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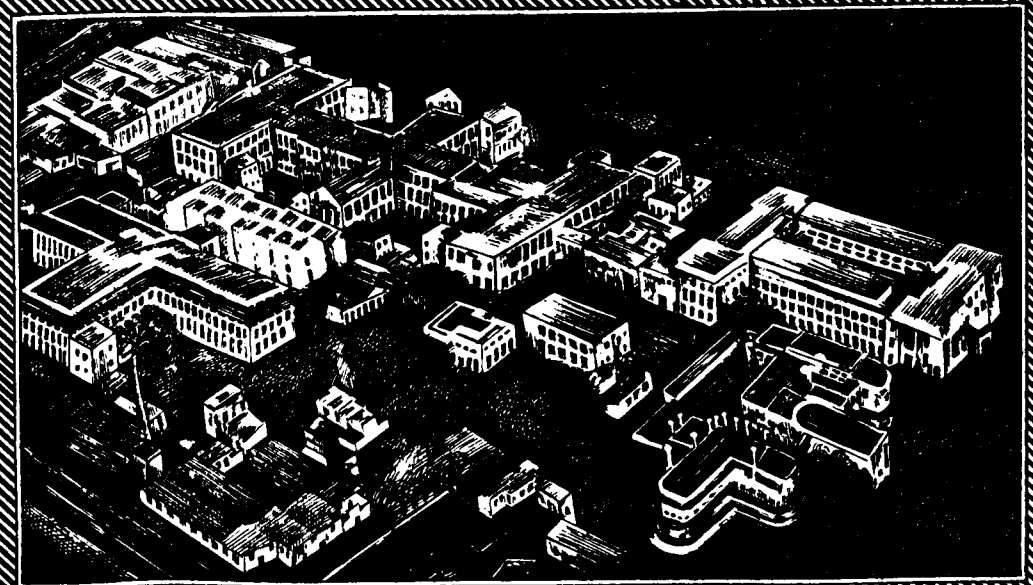
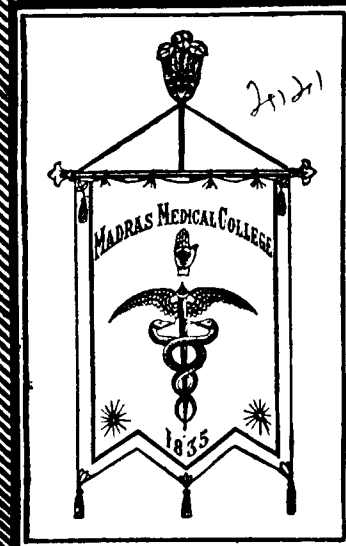
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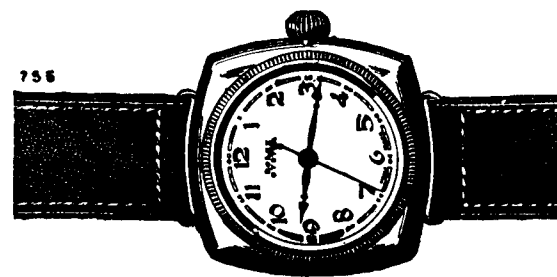
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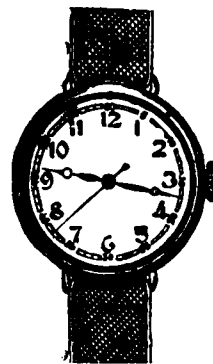
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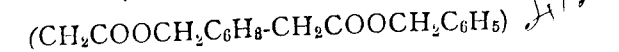
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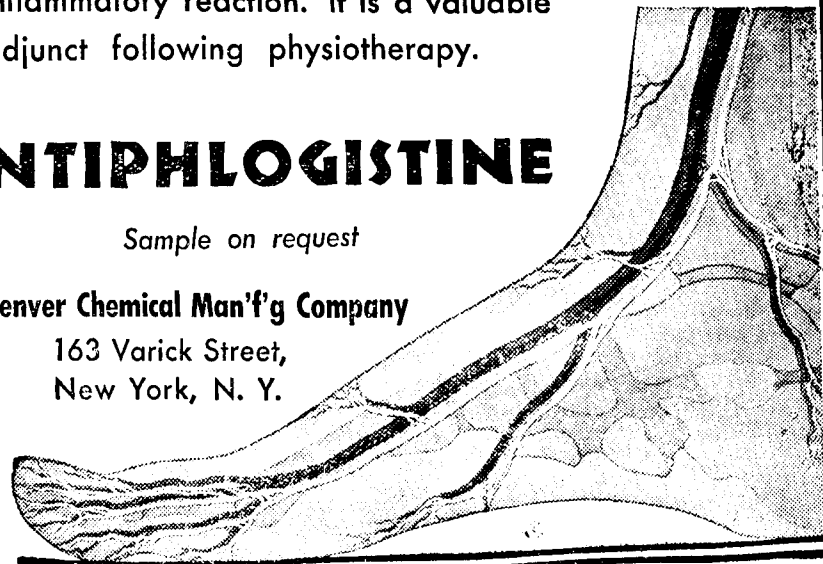
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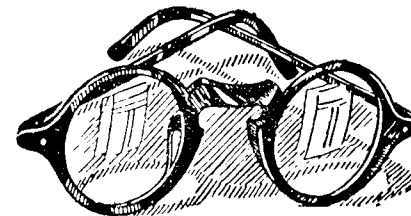
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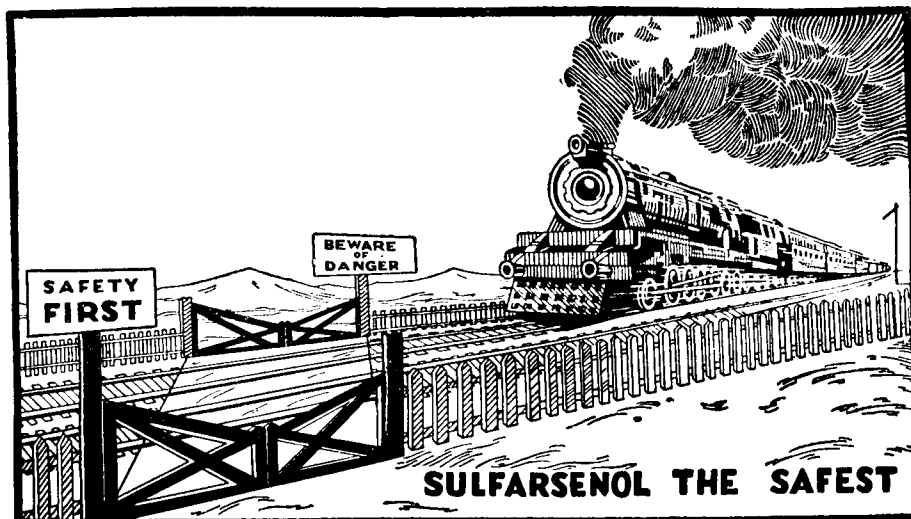
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Vol. XVI. No. 2.

