in need of the bed pan it is still worse. You may not be able to control your calls but it is all the same to Rama. *If the mark of the mint changes hands you have an easy time.* The answering grin is an assurance that your troubles are over; otherwise “Vengeance is mine” sayeth Rama, and he is in a class by himself even in having his revenge. Whenever an opportunity occurs for giving an enema an irrigator full of soap and water gets into your system irrespective of whether it pains you or not. On the contrary if the coin had changed hands the considerate irrigator will contain only half a pint of soap and water. Figure to yourself, readers, the plight of the proverbial jew who has the misfortune to be in our hospital. And yet the late lamented Lord Sinha boasted “I am proud to say that my people are the only people who have never persecuted jews.” Owe unto the jew who forsakes Jehovah and seeks the refuge of Rama.

At 9 o'clock you get the meagre repast for which ‘Breakfast’ is a misnomer. It makes you all the more hungry. The assistant surgeon would come, and everybody start shouting “Doctor! Doctor!!” I did not know the cause of such a hubub. I learnt only afterwards, that they were the plaintive cries of half starved men demanding more diet. From the next day onwards I promptly joined in the hue and cry. Just like giving a sugar loaf to a dog, to please us, he would add a single biscuit to the existing diet. To us, hungry and emaciated as we were even that solitary biscuit, was like manna to the Israelites. Many a time and oft we have heard of civilized men turning cannibals unable to bear the ravages of hunger. Usually good dinners begin with a sweet dish and end with another. Naturally one nurse will go in first and they will polish it off with another. To prevent such a catastrophe may I suggest a fifteen day course of starvation for doctors before they qualify (with nothing but a cup of milk *t.i.d.*) the writer being excluded since he has put in more than the necessary number of days. That will put them in tune and make them scrupulous regarding a patient's diet.

A gentleman opposite to me had been starving for nearly three months. He told me the history of his illness, compared those palmy days of health and plenty with the present which consisted of nothing but scarcity and starvation and shed a tear or two. Indeed it was very sad when he told me, he had never taken his meal without five or six

hors d'ouvres. That reminded me of these two lines in the Deserted Village,

"Those were thy charms sweet village,
But all those charms are fled,"

I consoled him by saying that in the Eastern system of medicine starvation is considered to be a panacea for all illness.

I found the gentleman on one side of me was Nelson and the one on the other side was Kitchner. That gave me the consolation that with the hero of Trafalgar on one side and the more modern Field-marshal on the other, there was neither the fear of going to hell nor the unpleasantness of going to heaven.

Men who write ponderous tomes condemning the communistic ways of Socialist Soviet Russia seem to forget that there are such things as bath rooms in our hospitals. On my first visit to that *Sanctum Sanctorum* I was shocked to see five or six half naked figures attending to their calls while,

"News much older than their ale went round."

A figure completely nude except for his spectacles gave me the blues. Surely, I thought, whatever my other views may be I will never entertain communism in the bath rooms. Truly, this is not a 'report of an inspector of drains', but only experiences of a few days in the hospital, honestly depicted.

In certain circumstances getting discharged from the hospital is more difficult than getting divorced from a termagant wife. But when there is dire need for a bed off you go without notice and another bird is in your nest before you quit.

The hospital authorities have come to the conclusion that the patients are either immune or insensitive to mosquito bites, for the fans which were a sort of protection against the mosquitoes have been stopped since November last. A gentleman started using 'Flit' and succeeded so well in his enterprise that he managed to drive his share of the mosquitoes to us. He was so lighthearted about that he compared the mosquitoes to the bombing squadrons of the Italian airforce and the 'Flit' gun to the Ethiopian anti-aircraft guns. The

When the Tables are turned

result was, according to his version, his 'chokra' became a good gunner, in a day or two. This is the sunny side of the affair.

One day I had a surprise in the shape of a pillow hurrying through the verandah. I had my own misgivings about it but a neighbour illumined me with the information that it was a nurse straight from the operation theatre.

On another occasion, a patient who was undergoing a stormy course of illness, without any prelude suddenly gave us a brilliant lecture on Chemistry that would have astounded Bequerel, or Madame Currie or our lecturer in Chemistry. The very next minute he was cross with the nurse for no reason and began to call her "You son of a sea crook, son of a three cornered whisky bottle, son of kong, son of a gun" and so on without caring even for the gender of his remarks.

Even in a hospital entertainment is not wanting!

Good-night.

By

"BOILER."

'What is in a name' said the bard of Aven. But what you call 'Good-night' would not by any other name be half so good. By Good-night more is meant than meets the ear. Hail the name if you feel like it—either from the O. P. terrace or from the centre of Broadway. More than a score of blokes with scant vegetation on their scalp would suddenly wheel round and open their eyes wider than saucers as though they had been shot through. The funniest part is almost every bald man seems to know his label. And what is worse, not stopping with himself it is being handed down to the members of his family as a "hair loom." They are styled Mr., Mrs., Master or Miss Good-night, according to circumstances.

History does not say who was the first unfortunate individual to be christened with this rather odd name, or who stood his god-father. Patient investigation by a few—who had nothing better to do—throws some light on this problem. Till a few years back a local cinema ended its shows—it is not exactly stated whether it was before or after the National Anthem—with the picture of a Robertson Hare-like celebrity across whose pate was written in bold letters, 'Good-night'. That is so far as philology goes.

Though Nature has been unkind to her bald sons, yet the good Mother has tried to compensate them with a larger slice of popularity than they actually deserve. If the number of endearing names by which they are addressed is an index of their fame here is a list:—Archibald, Baldwin, Baldie, Stanley, and lastly the title of this article itself. All these titles are not universally applied. One or the other is current in a particular circle or society. With most of these people whom you meet every day, you can adopt a hail-fellow-well-met attitude and what is more get off with it.

Truly baldness seems to be a sign of greatness. Famous statesmen like Mussoloni, Baldwin, Jawaharlal Nehru, or the Aga Khan have not escaped it. While most great men are bald it does not necessarily follow that all bald men are great. It is common knowledge that the malady affects the thinker. But if this view were to be strictly true, one would not agree with Milton when he said that the idle man's brain is the

Good-night

devil's workshop. A bald tram-conductor does not think much except perhaps to punch the ticket at the right place and ring the bell at the wrong one. But editors on the other hand, whether student or general really think too much—of themselves?—The evidence for their worth is an examination of the occipital region of their scalp.

This shedding of hair like sheep doing away with their wool in summer is a universal disease, that does not make any distinction of caste, clan, or creed. It affects all mother's sons from the multi-millionaire Rockefeller down to the wretched urchin from the gutter, from the born genius down to the congenital idiot, and from great monarchs down to humble peasants. It neither spares the young nor the old neither the surgeon nor the physician and neither the strong nor the weak. Its incidence in the old is fairly more common but that is not so much a source of embarrassment as when it occurs in the young.