NOVEMBER, 1936.

The Madras Medical College Magazine

Published under the auspices of
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Vol. XVI	November 1936	No. 2
	CONTENTS.	PAGE.
1. ADVICE TO THE GRADUATES By Rao Bahadur Dr. T. S. Tirumurti	...	97
2. CHRONIC MYOCARDITIS By Dr. M. Seetharama Rao, M.D., M.R.C.P. (Lond.) D.T.M. & H. (Eng.)	...	106
3. LYMPHOGRANULOMA INGUINALE By D. Sundareeswaram, M.B.B.S.	...	109
4. JAUNDICE By D. Govinda Reddy, M.D.	...	114
5. A CASE OF ANEURYSM OF THE ABDOMINAL AORTA By Miss A. Samuel, M.B.B.S.	...	118
6. "A CASE OF AMYOTONIA CONGENITA" By Dr. R. D. Vaidya	...	123
7. A CASE OF MEDIASTINAL NEW GROWTH By Rathnavelu Subramaniam	...	126
8. EDITORIAL	...	131
9. COLLEGE COMMENTS	...	133
10. LEST WE FORGET—MONKAMBU KRISHNAIYER SAMBASIVAN, M.B., B.S.	...	136
11. PERSONAL NOTES	...	137
12. THE MODEL SCIENTIFIC ARTICLE By Capt. C. S. S. Sarma	...	137

CONTENTS.	PAGE.
13. THE PUFF THAT CHEERS By Nivis	... 139
14. OUR PERSONALITIES By N. Money	... 147
15. ON PURGATIVES By "N."	... 151
16. TEASERS	... 153
17. MY PURSUIT By T. K. N.	... 154
18. LEAVES IN THE WIND By Boiler	... 156
19. ETHICS OF ELECTION By A. K. Krishnaswami	... 158
20. OUR BUS	... 162
21. TEASERS—(Answers)	... 164
22. SMILE A WHILE	... 166
23. LETTERS TO THE EDITOR	... 168
24. ASSOCIATION NOTES	... 169
25. CRICKET THIS YEAR By G. Atmaram Rao	... 172
26. THE WOMEN MEDICO'S CLUB	... 173

The Oath of Hippocrates.

I SWEAR by Appolo the Physician, by Asklepios, by his daughters Hygeia and Panacea and by all the gods and goddesses, that to the best of my ability and judgment I will faithfully keep this oath and obligation.

THE master that has instructed me I will esteem as my parents, and shall supply to him, as occasion may require, the comforts and necessities of life. His children I will regard as my own brothers, and if they desire to learn I will instruct them in the same art without any reward. My patients shall be treated by me to the best of my power and judgment in the best manner, without injury or violence.

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

MAY I be prosperous, honoured and esteemed by all men as I observe this solemn oath, and may the reverse be my lot if I violate it and forswear myself.



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My dear honey.

Thank you very much
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which you send me on behalf of
your Magazine Committee. I very
much appreciate their kind
message; was one of its original
members I am very glad indeed
to hear of its continued success
prosperity.

I hope I shall have an
opportunity of visiting the
Madras Medical College; for
which, & for its students I
always have a very high
regard.

Yours sincerely
W. C. Bradfield

The Madras Medical College Magazine

VOL. XVI

NOVEMBER 1936

No. 2

Advice to the Graduates*

BY RAO BAHADUR DR. T. S. TIRUMURTI.

MR. PRESIDENT, LADIES AND GENTLEMEN, AND THE NEW GRADUATES OF THE YEAR.

I have considerable pleasure in being allowed to participate in this pleasant function of the Reception to the graduates of this year and feel thankful to the Presidents of the College Students' Association and the College Magazine Committee for their kind invitation to me to address you this evening. It was probably their intention to parade me before you, being the latest addition to the College teaching staff.

Very warmly I congratulate you on your graduation from the University and the degree which has been conferred on you in recognition of your success in the examination, which you have won by dint of hardwork, after expending much money and many anxious days in the

preparation for your examinations. Accept my hearty felicitations.

You have made solemn promises that you will in your daily life and conversation conduct yourselves, as becomes members of the University; that, to the utmost of your opportunity and ability, you will support and promote the cause of sound learning and set an example of high principle and conduct; that you will, as far as in you lies, uphold and advance social progress and the well-being of your fellow men; and that you will faithfully and carefully fulfil the duties of the medical profession and will, on all occasions, maintain its purity and reputation and will never deviate from the straight path of their honourable exercise by making your knowledge subservient to unworthy ends. I am unfortunately expected to make a pleasant occasion like this by giving you some

* Address delivered at this year's graduate's reception.

advice but it will be considered presumptuous on my part to offer any to you, the new graduates of the year, who have sworn before God and the intellectual aristocracy and the intelligensia, who had assembled to witness the convocation ceremony, to such high principles, noble conduct, great ideals, selfless social service and proper professional services.

Older men, however, presume that they are competent to advise younger men, because they imagine that with their grey hairs they have gathered greater experience and gleaned precious wisdom. They scarcely pause to consider whether the young folk are in a mood to hear any advice, though they may tolerate, for a little while, the association, in deference to old age and whether they agree to the proposition that wisdom always goes with age. "மூத்தோர் சொல் வார்த்தை அமிர்தம்" is a copy book maxim not taken seriously by young men in these days. Youth is in revolt and is actuated by great ambitions to mould a new social order, to build a new world. We look forward to the youth to go forth bravely with stout hearts, proper mental and physical equipment, settled convictions and firm resolve to weather the storms, break the barriers, overcome the obstacles and plant its banners in the frontiers of social, political, economic, and scientific progress and demonstrate their achievements in all such directions. Glorious is the period of youth, more so is that active period of adult age, when its

powers and knowledge are put to the test.

You belong to the noblest of professions. Possibly some of you did not join the College, because of your love for the profession. It may be that yours was a Hobson's choice. But on account of that I should not style you as a "Vidhileka Vaiyudu". I believe that your curiosity in medicine has been gradually developed by your earlier studies of the basic sciences, until your curiosity became an active interest in the later studies and finally turned into a firm attachment, may I say 'love', to the noble Science and Art of Medicine. Many of you may have experienced such gradual evolution of love and others will sense it in the near future. This is how love grows or at least is expected to grow in the usual traditional and customary type of Hindu marriages. You were wedded to the medical profession when you joined the College and I am sure you love her now, and will continue to love her and honour her during the rest of your lives.

You, the graduates of the year, are like new laid eggs (please excuse the comparison) of your *Alma Mater*, the Madras Medical College. She now conceives twice in the year and lays eggs. It is difficult to say whether all the eggs will hatch and whether all the chicken will survive to develop into big fat poultry. I hope none of the eggs will prove sterile or become rotten.

The gentlemen graduates will, I believe, stick to their noble calling. None

I hope will stray to other vocations hereafter. Let me wish that the imaginary fear of unemployment does not drive any of you to become agents for the sale of proprietary or patent medicines or partners of commission agents of insurance companies and the like vocations.

But, as regards the lady graduates, I am not sure whether they deliberately took to medical studies to remain in that calling or whether they considered that the medical degree will add to their other qualifications to matrimony and motherhood. In the latter, I entirely agree with them. I wish them good luck at the earliest marriage season. But I dare not prognosticate which of them will continue to remain in our profession and which of them will fall a victim to cupid's arrows. Those that succumb at the sight of an Adonis will I hope shine as excellent wives and exemplary mothers. God bless them! But there is enough and more work for the members of both sexes in our calling. There is a greater need for women doctors than for those of the opposite sex.

AMBITION AND REALISATION.

By all means be ambitious. Aim high. He who aims at the star shoots at the tree. One who is not fired by enthusiasm and ambition is a failure in life. I do not know what the objects of your ambition are. They may be acquisition of material wealth, the desire of usefulness to the sick and the suffering or the

love of fame or something else. Though we may not all obtain eminence in the profession, we can at least attain the average, expected of every member of our calling. If the best things are not within our reach, let us not consider them to be sour grapes. Grasp those which are within reach and make the most of them.

TWO AMONG THE IMPORTANT KEYS TO SUCCESS—HEALTH AND CHEERFULNESS.

The public knows the old adage.—"Do not trust to a sick physician." A physician, robust and full of health, will be preferred. 'A sound mind in a sound body' applies equally to the physician. With a view to maintain your mental and physical health, you should live temperately and comfortably. Avoid the risk of premature break-down, as happens to many members of our profession. It is your cardinal duty to have your meals, your constitutional exercise and your sleep as regularly as possible. It is not mental activity, however great, but mental worry, which tends to shorten the physician's life.

Just as you would wish to maintain your industry and your honour, you should maintain also your health. If you do so, you will be a mental, a moral and a physical success in the profession.

It is said that our brotherhood is made in the Colleges but tried in the world. Our personality and deportment in the presence of our patients have much to do with our success. Our perso-

nalities depend to a great extent on our endocrine make-up. We may not be able to change hereafter our faces or features, our stature or body-build, our physical defects or deformities. But we can certainly cultivate a cheery disposition, which will express the desire for friendship and good-will. A cold, cheerless, ice-berg manner discloses an attitude of indifference and fails to inspire confidence in patients. The cheery physician has that intangible something in him which earns for him the reputation of being a "very nice man". The public clubs solemnity with stupidity. The practice of medicine is not a cold melancholy mournful occupation. Remember that the cheer which the doctor brings with him into the sick room infuses courage into the patient and it is a great thing, often a large part of the treatment. The pleasure of pleasing is very sweet.

PHYSICIAN AND HIS RELIGION.

Respect the religious belief of each and every patient. Each religious sect has for its object the worship of God and a clergy of its own to teach people its faiths and formulae. If you feel that there must be another and better world, then any religion is good which teaches man to be good. There is no religion higher than truth. Religion is a vital need to humanity, not only hereafter, but here. But do little or no theological teaching yourself. Eschew religious factions, as you should local politics or political parties, if you wish to succeed in the profession. But feel and show

Medical College Magazine

proper respect for all religions as for your own. Yearn for God's favour and friendship and God will bless you.

UNEMPLOYMENT.

You are fully aware that the spectre of unemployment stalks the land and stares in the face of the educated youth of the country. You would have been told that the medical profession is overcrowded, that you would have to face a cut-throat competition, and that you were not wise in making the choice of your profession. Don't you be discouraged by any such fears. Those statements are made only by the brother older members of the profession, who find themselves left behind in the race to keep in touch with the rapidly expanding spheres of the various branches in the science of medicine. Compare the percentage of medical men to the population in India with those in other countries and compare the figures of sickness, mortality (general, infantile and maternal), morbidity, and the number of preventable diseases and special diseases (pertaining to the tropics) in this country and elsewhere. To say there is no employment for you in the midst of such great amount of preventable sickness and suffering in the land is utter nonsense.