Probably baldness may be due to constant dehydration of the scalp as observed in those who have always been under fans or in those who travel fast in exposed vehicles like lorries or motor cycles. On this account they are not infrequent source of trouble. The glare from their crown causing traffic troubles such as congestion or collision, is a stale joke older than the hills. Talking about motor cycles would remind you of one particularly bald student who goes about on an A. J. S. He meets with more accidents than all the other motor cyclists in the college put together. Every other day, a car, a cycle, on a poor pedestrian runs into him. But he, the robust rider that he is, has till now successfully defied all such invasions to upset his equilibrium. Not only every morning with its eternal sunshine that settles on his head, but every evening with its glow of electric lamps, also brings him a golden chance to set at nought the well ordered life on the city roads.

Another instance of one of these unfortunate individuals being more a nuisance than anything else is worth quoting. A tennis player of our college represented the *alma mater* in a mixed doubles match at the capital of a large Indian state. The evening was not far advanced when the match began. Since no lady went along with our team the college representative, the Admirable Crichton that he was, procured one of the local talents of the state to partner him. That is by the way.

The opponents could not play the first few balls and the lady on the other side asked the picker to get her sun vizor. Still she got a beam of bright light right into her eyes. 'Picker' shouted the lady "get my goggles." Our friends' services were aces. The picker procured the goggles, but that did not in any way improve the situation. The fair opponent was entirely off colour and despite her colleague's brilliant display they lost that set. Then only the lady pondered for a while, and there came a tide in the affairs of men--'man' includes 'woman'--which the lady took at the ebb. Picker she bawled--a girl is capable of such a feat--"Get the gentleman on the other side his lid." No doubt it led her on to fortune for they won the next two sets and so the match. You may guess what the trouble was with our representatives head. The onlookers got into their head somehow that the first set was won through mean tactics. It may happen that the glory of the Medical College in the sporting world will be out shone by the radiations from the shiny vertices of the few of her players, unless they get the proper head gear when they take part in any match.

Alopecia, as the erudite medico would term baldness, is said to be a disease of the skin. But any patient who comes to consult our skin specialist might say 'Physician! Heal thyself'. Every sufferer tries all artificial aids to enrich the fertility of his dome. In nine cases out of ten the efforts are futile. The Market is flooded with pomades, hair oils, lotions, stuff like 'Baldex', 'Hairex', 'Vilex' and what not. Each in its own way is reputed to secure an abundance of raven locks to the user. Some guy with an eye for novelty go in for vacuum suction of their scalp. So long as this apparatus does not evacuate the contents of their cranium they should rest content. The last resort would be a wig which at one time stood the wearers in good stead.

While these billiard ball headed chumps are engaged in a fight to obtain what has been denied to them, the irony is there are several others who try to simulate their condition either partly or wholly. Some of the Christian clergy obtain a halo with a razor. The religion dictates the orthodox Moslem and some Hindu relicts to have a 'turret-top'. That perhaps is a point for the politician indicating the lines along which to develop the Hindu-Moslem interests. It is a strange world!

Good-night!



S. V. T. CHARI IN ACTION.

Courtesy - the 'Hindu.'

Our Young Cricketer.

The Madras Medical College, uniquely enough among colleges in South India, can now boast of an individual being selected to represent India in a test match. This is the first of its kind in the history of our college and the one on whom this unique honour has been conferred is none other than our unassuming friend S. V. Thiruvengkatachary. He is a sportsman in the true spirit. His cricket talent came known to the public when he was playing for the Presidency College cricket eleven.

After finishing his Intermediate course with brilliant success he joined our college, and in his first year he was no more than an assiduous student. He is a queer specimen of a student who did not like to avail himself of the exemption from examination so kindly granted by his principal and had to be pulled out of the examination hall to the cricket field. The next year he got a place in the college eleven and in the same year he was selected to go to North India with the Madras 'Varsity team where he acquitted himself with credit. Against a strong opposition he was included in that year's annual presidency match against the Europeans in which he won the admiration of no less a player than Major C. K. Nayudu who played with him.

He showed an instinct for leadership, and captaining the college team he built up a happy family. Last September our college cricket side visited Hyderabad and in a total of over 500 runs scored against us no bye was left—a record of which even the prince of wicket-keepers may be proud of. The next excursion of our hero was to Bombay with the Madras 'Varsity cricket eleven. All eyes were on him and

Bombay which is known for its cricket sense was so pleased with his performance that it marked him for a place in the next Quadrangular contest.

With the visit of the Australian team to India speculation was up whether recognition will be accorded to our friend. However the India cap was awarded to him at Madras and in his first operation with Muhammed Nissar and Amarsingh he gathered the ball easy and showed himself up. Critics readily acknowledge this Boy-wicket-keeper as India's first and foremost wicket-keeper of to-morrow. His ability as a batsman is of no less order as seen by his performance against the Australians where he showed science and grace in his 'classy innings.'

It is generally said that sport and study do not go hand in hand, but with our Chari it is a happy combination of both. He is one of the good students in our class and has won prizes and certificates of honour to his credit. We are highly proud of him and wish him success in his cricket career as well as in his studies.

J. J. DHARMARAJ.

Editorial Notes.

The delay in bringing out this number is much regretted as we were in the midst of the centenary celebrations and the exhibition connected with it.

* * * *

Lieut.-Col. R. E. Wright, C.I.E., I.M.S., has gone to the U.S.A. to attend an International Ophthalmic Conference and is expected back in India by the middle of March; Dr. Koman Nayar is acting as Superintendent and Professor of Ophthalmology.

* * * *

Dr. A. N. Goyle, M.B., Ph.D., Professor of Pathology, has been appointed to a new post in the Central Research Institute at Kasauli. He was very popular with the students and the staff of the College. It is customary to give exaggerated laudatory statements about people on the eve of their departure; in the case of Dr. Goyle every one will bear out that he had a genial temperament and unassuming manners.

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Dr. A. Vasudevan, M.B.B.S., to act as Professor of Pathology in the place of Dr. A. N. Goyle, M.B., Ph.D.

* * * *

This time the Primary Fellowship examination of the Royal College of Surgeons was held in Calcutta and a large number of students appeared for the examination from all parts of India. 12 candidates were successful and of these 6 were from Madras and out of these 6, four are undergraduates from our Medical College—Rebello, Mohana Rao, Anandakumara Menon and Ramachandran; of the doctors Dr. Thaymanaswami and Dr. P. T. Joseph. All these deserve our congratulations.

U. T. C. Report.

The beginning of the year saw us with 55 men out of a possible 77 and the vacancies were filled up by selecting the best out of the large number of students who applied. The routine parades were carried out as usual and it was noticed that the cadets were smarter and more keen than those of the previous years.

In July our Senior Under Officer O. G. Eapen left the College as he was offered a commission in the Indian Territorial Force. He was universally acknowledged to be one of the smartest and ablest men the corps had ever known. The Commandant has often said that he had taken the wrong line when he joined the Medical College and we are glad that he was able to get into that walk of life to which he is best suited by his natural talents, before it was too late. We wish him every success in his career.

To fill the gap, caused by the resignation of Lieut. Ramakrishnan, Dr. Chandrasekaran, well-known to the staff and the students as "Unna", was taken on as a Probationary Officer. We give him a hearty welcome and we are sure he can fill in any gap!

The long awaited centenary celebrations held in November gave us an opportunity of showing the other members of the College, of the stuff we are made. We formed a Guard of Honour to His Excellency the Governor and we are glad to say that he was very favourably impressed by our turn-out and drill.

On the 8th of December we strapped on our water bottles and haversacks and in full marching order set off in high spirits for the Annual Camp at Pallavaram. We were more fortunate this year in that one of the barracks was allotted to us, though there were some who preferred to be under canvas as in previous years. Though we were hard worked the diversions of the evening removed the weariness of the day's toil. Songs, dances, practical jokes and other amusements peculiar to camp life kept our spirits at a high level. The songs and stories were of the real army type, if not better! In this connection, mention

U. T. C. Report

169

must be made of Cpl. Santhosham, who though appointed the Medical Corporal was more often found in the barracks, after having instructed to the care of the orderly, the lives of his patients. We wonder if the latter ever realised their good fortune! Anyway it is no exaggeration to say, as he has himself said very often, that Cpl. Santhosham was the most popular figure in the Camp, barring the C. O.!

The competition week saw some real 'esprit de corps' among the men. Though some were taken and some were rejected for the various teams, it must be said that every member put forth his best for the good of the contingent. We fared quite well this year, having secured three trophies. Our O. C. by winning the officers shooting cup raised the number to four. We congratulate Sgt. Khaleeli, Cpl. Dhirar and the men of the guard for winning, in convincing style, the guard mounting competition. Together with the Engineering College contingent, with whom we form the 'A' Coy., we secured the Football cup after an exciting replay. A new Trophy was awarded this year for "Internal Economy." We are not quite clear as to what this means, but we are glad to say we won it!

The Battalion concert brought the Medicoes to the fore once again. Most of the items, in fact all the good ones were contributed by the 'A' Coy. The criticism by the other companies that we monopolised the show goes to prove the truth of the statement.

Our thanks are due to S. S. I. Hearnden and our temporary Instructor Varley for the pains they have taken initiating us into the mysteries of military matters.

Last but not the least our thanks should go to our kind officer Lieut. Viswanathan who took care of us as a hen taketh care of its chickens. Every success of ours we owe to him.

M. ABRAHAM,

Under Officer.

The Medicoes U. T. C. Marching Song.

1. Hark! Smiling singing onward go
With shouts of ho! ho! ho!
Sweating faces in sunlight glow
And perfect joy they show.
Sing a happy song
The way is not too long.
2. If your foot and boot fit tight
Then that would be alright.
Suddenly if it starts to bite
This is the way to fight
Sing a happy song
The boot is not too strong.
3. For if you cry the boot bites you
Although it may be true,
You know what commandant would do
He'll make you bite the shoe.
Sing on him a song
He means not any wrong.
4. The band is front goes banging on
But soon their wind is gone.
But then our throats are fresh and strong
"Hey! boys so come along."
Sing a happy song
When your throats are strong.
5. The pipers feel their guts are out
Now and then without doubt.
Medicoes never loose their wind
Distance they never mind.
They keep singing their song
As they're marching along.

Medicoes U. T. C. Marching Song

171

6. Because our officer was stout.
And that was why methought
We lost our trophy for the route
Thoug 'ur steps were never out.
To forget sing a song
God only made him wrong.
7. Of course in the cross country race
We did not have a place.
Instead of race we did a chase
One of our funny ways.
Keep it for your song
In race waste not your lung
8. Marching in file with arms at trail
During the battle drill,
Forget your pal for just a while
Lest you drop that rille.
In parades sing no song
But grip the rifle strong.
9. In midnight dreams thus spoke a man,
His mind to college ran,
"Miss—amma your slide is broken
So please beg your pardon."
Sing a happy song
In dreams too keep it on.
10. And when at four our beds we fold,
To keep us from the cold
We sing the song of old King Cole,
The rest cannot be told.
Keep singing that song
To make you warm and strong.
11. The wildest man was mild and tame
For friendship reigned supreme.
No one would grudge no one would blame
Even the worst nick name.
Sing a happy song
Call that man King Kong.

12. There was a man with huge big frame
 We gave him a nick name
 He was called Kipps Apparatus,
 Supplying heich-two-yes (H_2S).
 Sing that snappy song
 Commandants bowleg song.
13. Oh! gone, Oh! gone bright days are gone
 May it come again soon,
 Though light is gone and night is on
 We shall soon see the moon,
 Pack up the King cole song
 In kits but not for long.

M. SAN-TONHAM.

Medical College Athletic Club

CRICKET (THE TOUR).

We left Madras on a tour to Secunderabad on 20th September 1935 and reached our destination in very light spirits the next day.

Thanks to Mr. G. A. Aleem's previous arrangements we were lodged at a Palace and to put it in his own words "our food was in one John & Co." This boarding hotel was "just around the corner" and the famous corner was only a mile's walk from our Palace. Otherwise the tour was well organised; but things would have been more wholesome if only some responsible member of the staff had come along with us.

We have to make special mention of the hospitality and kindness of our hosts at Secunderabad and more than all we are highly indebted to Major Hart and Mr. S. M. Hadi for all the trouble they took on our behalf. Major Hart's inspiring presence was always looked forward to with very keen enthusiasm by every member of the team in every match.

Our touring cricket team was not fully represented when we left Madras owing to Messrs. Garson, Wilkinson and Sivaraman deserting us at the last moment. However we managed to get Garson and Wilkinson by wire, the former in time for the first match. Sivaraman also joined us despite very great domestic inconveniences.