To say that there is no employment for you or that it is not sufficiently remunerative, or is not as remunerative as it was some years ago are two different statements. I demur to the former but agree with the latter. In the papers we find now-a-days most of the articles

Advice to the Graduates

written, or lectures delivered, or discussions held, are on the subject of unemployment of the educated youth, especially, the University graduates. It only shows that the problem of unemployment is being seriously considered, and discussed. Without minimising in any way the serious proportions, which this unemployment problem is assuming among the arts and science graduates, and those belonging to professions other than the medical, I may state that the crowding in our medical profession has not become so bad as to cry halt to the continuance of this medical college, or to the restriction in the number of students admitted into the college every year. At the time of the selection for admission this year, a resolution was passed by the selection committee that the admission should be increased from 100 to 150. I doubt very much whether this is a practical proposition, as the acceptance would mean greater expenditure for accommodation, staff and equipment. Those who have the interests of the furtherance of medical education here are rightly aiming at a better quality of practitioners and not for augmenting the quantity of them sent out every year, not because a larger number of medical men are not needed but because it is not possible with the finances available at present.

Selfish views on individualism and perverted ideas of nationalism, irreligion and worship of the yellow metal are driving other nations to mutual acerbities, national jealousies, economic unbalance and international hatred, which

engender in their train, war fear, national-hysteria and a feverish race to pile up armaments for destruction, in the belief that such preparations for war will ensure peace by perpetually keeping in each other's mind the dread of destruction. Moreover the youth in these countries are being prepared for such national needs as fodder for cannon and are made to forget the sanctity of human lives and the great truths of religion, the Fatherhood of God and Brotherhood of Man.

WAGE WAR AGAINST DISEASE NOT AGAINST YOUR BROTHER.

In a country like ours where we have the demons of Malaria and Cholera, Dysentery and Tuberculosis and Plagues and Pestilences of many kinds, which are daily taking a heavy toll of human lives, we have enough enemies to war against but we require for this great war men and munition of a different kind. We want martyrs who may have to give up their lives, unseen, unheard and unsung, in the service of their fellow men, men who are prepared to die in saving other men, not in killing them, and munitions, which are very simple and comparatively inexpensive, such as, proper food, better housing, improved sanitation, etc. Is it not, therefore, highly desirable to harness the youth of India in this great war—war against disease, unnecessary suffering, and premature death? Therefore, go into the profession with courage, undismayed, and a conviction that there is plenty of work awaiting you and that, in accomplishing even a small fraction

of that work, a rich reward awaits you in the gratitude of your patients, esteem and regard of your professional brethren and the blessings of God.

But you will ask "Who is going to employ us. The Government jobs are practically negligible. The country is poor. The cities are over-crowded with medical practitioners. The rural areas are unable to support me and my family. I must earn my bread. Manna does not drop from heaven to feed me and my wife and children. What is the use of your generalisations and unpractical advice to us? You belong to a previous lucky generation, when you secured admission into the College for the mere asking, when you had no necessity to humble-tumble yourself in many ways by carrying recommendations or interviewing, personally or with your father, father-in-law, guardian or friend, any or all of the members of a selection committee, which did not then exist; when you had to spend less and got easily employment in the Government service, with or without even a competitive examination, whereas the cost of producing the commodity has considerably risen now without a corresponding increase of purchasing power; when in most of the mofussil towns you were probably the only well qualified medical practitioner and the economic condition of the people was better and they were able to pay for medical relief; when there were not so many hospitals and dispensaries; when there were no L. I. M. practitioners to compete with

you; when only very few had foreign qualifications, and your chances of competition with them were not heavily weighted against you." I grant all these, but shall still stoutly maintain that the possibilities of making a decent living in your honourable calling, even in the rural areas, are still present. There is no use crying for the old days to return or sorrowing that the golden age is past. The conditions in the country are changing with over-population, fragmentation of land, diminished earning capacity and various other causes. We have to adapt ourselves to our changing environment, as otherwise Nature will weed us out.

Consider for a while what the youth who come out of the medical schools in other countries do. They never entered the College with the hope of securing any employment under the Government, for the simple reason that there is no Government civil medical service and Government hospitals as in India do not exist. There are no Surgeon-Generals or District Medical Officers. Most of the hospitals are maintained by charities, managed by lay committees or aided by contributions from local bodies. The large majority of medical men (except the House Physicians and Surgeons, who may get only a little pocket money, food and quarters) serve in an honorary capacity in these hospitals. There is no antagonism between the paid staff and the honorary staff, as it does show its ugly face now and again in this country, because there is no permanent paid staff, except the resident surgeon or pathologist

The hospitals are maintained by the well to do and the charitable public and are mainly for the gratis treatment of the poor and the professional services are freely and willingly rendered to the patients by the honorary doctors, who are attached to these hospitals. There is considerable competition to secure such honorary appointments in the hospitals. Every new fledged medico has to start only in the lower ranks as a house surgeon or physician and it is only after years of patient toil and hard work, that he hopes to rise in the honorary ladder, step by step, to higher and more responsible posts in the hospital. "How do they maintain themselves you may ask. They do so only by depending mainly on private practice. It is by serving the poor in hospitals in an honorary capacity that they improve their professional knowledge, and get themselves known to the paying middle classes and the rich and gradually build up a practice. Those that are not lucky in securing honorary hospital appointments have also to practise as independent general practitioners or as specialists and a few take to research appointments. All belong to *one undivided medical fraternity*. Indeed the medical profession is a noble profession, especially when you see the system obtaining in other progressive countries. You can never see there the sorry spectacle of a single medical man, discharging in the course of a couple of hours a hundred or two hundred out-patients. Hospitals including special ones are served by a group of honorary professional men and all the general hospitals have

attached to them honorary consultants and specialists in all important branches of medicine.

A beginning was made here in this direction some years ago and the experiment having proved successful, further additions to the city hospitals' honorary staff and extension of the system to the mofussil hospitals have been effected by Government. This is not the time or the place for me to discuss other ways and means of employing more members of our profession nor is it in my province. It is possible to absorb all the unemployed diplomates and graduates in medicine if a more extensive scheme of medical relief and public health is embarked upon. But I may be given the indulgence to give expression to an ambitious scheme of mine *i.e.*, to induce as many of the medical graduates as possible, who have the desire, to specialise for a year or two after graduation in Practical Pathology, Bacteriology and Bio-Chemistry, so that they may be capable of running independently a good clinical laboratory in every large city or district headquarters and giving a reliable report on specimens sent to them for examination or may attach themselves (honorary or part-paid) to such a laboratory, which ought to be a functioning unit at least in every district headquarter hospital. I do not consider the scheme to be Utopian. No hospital can be called well-equipped or properly staffed without such a laboratory and specialist. It would contribute to a better and quicker diagnosis of diseases and thereby to a

speedy and proper attention to treatment.