There was excellent teamwork throughout. Those on whom we relied very much for great things did not come up to our expectations but the team as a whole did very well. Garson was off colour throughout. Sivaraman did very well only once. Rama Rao could certainly have bowled very much better despite the fact he topped the bowling averages for the tour. He did very well as a batsman being the only one to score 20 or more runs in every one of the four matches and topped the batting averages also for the tour. S. V. T. Chari did very well with the bat in the first two matches and was in an inspired form of wicket-keeping. Wilkinson and Rajagopalan had to do things to

which they were not accustomed. Rajagopalan had to bowl a good deal more than usual, and was always sent in early to bat while Wilkinson's catch in the rib and poor state of health were very naughty things indeed to play with. D'Costa touched form in only one match and his fielding was always up to the mark. It is a great pity that Stephens, one of the most sporting members of the team, could not be with us during the tour.

To the games proper:—Our first match was against the Srinagar XI, a representative side of the Hyderabad State consisting of such outstanding players as the famous brothers, Lt. Md. Hussain and S. M. Hadi, Hyder Ali, Isa Khan, Bhoopathy and others. They batted first and declared at 200 for 8. We lost the match due to the very good batting of Hyder Ali who made 84 and was eventually stumped brilliantly by S. V. T. Chari off Rajagopalan. Our fielding lapses were a bit too many that day. Lt. Md. Hussain was clean bowled by Rama Rao for 30 runs and S. M. Hadi made only 14 runs. The most successful bowler of the day was Rajagopalan who got 3 good wickets for 60 runs and Aleem accounted for 2 wickets at a cost of 34 runs. Entering next we made in all 108 runs. S. V. T. Chari and Rama Rao saved the side from collapsing for less than 60 runs. S. V. T. Chari scored 32 runs in fine style and Rama Rao contributed 25 runs. Though we were beaten, our show against such a heavy side as their was very creditable of a college side like ours. We exhibited skill in bowling and resisted the best of their attack (through S. V. T. Chari and Rama Rao) in a very critical situation after losing 5 wickets for just over 30 runs.

Batting first in the second match against Secunderabad Gymkhana we declared at 201 for 7 (S. V. T. Chari 38, Rama Rao 34 not out, Atma Ram 33 not out, Sivaraman 30). Rama Rao and Atma Ram scored nearly 70 runs for the seventh wicket. In the hour and a half our opponents played, they made only 49 for 6. Rajagopalan's accurate attack fetched him 4 wickets for 26 runs. The stumps were drawn a quarter of an hour earlier than the time fixed upon and besides our captain did not wish to take the risk of declaring our innings closed earlier. In fact none of us had any idea of the strength of our opponents and we depended on what the spectators told us about them and so the match was drawn.

Our match against the Nizam's College was on a rainy day. Batting first our opponents had the advantage of a wet ground and made 148 for 4 and declared. Moazzam played very well for his contribution of 110 not out. With the exception of Rama Rao, all our bowlers were helpless that day. Rama Rao got 3 wickets for 28 runs in 17 overs, and Aleem who bowled 15 overs gave away only 17 runs though he did not get a single wicket. We were 127 for 9 when stumps were drawn; thanks to Madhava Rao who batted boldly but for whom we should have lost the game. Our main scorers were D'Costa 32 runs (including a six), Rajagopalan 26, Hogg 21, and Rama Rao 20.

Our last match against the Osmania University was also drawn. We batted first and declared at 169 for 9. Rama Rao and Rajagopalan opened the innings and put on 30 runs when the latter was adjudged *l. b. w.* Then Sivaraman joined Rama Rao and the pair put on for the second wicket 42 useful runs when the latter batsman was out to a catch. Rama Rao scored 37 runs in a charmed life of four chances. Sivaraman was unbeaten with 63 runs. Our bowling was of a high standard and the opponents could make only 105 for 7 when stumps were drawn. Rama Rao bowled well in his second spell and bagged 4 wickets for 27 runs including that of Alibara, one of the class batsmen of Hyderabad, who was clean bowled for a meagre 19 runs.

The outstanding features of the tour were able captaincy of Rama Rao, his consistent performances both as a batsman and a bowler, and the brilliant wicket-keeping of S. V. T. Chari who did not concede even a single bye out of a total of 502 runs scored against us and hardly ever let go a single stumping chance or a catch.

M. SOMASUNDARAM,

Scorer.

FOOTBALL.

Our Football "eleven" acquitted themselves very creditably during the recent tour to Hyderabad. The first match was played on the Nizam's College Grounds against the "Orasshoppers" a representative team in Hyderabad. The teams balanced very well and the game was "midfield" throughout. Our forwards took sometime to settle down and still they tested the opposite goalie several times and before a few

minutes to the finish, Haridoss, off a pass from Cullen scored the winning goal for our side.

The next feature was against the Nizam's College eleven. Though it was a tough match we were undoubtedly the better team. Our forwards were in fine form and Cullen scored twice early in the first half. The second half proved more exciting. The Nizam's College forwards pressed hard. But our defence rose to the occasion and was found "impenetrable". Anantha Narayana Iyer in the goal brought off many beautiful saves. Our half backs fed the forwards well who increased the lead by scoring three more goals. Cullen, D'Costa and Haridoss each having one to their credit.

The last game was played on the Osmania College grounds against the Osmania University team (past and present Champions of Hyderabad) and we were unlucky to lose 2-5. Considering the day's game the University eleven played better Football. Most of our players got injured in the previous matches and we felt keenly the absence of D'Costa. D'Costa was replaced by Orton and his place was taken by C. W. Chacko. We gave them a good fight and Cullen scored the two goals for our side in fine style. This was the first defeat of the season and we took it cheerfully.

The team is to be congratulated for their fine performance at Hyderabad and for the sporting spirit they have shown both inside and outside the field. We were much impressed by the kind hospitality shown to us by the sports loving people of Hyderabad and we still carry with us memories happy and pleasant of our tour in Deccan.

Mention must be made of our energetic sports Secretary Mr. Panchabikesan and the team's Manager Mr. Aleem for the fine arrangements they have made to make us comfortable and they deserve our warmest congratulations.

We have had a very successful Football season this year. We won the Inter-collegiate League Championship and we are defending the Wilson cup this year.

P. O. OOMMEN,
Captain.

TENNIS.

Only 2 matches were played at Secunderabad during our tour and both were won by us, Messrs. Haridas and Natarajan playing for our college.

Last October Goodsir Cullen played the final of the Inter-collegiate Tournament against the Engineering College representative Mr. N. Rama Rao. Cullen played splendid Tennis snatching a love-set from his opponent before conceding the match. He 'aced' often with his spectacular Top-spin drives, the spectators lustily applauding his full-blooded strokes. The match went to 4 sets and his unfailing stamina and fleet-footedness were justly admired by all present.

The annual Mixed Doubles Tournaments was played at 'Wallajah Bagh'. The holders, Miss Komalavalli and Mr. Haridas being eliminated in the Semi-final, the final match between (Miss Thorasingham and Mr. Mohan Rangam) and (Mrs. Bal and Mr. Vincent) was played before a large gathering. The match produced high class Tennis resulting in a win for the former. Pair at 6-2 and 6-2. Miss Bal played sound ground-shots and Vincent was terrific overhead, but the winners set up a fast pace nibbling the lines often. Miss Thorasingham 'aced' frequently with her low cross court shots and judicious lobs while Mohan Rangam serving fast with occasional spinners displaced his opponents by his mid-court volleying and measured drives along the side-lines.

In the recent open Championship Tournament held by the M. U. C. Mohan Rangam playing for our college met the redoubtable Andhra Champion Balachandra Rao and the match ended in a most unfortunate manner Mohan Rangam retiring due to an attack of cramps just when he was clinching the 2nd set with a lead of 6 games to 5 and 40-15, though he had lost the 1st set at 8-10. Throughout the match he varied his speed and length cleverly, angling his shots deeply. He showed a good variety of strokes and with a timely net attack kept his opponent constantly on the run. The leading exponents of the game in Madras prophesy a bright future for him.

The standard of Tennis in our college is high compared to that of other Colleges and much may be expected of our players in the coming tournaments. Now that there are courts in our College, the general standard is bound to improve.

A FRIEND.

‘The Pet of My Boss.’

(TONE, ‘VICAR OF BRAY’)

1. Out in our hospital wards
Some butterfly like nurses,
And some others like frogs and toads,
But why speak of *their* faces.
The Bosses go about like lords
Their mouth all full of curses.
Although it is so very hard (yet)
I’m the pet of my bosses.

Chorus: This is the law that I’ll maintain
Until I get my pass; sir!
That; whoever may complain
Still I’d be the pet of my Boss, Sir!

2. With case sheet reading they worry
When they begin to lecture.
Starting from ancient history
Up to the patients future.
How many wives one, two, or three?
Their facies and their features;
Although they’ve unnecessary
Still I’ve to please my teachers

Chorus.

3. Constipation to convulsion,
And all their complications
Pass through the same examination
Whate’er be the condition.
First inspection, then palpation,
Percussion, auscultation
All these ends in your confusion,
And patients provocation

Chorus.

‘The Pet of My Boss’

179

4. Urine, blood, spatum, and motion
Every damn thing for culture.
Here does not end examination;
What about X-ray picture?
Stating there’s no bony lesion
When patient has a fracture!
Still I shan’t raise an objection
To keep up my crowing nature.

Chorus.

5. While Boss in this testing stage
The patient takes his ticket.
To say in common folks language
The patient kicks his bucket.
When I sing this song in the stage
You’re say’ng I need some tact yet
But still without losing courage
At crow catching I’ll try my luck yet.

Chorus.

A. W. MATHURAM SANTHOSHAM.

Out-Patient Students' Worries.

I'm up at 5 a.m.
But unlike other men,
I cannot bathe, nor swim, nor shave,
I must get up and go to work.
Health exercises I leave undone
For my troubles have begun
At the out-patient department.

II

I hurry, scream and shout,
For "chota" is not out,
The cook decides, that suicide,
is better than lurking around.
He grumbles quite aloud,
And asks an honest doubt,
"Is the Mr., Miss or Mrs. suffering from Gout" ?
He says, "I will resign,
This moment is sublime,
Its the O. P. posting time" !

III

I canter for a tram,
But remember the ban,
That Sunday is the Sabbath day
Time for rest and time to pray ;
But this is not the condition
Printed in the new edition
Of the O. P. department.

IV

Every morn when I awake,
The thought of O. P. makes me shake,
My health is at a stake,
My heart it palpatates
My head, oh ! how it aches !
My B. P. rises high,
And I begin to cry !
Hot tears flow from each eye.

Out-Patient Students' Worries

181

V

I must be there at seven,
Five minutes late ! Good Heaven !
The roll is called, my name is scrawled,
A Pen records the date,
The Register seals my fate !
"Dear friend, you are too late : -
A Capital "A" is given per day
You may work or play
There is nothing to say."

VI

The "A's" increase by dots,
I cannot escape my lot,
Another month's posting
Is what I expect,
"Merci" ! I say, with due respect.
And now a request I make : -
"Kind Generals, Colonels, Majors, and Captains of our stite,
Please hearken to our needs,
An unwritten law concede,
Your mercy, we implore !
This on us bestow,
That, -at a future date
Students may come late,
At half past seven
Not Eight" !

"DIRE NEED"

The Question of Examinations.

LONDON, Dec. 6.

In the past week or two there has been a tremendous amount of discussion concerning examination results and the vagaries of examiners who mark the test papers. Experts on the examination system have declared that no two examiners will mark their papers in any way alike, and the result of any examination depends upon the personal feeling of the examiners!

A pamphlet entitled "An Examination of Examinations", which is the report of an authoritative investigation into the examination system in schools and colleges states that examiners, those mysterious beings, the terror of the classroom, are self-confessed incompetents.

Here is the pamphlet's evidence of examiners' incompetence or negligence;

An English committee of investigation (of which Sir Philip Hartog was the Director), set up following an International Conference on Examinations, selected scripts written by candidates in the course of ordinary examination.

The scripts were sent to different examiners, and then, after an interval, again to the same examiners.

Fifteen scripts so dealt with had been awarded a "middling" mark by the original examining body.

On the first occasion they were submitted to fifteen examiners selected by the committee, these scripts were allotted 43 different marks out of a maximum of 96, varying from 21 to 70,

On the second occasion—months later—the total number of different marks was 44 and the marks varied from 16 to 71.

It was found that in 92 cases out of 210 the individual examiners gave a different verdict on the second occasion from the verdict awarded on the first.

One examiner changed his verdict in regard to eight candidates out of 15.

Was there ever more damning evidence of failure in a system?

In Lighter Vein.

From the U. T. C. Hospital.

Patient.—Sir, My boot 'bite' my finger.

Doctor.—Let me see—(so saying he holds the fingers).

Patient.—No sir, (Taking off his hand) My leg fingers.

Bubbles.

Patient.—Sir, due to yesterday's route March I am suffering from feet BUBBLES. (Meaning Blebs).

Doctor.—What is wrong with you?

Patient.—Yesterday 'I was fainted sir,' at Sentry duty, and now my stomach is fighting inside.

Too Hard to Swallow.

The Medical Corporal placing a thermometer in the mouth of one of the Cadets who reported sick, went away to attend on another patient. When he came back he found the patient hurriedly spitting out something. At this the Medical Corporal asked "What are you spitting for."