THE FUTURE OF THE MEDICAL PROFESSION.

Mahamahopadhyaya Vidyavachaspati Kuppaswami Sastrigal said in his address at the recent Convocation, in which you took your degrees, "the promise of a better future for India is to be looked for only from those to whom her past is dear. A true Indian has his life certainly in the present, but he finds the roots of his life in the past, and has his eyes turned towards the future. Any attempt to write on a clean slate and to demolish the past completely and build anew is against the nature of India's genius and such attempts will prove to be dismal failures". These statements apply also to our profession. Our College is one of the premier and earliest medical institutions. We celebrated the centenary of our college last year. She has continued to maintain in a creditable manner the first place in respect of medical educational progress and the *alumni* of this College have earned a name and a reputation for professional skill and knowledge, not only here but in the other parts of India and abroad, and the services of the Madras Medical College graduates were highly spoken of in the official records and despatches during the last Great War. It is now up to you the young entrants into the profession to keep the good name untarnished and add lustre to it by your work and achievements.

Medical College Magazine

CASTE IN THE PROFESSION.

The training in our College and hospitals is such that all narrow and irrational ideas of caste and colour are wiped out of the minds of the students and before they emerge from these institutions, they become well imbued with broad and liberal views. You have to treat patients from all grades of society and all ranks of social status men of all types and conditions,—the prince and the peasant, the rich and the poor, the capitalist and the labourer, the beautiful woman and the hideous hag, the chaste and the sinner, the brave and the coward. Helping the sick out of their ailments, relieving suffering and curing disease, if possible, are your aims and objectives. You do not care to enquire about the patient's political opinions or religious beliefs. You lose all wrong sense of caste, so far as your patients are concerned. As physicians, we are half-brothers to the whole world.

THE NEED FOR UNION IN THE MEDICAL PROFESSION.

But what about ourselves in the profession? We are divided among us into various castes, each caste having an association of its own, spitting venom at each other and working in a spirit of isolation, hate and bad-will for temporary gains and advantages over each other fondly believing that progress lay in those directions. What is our individual contribution to the crumbling of our class barriers. Have we banded ourselves into a medical fraternity of which the

Advice to the Graduates

whole of India may feel proud? Have we anything on the model of the British Medical Association or the American Medical Association, of which those countries are justly proud and which enjoy a high reputation and wield much power and influence in their respective countries and great regard in other parts of the world.

An attempt in this direction should be made for the constitution of an All India Medical Association. If this is done, in the course of a few years we also will have the satisfaction of belonging to an association which will command respect from the public and will be treated considerably by the sister associations of other countries. "In union is strength, divided we fall" is a well known proverb. Let us all work towards this glorious future of the medical fraternity in our country and may God bless our attempts.

India's contribution to Medicine in the past has been great. It is from India that the Art of Medicine spread to the Arabs and the Greeks and thus to the rest of the western world. Her present progress in medical education by contact

with the west is also steady and satisfactory. Her future in Medicine should be also great. We are now mostly borrowers of knowledge from other countries. Are we going to contribute to knowledge and advancement of science and repay our debts with compound interest? or are we going to remain for ever a debtor medical fraternity? Revere the past, have confidence in the present, and hope for the still more glorious future of our profession.

Regular Medicine is one of the three liberal professions—Ecclesiastical, medical and legal. The term 'liberal' has been long applied to this triad of professions because of the pursuits in—preventing and curing sin, preventing and curing disease and preventing and curing legal wrong—all three uniting to protect man's soul, body and estate. You should therefore feel proud to belong to the noble liberal profession of Medicine.

Therefore "make Physiology your Grammar, Pathology your Dictionary, Physical Diagnosis your Crowning Study and Therapeutics your Medical Bible".

Wish you splendid health, unclouded happiness, and great prosperity.

Chronic Myocarditis

By

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"In acute affections we concentrate our attention on the diseased organ, whilst in chronic cases we keep the general condition of the patient more in view."

Diagnostic terms in clinical medicine are often very hard to dislodge. Sometimes they mean nothing but at other times can be positively misleading. The term "chronic myocarditis" belongs to this class. And yet it is very often used among diagnostic terms. Any term used in medicine must have a definite meaning. It should either state a pathological fact or help in treatment of a case or be of help in prognosis. Correct conception of the underlying pathological state leads to the use of a correct diagnostic term, which in turn helps in correct treatment and a scientifically based prognosis.

When we use the term "chronic myocarditis", we mean that there is a chronic inflammation of the heart muscle. In a chronic inflammation of any other tissue or organ of the body, we find certain definite pathological changes, *viz.*, varying degrees of necrosis of the parenchyma of the organ with replacement by fibrous tissue, presence of inflammatory cells, etc. Do we find similar changes in a case of chronic myocarditis diag-

nosed as such? The answer is in the negative.

Take the case of a patient with "chronic myocarditis" in a very advanced stage of a congestive heart failure. The patient is breathless, cyanosed, waterlogged and *in extremis*. If this patient died and we performed a *post mortem* on the body, would you find a great part of the heart muscle disappeared and replaced by fibrous tissue and the presence of an abundance of inflammatory cells? Again in a case of Diphtheria with sudden death, or in a case of Beri-beri with sudden death, do we find extensive inflammation of the myocardium? The answer is again in the negative. Why? Because it is not the quantitative pathological changes occurring in the myocardium that are important. It is some qualitative change that occurs, about which we do not as yet know, and which cannot be detected by the microscope. Often a heart which has failed with dramatic suddenness or one which has shown signs of great labour during life disappoints one when examined after death, with paucity of changes which had led to its failure.