The patient explained himself by saying "Please excuse me Corporal I simply couldn't swallow the hard things the soft ones I swallowed alright."

From the College.

While teaching the causes of pimples the professor says. "You know pimple is only common among young adolescents, *i.e.*, girls between 12—15 and boys between 15—17. This is because of certain things peculiar to boys and girls at this age. You may not like my

saying it out, why! Most of you might even take it as an insult. But still there is the truth which none can deny. After all we are going to think about it in a scientific point of view. When I say it out, please do not get offended. And now, you know what boys and girls of this age like; I think I better say it out. (A smile and a downward look in the professor's face—A moment of silence—and then). They like chocolates, starch and sugar; That is one of the causes of pimples.

Student attending skin clinic (to the skin specialist) Sir, what is the treatment for my pimples?

Skin clinician.—Marriage.

Student.—Can I get it in our dispensary, Sir?

The professor of mental diseases and Superintendent of Mental Hospital during the course of his lecture to the final year students said, "You boys are not any better than my patients. Shall I prove it, shall I?"

The next day morning a doctor took a lunatic to the mental hospital to admit him. But as soon as the Superintendent entered the patients waiting room, before he could take his seat the lunatic jumped to the front and said, pointing to the doctor "Get him to bed at once, and shave his head; he's violent. Think; himself a doctor, poor fellow, you must humour him!"

The doctor of course protested and tried all means to make the Superintendent believe that he was a doctor. But all his endeavours were of no avail. He was shaved and dressed in the hospital coat.

The mistake was found out two days later.

In the next lecture the Superintendent said "You boys are not half as good as my patients. I have proved it, Havn't I?" and quoted the above case.

A lady medical student was entering the mental hospital rather frightened. As she was walking along with shivering legs one lunatic who crossed her way asked her in a thundering voice—"Who are you?"

In Lighter Vein

She answered—(taking sometime to gather up her courage) I am a newly appointed doctor here.

The lunatic replied, "It won't take long for them to knock that down of you. When I came here I was Napoleon."

In the Obstetrics Palpation Class.

Student says.—Primi para, all natural, No forceps.

Responsibility from Boss to Boy.

Boss.—(Finding a bug in a bed) "How often do you fire the cot?"

Assistant.—"I'll find out, Sir." He runs to the nurse and asks "How often do you fire the cot?"

Nurse.—The boy does it once a week."

Gathering Clinical Abnormalities.

Student.—(To girl patient operated for appendicitis) "What was your weight before the operation?"

She.—"One hundred and five."

Student.—"And now?"

She.—"Ninety-five."

Student.—(Suddenly got bleached and goose skinned) and said, "The heaviest appendix on record!"

Patient.—(Old lady.) But er-Doctor. Is snuff injurious to the brain?

Doctor.—No. For, no body ever takes snuff who has got any brain.

A Novelty in Accountancy.

Refer to Women Medicoes Receipts, Expenditure and Balance or page 300 of the May issue 1935.

It is said that a Philadelphian who recently committed suicide left the following note :

" I married a widow with a grown daughter. My father fell in love with my step-daughter and married her, thus becoming my son-in-law, and my step-daughter became my mother because she was my father's wife.

" My wife gave birth to a son, which was, of course, my father's brother-in-law and my uncle, for he was the brother of my step-mother.

" My father's wife became the mother of a son. He was, of course my brother, and also my grandchild, for he was the son of my daughter.

" Accordingly my wife was my grand-mother because she was my mother's mother. I was my wife's husband and grandchild at the same time, and as the husband of a person's grand-mother is his grandfather—I am my own grand-father !

Bartenders' Thoughts.

Two bartenders, standing on the beach of an Atlantic summer resort, gazed out on the ocean and contemplated it deeply.

" What do you think would happen, Joe," said one of them, " if all this turned into wine ? "

" Well," answered the other after a little thought, " with that much wine, we'd at least need the Pacific Ocean to water it."

Lawyer to Coloured Prisoner : " So you want me to defend you, Mose. Have you any money ? "

Mose : " No, but I's got a mule, a few chickens, and a hog or two."

In Lighter Vein

Lawyer : " I think I can take your case. Let's see—what do they accuse you of stealing ? "

Mose : " Oh, a mule, a few chickens and a hog or two."

Irate Madame : Hilds, why is it taking you so long to fill that salt-shaker ?

Equally Irate Maid : If you'd buy a shaker with bigger holes in the top, I could do it a lot faster.

*He—*Will you sail with me on the sea of matrimony ?

*She—*Yes, after you have made a raft of money.

Well, it was Somebody's Fault.

Jimmie was absent from school one day. The next morning he carried the following excuse to his teacher. " Please excuse Jimmie for being absent...he had new baby brother. It was not his fault."

University of Madras

Pre-Registration Examination, 1935

INORGANIC CHEMISTRY

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

Maximum : 100 marks

NOTE : Candidates must use separate books for PARTS I and II.

PART I

1. Write short notes on :—(a) supersaturated solution, (b) cation, (c) hydrolysis, and (d) reversible reaction. Give **two** examples of each. [16]

2. What do you understand by oxidation and reduction ? Give examples of the use of the following substances in effecting **one** of these processes :—sulphur dioxide, hydrogen sulphide, sulphuric acid, hydrogen peroxide, hypochlorous acid, nitrous acid. [14]

3. What is the experimental evidence for the belief that acids, bases, and salts are more or less ionized in aqueous solution ? Explain, on this belief, (a) the alkalinity of sodium carbonate solution, (b) the acidity of ferric chloride solution, and (c) the action of ammonium chloride in preventing the precipitation of magnesium salts by ammonia. [20]

PART II

1. A one per cent. solution of cane sugar freezes at -0.0546°C . Calculate the osmotic pressure of the solution and the molecular weight of cane sugar, the molecular depression for water being 18.6 [16]

2. Describe what happens (a) when a dilute solution of salt is progressively cooled, and (b) when a dilute solution of hydrochloric acid is progressively distilled. [16]

3. Describe the properties of colloidal suspensions and show how these properties can be experimentally demonstrated. [18]

189

University of Madras

Pre-Registration Examination, 1935

PHYSICS

TUESDAY, 10TH DECEMBER. 2 P.M. to 5 P.M.

Maximum : 100 marks

NOTE : Candidates must use separate books for PARTS I and II.