There are however certain definite changes that occur in the myocardium, as

Chronic Myocarditis

a result of certain definite noxious agencies. About these, however, there is nothing vague, and the term myocarditis may be justifiable as satisfying the canons of pathology.

These are as follows:

I. Toxic Factors: The toxic factor is present in conditions like diphtheria, typhoid, typhus, yellow fever, scarlet fever, etc. Clinically there is scanty evidence of involvement of the myocardium. All that we can see is shifting of the cardiac impulse outwards, progressive softening of the mitral first sound, rarely a heart block and still more rarely auricular fibrillation. *Post mortem* reveals cloudy swelling of the heart muscle fibres with a slight degree of necrosis here and there and presence of inflammatory cells.

II. Nutritional factors: Severe anaemias, chronic nephritis and chronic infections, can produce definite fatty degeneration of the myocardium.

In coronary occlusion, a massive necrosis of a chunk of heart muscle occurs, followed by aseptic inflammation and fibrosis.

III. Mechanical factors: The myocardium is probably affected by the strain of a number of diseases as in lobar pneumonia, broncho-pneumonia and chronic pulmonary tuberculosis. There is no myocarditis as such but probably myocardial weakness only.

IV. Rheumatic infection: Rheumatic infection of the heart stands in a class by

itself. The aetiology is still *subjudice* but the pathology is definite. The fundamental unit in the pathology of the carditis of rheumatism is the Aschoff's nodule. In addition in the acute stage there is oedema of the muscle fibres. Note that the endocardium and the pericardium are also affected. There is a true carditis.

V. Syphilis: I wish to particularly emphasise the role of syphilis in "Chronic Myocarditis". The brunt of the damage is really borne by the aortic arch. A diffuse syphilitic myocarditis or local gummatous deposits may undoubtedly occur but are not common. Narrowing of the mouths of the coronary arteries as the result of syphilitic mesaortitis is commoner. The old idea that syphilis affects the myocardium by setting up a diffuse luetic inflammation is not supported by the facts of pathology and in the large number of cases such damage as the heart muscle suffers in cardioaortic syphilis is due to the reduction in the arterial blood supply.

Let me now draw attention to the maxim quoted at the beginning of this paper. It is particularly true in the case of "Chronic myocarditis."

Our chief concern in any case of heart disease centres round the myocardium and its functional efficiency. We have to grasp certain fundamental facts, about the myocardium, in the proper understanding of any case of heart disease, so as to sum up an individual case and rationalise our management of the case.

The blood supply of the heart is peculiar. There are only two coronary arteries with very poor anastomosis between their smaller branches. And the coronary arteries have to maintain the blood supply of the heart muscle under all conditions—of rest, work and abnormal work. When a heart enlarges greatly in size as the result of disease, there is no corresponding increase in the size of the coronary arteries. As age advances, these arteries are liable to atheromatous changes. This still further reduces the blood supply to the myocardium.

If now the patient has chronic lung disease or chronic passive congestion of the lung, the factor of *anoxæmia* creeps in. To sum up, an inadequate blood supply, still further reduced by arterial disease and of a blood deficient in its quota of oxygen. The heart muscle consequently suffers like any other muscle of the body.

Consider next the factor of mechanical strain. The heart muscle may be burdened by a valvular defect or adhesions to the mediastinal walls. Again with advancing age there is the question of a rising systemic blood pressure. If there is also chronic lung disease again, *e.g.*, emphysema, the burden on the right ventricle has to be considered, and then there is the strain of powerful coughing. A myocardium, labouring under these burdens, is very apt to set up auricular fibrillation, which is a further heavy load on the myocardium.

Then there is the very important factor of *Infection*. In any heart condition, the presence of infection, often in the respiratory tract, adds to the inefficiency of the myocardium. This certainly has to be taken into consideration in treatment. It is a well known clinical fact that a heart case deteriorates further after every attack of a "bronchitis" or "influenza". Every chronic heart case has to avoid these intercurrent infections like the plague.

My plea now is that what I have presented above is really the substructure underlying many cases of "chronic myocarditis" diagnosed as such. The myocardium is being undermined not by a right royal inflammation with its sequelæ as such but by varying combinations of the above factors. It therefore pays in every case of "chronic myocarditis" to search for these factors and as far as possible help the myocardium labouring under the defects.

In conclusion, I wish to state that in "chronic myocarditis" various factors are at work. As a pathological term, it certainly overstates the facts and is misleading.

No originality is claimed for any of the observations above. I have freely drawn from my notes of lectures at post graduate clinics in London and from Lewis' admirable book *Disease of the Heart*. I have purposely made the paper very brief after pruning it several times so that the essentials may not be lost in a mass of discussion.

Lymphogranuloma Inguinale (CLIMATIC BUBO)

BY

D. SUNDARESWARAN, M.B., B.S.

Lymphogranuloma inguinale, Climatic bubo, Paradenitis, Lymphopathia Venereum are some of the names by which this malady is known. Stannus calls it 'the sixth venereal disease'. The disease is caused by an ultra microscopic virus, which has a peculiar predilection for the lymphatic system. There are other clinical manifestations in addition to the bubo, such as elephantiasis of the genital regions in both the sexes, ulceration of the vulva, perianal elephantiasis, ulceration and inflammatory stricture of the rectum which are included under this heading.

Geographical incidence.—The disease is commoner in warm climates, tropical and subtropical.

Sex incidence.—Again it is preponderantly commoner in men than in women and there are three explanations offered for the same. Firstly women are less susceptible to the virus than men. Secondly the virus might be a saprophytic inhabitant of the vagina. The last and the more rational view is that it is due to the peculiar disposition of the genital lymphatics in the female. The lymphatics of the lower half of the vulva, fourchette, vagina and cervix drain into the

glands of the pelvis but the lymphatics of the upper part of the vulva, and clitoris drain into the inguinal set of glands.

Age incidence.—The age incidence is between 20 and 60 years, the maximum being during the age of greatest sexual activity.

The Primary lesion.—The initial lesion is most often small, herpetiform vasicle or ulcer, single or multiple, circular in shape, nonitching painless and evanescent. Rarely it occurs as a papule or a nodule.

The commonest site is the coronal sulcus in the male and the fourchette in the female. The incubation period is anything from 3 days to 3 weeks.

Site of Bubo.—The inguinal bubo is usually unilateral occasionally bilateral. The associated iliac adenopathy is a notable feature. In extra-genital infections as in the case of surgeons, an axillary adenitis may develop. Cervical adenitis has been recorded as a result of unnatural sexual practice.

Onset and course.—The condition is insidious and subacute from the beginning. The first symptom may be aching

Lymphogranuloma Inguinale



Fig. 1. Climatic bubo.



Fig. 2. Genito-anorectal syndrome.

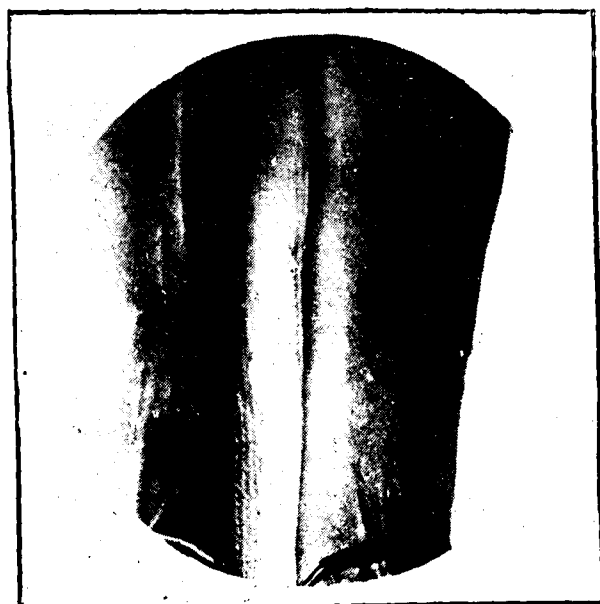


Fig. 3. Frei's test.

Left: Positive intra-dermal reaction.

Right: Saline control.

in the groin on walking followed by a swelling. The gland is discrete, slightly tender on pressure and easily movable. It resembles the glands of early syphilis very much. The inner set of inguinal glands are most often affected. This may retrogress or go on to suppuration.

Sometimes it is a more chronic indolent condition. The pathological process is confined to the inguino cruro iliac group of glands. The mass of glands gets matted up. Peradenitis is marked, the skin becomes adherent and assumes a purplish colour in fair individuals. An oval lobulated swelling parallel to the inguinal fold occupies the groin.

Breaking down takes place at multiple points of suppuration, and these discharge, thick, greenish viscid, tenacious gluey pus. In a neglected case, the groin may be riddled with multiple discharging sinuses.

Changes take place in the areas of skin drained by these glands. A subacute lymphangitis with oedema or chronic indolent ulcers on the skin of the penis, scrotum and thighs probably due to the lymphatic stagnation and invasion by secondary organisms.

Occasionally the iliac set of glands may suppurate, forming an intrapelvic abscess, causing pressure symptoms, which opens in the loin.

Pathology.—Naked eye examination reveals a mass consisting of an agglomeration of enlarged glands glued together by a plastic periadenitis.

On section, the glands exhibit various stages in one process patchily distributed, and in colour may be red from engorgement, or varying to a grey colour.

The capsule is thickened and fibrous and shows recent vascularisation and infiltration with plasma cells. The capillaries show dilatations, periarteritis, others an obliterative endarteritis.

The essential lesion consists of little pinpoint epithelioid formations scattered throughout the gland substance. Subsequently degenerative processes occur and tiny micro abscesses result. Isolated giant cells are also seen in chronic cases.

The gland parenchyma are replaced by an inflammatory mass of young fibroblasts, and a cellular infiltration remarkable for polymorphism.

Constitutional symptoms.—The Constitutional symptoms may be mild, severe or relapsing in character. They include fever, rigors and sweats, anorexia, nausea vomiting, loss of weight and lassitude. Rarely pulmonary reaction with bronchitis, meningeal reaction with stiffness of the neck and intense headache may occur. Continued pyrexia with delirium and typhoidal state is occasionally seen in a few cases, but in the majority of cases, the pyrexia is only slight with a tendency to exacerbation in the evenings.

The blood picture shows moderate leucocytosis and secondary anaemia.

Skin conditions such as erythema nodosum, and erythema multiforme have

been reported; but a pustular impetiginous eruption has been noted among the cases seen in the venereal department.

Other coexisting venereal diseases do not alter the course of the disease.

Wassermann reaction.—In a certain proportion of cases of Lymphogranuloma the blood shows a positive Wassermann reaction even in the absence of syphilis, which tends to become negative as the conditions subside.

Frei's test.—The introduction of the skin test by Frei is a milestone of great importance. The virus of climatic bubo is transmissible to rabbits, monkeys, guinea-pigs and mice. Intra cerebral inoculation of the virus produces an encephalitis in these animals.

Preparation of the antigen—Pus aspirated under aseptic precautions from a case of lymphogranuloma is mixed with saline in the proportion of 1 : 5 or 1 : 10. It is heated to 60° C for 2 hours on the first day and for 1 hour on the subsequent day. The heated saline pus emulsion is tested for sterility 0.1 c.c. of this antigen is injected intradermally into the forearm of the suspect and 0.1 c.c. of saline also as a control. The result should be read after 48 hours. A positive reaction consists in the production of an infiltrated, inflammatory dome-shaped papule $\frac{1}{2}$ to 1 cm. in diameter. In some cases, there is a tendency to central necrosis of the papule.

Diagnosis.—Diagnosis is made by the presence of a tiny, superficial painless,

fleeting fertile lesion and more often by its absence, the subacute inguinal adenitis, the slow course with a tendency to multiple foci of suppuration, the iliac adenopathy, a positive Frei's test, negative Wassermann and D'Melcos tests.