PART I

1. Explain how the following instruments are constructed, graduated, and used :—(a) the variable immersion hydrometer, (b) the aneroid barometer, (c) the clinical thermometer, and (d) the differential air thermometer. [18]

2. Define the coefficient of viscosity of a liquid, and explain how you would determine this constant for tap water, and compare it with that of kerosene. [16]

3. Give experimental and quantitative details for the determination of (a) the specific heat of air at constant volume, (b) the velocity of sound in glass. [16]

PART II

1. Define 'dispersive power' of a transparent medium. Explain the construction of a direct-vision spectroscope. Describe what you will see when you look at (a) a glowing neon lamp, (b) a carbon arc, (c) a sodium flame, through a direct-vision spectroscope. [16]

2. What are 'cathode rays' and 'positive rays' ? Describe **one** important practical use of each kind of these 'rays'. [18]

3. Write short notes on :—(a) critical angle, (b) an electrically driven tuning-fork, (c) variation of the temperature of the atmosphere with altitude, and (d) the effect of change of temperature on the refractive index of a liquid. [16]

Pre-Registration Examination, 1935

BIOLOGY

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

Maximum: 100 marks

NOTE: Candidates must use separate books for PARTS I and II.

PART I

1. Describe the general structure of a Tapeworm and a Bladder-worm. What relationship does the Tapeworm (*Taenia*) in man bear to the Bladderworm (*Cysticercus*) in the Ox or Pig? How is infection of the respective hosts brought about? [16]

2. What are Thallophytes? Explain the differences between Algae and Fungi. Describe briefly the life history of any Fungus with which you are acquainted. [16]

3. State briefly what you know of the following:—

(a) The foetal membranes.

(b) The germinal layers.

(c) The poison apparatus of a Viper. [18]

PART II

1. State what is meant by the maturation of a germ cell. Describe the changes that occur during this process and discuss their significance. [18]

2. Describe in detail the structure of a grain (fruit) of paddy, and give an account of the changes which take place in the seed during germination. [16]

3. Give an account of the evidences for evolution. [16]

First M.B. and B.S. Examination, 1935

ORGANIC CHEMISTRY

MONDAY, 25TH NOVEMBER. 10 A.M. to 1 P.M.

Maximum: 50 marks

NOTE: Candidates must use separate books for PARTS I and II.

PART I

1. Give a short account of the methods of formation, properties, reactions, and derivatives of acetic acid. [8]

2. Write the structural formula of urea according to Emil Werner. How is this formula supported by the synthesis of urea from ammonium cyanate, and by the reactions of urea? [9]

3. Write short notes on:—(a) 'proof spirit', (b) esterification, (c) hydrolysis of esters, (d) quaternary ammonium compounds. [8]

PART II

1. What are the characteristics of unsaturated compounds? If you are given a mixture of ethane and acetylene, state how you would separate them and obtain each in a pure condition. [8]

2. By what methods may salicylic acid be prepared? Write the structural formula of its derivatives that are of medicinal importance. [8]

3. Give an account of the part played by malonic ester in the synthesis of organic compounds. [9]

First M.B. and B.S. Examination, 1935

ANATOMY, INCLUDING ELEMENTS OF HUMAN EMBRYOLOGY

MONDAY, 25TH NOVEMBER. 2 P.M. to 5 P.M.

Maximum: 100 marks

NOTE: Candidates must use separate books for PARTS I and II.

PART I

1. Describe the floor of the fourth ventricle. [17]

2. Give a detailed account of the apical (cervical) pleura. [16]

3. Describe the inferior vena cava. What do you know about its development? [17]

PART II

1. Describe the sensory nerve supply of the skin of the face and forehead. Explain briefly how the nerve areas are determined by development. [17]
2. Describe the sacro-iliac joint and discuss the nature of its mechanism. [16]
3. Describe the arrangement of the tendon sheaths and bursal spaces of the wrist and hand. [17]

First M.B. and B.S. Examination, 1935

PHYSIOLOGY, INCLUDING BIOCHEMISTRY

TUESDAY, 26TH NOVEMBER. 10 A.M. to 1 P.M.

Maximum: 100 marks

NOTE: Candidates should use separate books for PARTS I and II.

PART I

1. Discuss the origin and fate of urea in the body. Explain the basis and the significance of the result of Maclean's urea concentration test. [17]
2. Describe the influence of the vagus on the digestive system. [16]
3. What conditions give rise to increased pulmonary ventilation? Discuss the mode of production in each instance. [17]

PART II

1. Give an account of the corneoscleral junction of the eye-ball, and mention the functions of the structures described. [17]
2. Describe the effects which follow unilateral section of the spinal cord in the mid-thoracic region. [17]
3. What is meant by buffer systems? What part do they play in the maintenance of the reaction of blood? [16]

Second M.B. and B.S. Examination, 1935

PHARMACOLOGY

MONDAY, 25TH NOVEMBER. 10 A.M. to 1 P.M.

Maximum: 100 marks

NOTE: Candidates must use separate books for PARTS I and II.

PART I

1. A powder (Gregory's) contains rhubarb, magnesium carbonate, and ginger. Describe the pharmacological action of each constituent and of the combination. [14]
2. How would you proceed to determine the mode of action of a substance which is found to cause diuresis? Classify the more important diuretics according to the mechanism of their action. [20]
3. Describe the effects produced by therapeutic and prolonged administration of (a) thyroxin, and (b) insulin. [16]

PART II

1. Give an account of the pharmacological action of salicylic acid and its more common derivatives. [18]
2. Mention the anthelmintics used against (a) hook worm, and (b) tape worm. Describe in detail how you would administer them. What toxic symptoms may be produced by them, and how may these be avoided? [18]
3. Describe the physiological action of the alkaloids of belladonna. [14]

Second M.B. and B.S. Examination, 1935

HYGIENE

MONDAY, 25TH NOVEMBER. 2 P.M. to 5 P.M.

Maximum: 100 marks

NOTE: Candidates must use separate books for PARTS I and II.

PART I

1. Compare the relative merits and disadvantages of open and underground drainage systems. [16]

2. Describe carefully in detail the procedure that should be adopted to prevent the spread of an epidemic of cholera in regard to (a) the infected cases, (b) general preventive measures. [18]

3. What is fumigation? State the circumstances in which fumigation is used in preference to other procedures. Describe in detail the procedure adopted when cyanide compounds are used for fumigation. [16]

PART II

1. Write brief notes on:—(a) hardness of water, (b) bore-hole latrine, (c) pasteurization, (d) permissible respiratory impurity. [16]

2. How is relapsing fever spread? Describe briefly the methods of prevention and control. [17]

3. Discuss the importance of vitamins in dietaries. [17]

Second M.B. and B.S. Examination, 1935

GENERAL PATHOLOGY AND BACTERIOLOGY

TUESDAY, 26TH NOVEMBER. 10 A.M. to 1 P.M.

Maximum: 100 marks

NOTE: Candidates must use separate books for PARTS I and II.

PART I

1. Describe in detail the process of healing of a granulating ulcer. [16]

2. Describe the effects of nephritis on (a) the renal excretion, (b) the tissue fluids, and (c) the cardia-vascular system. [18]

3. Describe the morphology and the cultural behaviour of the cholera vibrio. What bacteriological methods would you make use of for the diagnosis of a case of cholera? [16]

PART II

1. Describe the process of thromboses in a peripheral vein. Discuss the causation and indicate the effects which may follow in the vessel and in other parts of the body. [18]

2. Describe the post-mortem appearance which may be found in a child dead from acute osteomyelitis of the femur. [18]

3. Describe the mode of formation of a tuberculous cavity in the lung. What happens if **either** (a) a blood vessel, **or** (b) the pleura should become involved in the tuberculous process? [16]

Second M.B. and B.S. Degree Examination, 1935

OPHTHALMOLOGY

TUESDAY, 26TH NOVEMBER. 2 P.M. to 5 P.M.

Maximum: 50 marks

NOTE: Candidates must use separate books for PARTS I and II

PART I

1. How would you treat a case of phlyctenular conjunctivitis? [9]

2. Describe an operation for entropion of the upper lid. [8]

3. Describe the signs and symptoms of an early case of senile cataract. [8]

PART II

1. Under what circumstances would you elect to do evisceration of the eye rather than enucleation? Briefly describe the operation of evisceration. [8]

Give very briefly the main facts concerning *Retinitis Pigmentosa*. [8]

3. What is Crdde's prophylactic method for the prevention of *Ophthalmia neonatorum*? [9]

Final M.B. and B.S. Degree Examination, 1935**FORENSIC MEDICINE**

MONDAY, 25TH NOVEMBER. 10 A.M. TO 1 P.M.

Maximum: 100 marks

NOTE: *Candidates must use separate books for*

PARTS I and II.

PART I

1. What are the signs of virginity and *per contra* defloration? What fallacies underlie the appearances of signs? [15]
2. Under what circumstances are dying declarations admissible as evidence? What are the precautions to be taken in obtaining them? [15]
3. Describe briefly the morbid appearances produced by corrosives on the gastro-intestinal tract. Mention the fatal dose and fatal period of each. [20]

PART II

1. How would you determine the age of an individual below sixteen? [15]
2. Write notes on:—(a) superfoetation, (b) cadaveric spasm, (c) malpraxis. [20]
3. What are the different modes of violent asphyxial deaths? Describe the appearances in any **one** of them. [15]

Final M.B. and B.S. Degree Examination, 1935**MEDICINE**

MONDAY, 25TH NOVEMBER. 2 P.M. TO 5 P.M.

Maximum: 100 marks

NOTE: *Candidates must use separate books for*

PARTS I and II.

PART I

1. Describe the visceral symptoms which may occur in the course of *Tabs dorsalis*, and give the treatment in each case. [18]

2. What are the symptoms associated with the presence of *B. coli* in the urine, and how would you treat such a case? [16]
3. Describe fully the differential diagnosis of subphrenic abscess. [16]

PART II

1. In what way does the examination of blood smears and leucocyte counts assist in the diagnosis of fevers? [16]
2. Give the etiology, symptoms, signs, and treatment of chronic gastritis. [18]
3. In what way does tuberculosis affect infants and young children? Discuss the diagnosis of the condition. [16]

Final M.B. and B.S. Degree Examination, 1935**SURGERY.**

TUESDAY, 26TH NOVEMBER. 10 A.M. TO 1 P.M.

Maximum: 100 marks

NOTE: *Candidates must use separate books for*

PARTS I and II.

PART I

1. Describe the pathology and treatment of carbuncles. [16]
2. Describe the anatomy of the arch of the foot, and discuss the etiology and treatment of flat foot. [17]
3. How are fractures of the vault of the skull caused? Describe their complications and treatment. [17]

PART II

1. What are the clinical manifestations of gonorrhoeal infection of the knee-joint? Give the signs, symptoms, and treatment. [17]
2. Describe the signs, symptoms, and pathology of acute appendicitis. Discuss its diagnosis and treatment [16]
3. Describe the different types of fracture dislocations at the ankle-joint. Discuss their diagnosis and treatment. [17]

Final M.B. and B.S. Degree Examination, 1935**OBSTETRIC AND GYNAECOLOGY**

TUESDAY, 26TH NOVEMBER. 2 P.M. to 5 P.M.

Maximum : 100 marks

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

1. Describe the changes caused by rickets in the female pelvis. How is this deformity produced?

How may a contracted pelvis affect the course of pregnancy and labour? [17]

2. What factors may predispose to development of the ovum in the Fallopian tube? In what ways may such a pregnancy terminate? [17]

3. An expectant mother comes to consult you in the seventh month of her first pregnancy complaining of persistent headache, visual disturbances, passing a diminished quantity of urine, and general swelling.

What further examinations would you make to enable you to diagnose the condition from which she is suffering, and how would you treat her? [16]

PART II

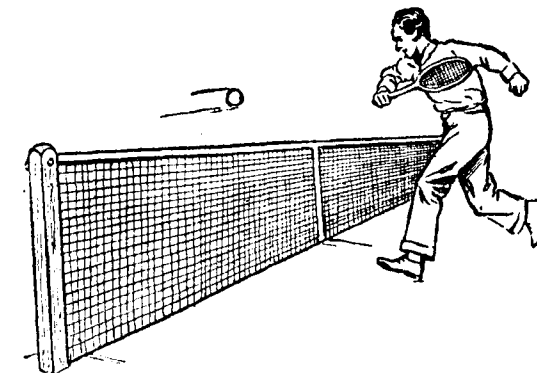
1. Discuss the causes of haemorrhage in a married woman at the age of forty who is not pregnant, and briefly enumerate the methods of diagnosis you would adopt. [17]

2. Discuss the part played by the endocrine system in the physiology of the female reproductive system. [16]

3. Discuss the changes that ovarian cysts may undergo, and state the lines of treatment you would adopt for a case of ovarian cyst complicating pregnancy. [17]

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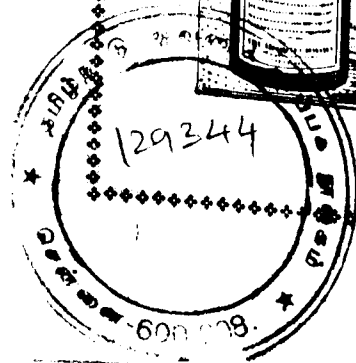
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