Treatment.—Various kinds of treatment have been advocated. Total or partial enucleation of the glands is suggested. The latter is more preferable as the former is associated with the risks of elephantiasis. Intravenous injection of Frei's antigen filtered through gauze, injection of solgonol B, injection of convalescent serum from a patient recovered from Lymphogranuloma inguinale, Protein shock therapy, injection of antimony salts and application of X rays have been advised. In the special Department of the General Hospital, the combination of protein shock therapy with antimony salts has given fairly good results.

The local treatment consists in the aspiration of the bubo and the injection of sterile glycerine.

The genito anorectal syndrome.—The lymphogranulomatous nature of this has been recognised now. It was thought to be syphilitic as the anorectal syphiloma of Fournier. Tuberculosis has been blamed for the same condition owing to the histological appearances resembling those of tuberculosis.

In women, this same condition was thought to be gonococcal in origin. The condition has also been variously inter-

Lymphogranuloma Inguinale

preted as Fissure anus, Fistula-in-ano, malignant ulceration of the rectum.

The actual clinical appearances noted are:

(1) Perianal ulceration with single or multiple irregular granulomatous ulcers with thickened polypoid edges stopping short of the anal region. The anus is surrounded by elephantoid masses of tissue covered by skin and ulcerated on the inner aspects. Deep fissures separate the masses.

(2) Elephantoid condition and ulceration of the labia-elephantiasis of the scrotum and penis.

(3) Perianal fistulae

(4) Rectal stricture. The infiltration of the perianal and anorectal lymphatics leads on to organisation. This results in a tubular narrowing of the lumen or a ring-like stricture. The mucous membrane over the stricture spot and above is smooth and non-ulcerated. That below is ulcerated, either due to secondary infection or trauma.

The distance of the stricture from the anus is from 2-8 cms.

Symptoms.—Passage of blood and mucus with increasing difficulty in

defaecation is noticed. Tenesmus with constipation and diarrhoea and a sense of imperfect emptying of the bowel are also seen.

The site and extent of the lesions, the prolonged duration, the history of previous bubo, a positive Frei's test and negative Wassermann reaction with absence of response to antisyphilitic treatment clinch the diagnosis.

The treatment is the injection of a course of Fouadin, starting from 1.5 c.c. increasing by 5 c.c. all up to 5 c.c. maximum for an individual dose with a total dosage of 50 c.c. The regular passage of rectal bougies in early commencing stricture. In more serious cases complicated by fistula and perirectal fibrosis, a colostomy with extirpation of the diseased part is the ideal to be resorted to.

I am greatly indebted to Dr. R. V. Rajam, for his help and guidance in the preparation of this article.

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Jaundice.

BY

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(An Extract from the Manuscript—The Handbook of Laboratory Medicine—Blood).

INTRODUCTORY.

Introductory.—Bilirubin is the non-iron containing moiety of haemoglobin. Daily, as the worn out erythrocytes are broken down, a certain amount of bilirubin is formed and gets into circulation. The splitting of haemoglobin and formation of bilirubin is done by the reticulo-endothelial system in the body, chiefly the Kupffer cells in the liver.

If for whatever reason, the haemolysis of erythrocytes is increased, the amount of bilirubin formed will correspondingly increase. In the normal course of events, this bilirubin, as it circulates in the blood, passes through the hepatic cells, and is excreted as bile. At this stage two important changes occur. (1) The bile acids (bile salts) are synthesized by the liver. The bilirubin when it passes through the liver cells and excreted as bile attains certain altered properties. For convenience, we will call the bilirubin that has not passed through liver cells as *Type i bilirubin*, and that, which has passed through the liver cells as *Type ii bilirubin*, (bile proper).

When fully formed bile reaches the large intestines, it is converted into

colourless substance, *urobilinogen*, by the action of bacteria. Most of the urobilinogen is excreted with faeces, and a portion is carried back to the liver by the portal vessels. Part of this is reconverted by the liver cells into bile. The remaining portion gains entrance into general circulation to be excreted in the urine. By the action of light, the urobilinogen of urine is converted into *urobilin*.

Vanden Bergh reaction. (Ehrlich's azo reaction) *Reagents* :—

Solution A.

Sulphanilic acid	...	1 gram.
Concentrated HCl	...	15 c.c.
Distilled water	...	1000 c.c.

Solution B.

Sodium nitrite	...	0.5 gram.
Distilled water	...	100.0 c.c.

N.B.—Sodium nitrite solution has to be freshly prepared, as it quickly deteriorates with time.

The two reagents are mixed only just before use in the proportion of 25 c.c. of solution A, and 0.75 c.c. of solution B. Ehrlich's diazo reagent is formed and when it combines with bilirubin, azo-

Jaundice

bilirubin, a purple coloured compound appears.

Technique.—About 5 c.c. of blood is required for the test. To prevent lysing of blood, a few crystals of potassium oxalate may be added. The blood is centrifuged and clear serum separated. The tests have to be done within a couple of hours, as otherwise paradoxical results are obtained.

Direct reaction.—To 0.5 c.c. of serum in a test tube, an equal amount of solution (A) and a drop of solution (B) is added. A purple colour develops immediately. Addition of a small crystal of Caffeine-sodium-salicylate accelerates the development of the colour.

(a) *Direct immediate reaction*.—Bluish colour develops immediately and reaches maximum intensity within 30 seconds.

(b) *Direct delayed reaction*.—A reddish colour deepening to violet, begins to appear in about 15 minutes.

(c) *Direct biphasic reaction*.—A reddish colour develops immediately and deepens into violet after a long time.

Indirect reaction.—To half c.c. of serum, about one c.c. of alcohol (96 per cent) is added, when a white curdled precipitate is formed. After centrifuging, the supernatant fluid is pipetted into a separate tube, and an equal amount of solution A, and a drop of solution B are added. A violet colour develops if the reaction is positive. An alternative method of doing the test is, to add 0.5 c.c. of diazo

reagent to 1 c.c. of serum and after a minute, 2.5 c.c. of 96 per cent alcohol, and 1 c.c. of aqueous ammonium sulphate solution. The contents are thoroughly mixed and centrifuged. The supernatant fluid shows the colour change.

Type ii bile (Bilirubin that has passed through both the Kupffer cells and liver cells) gives *direct Vanden Bergh reaction*.

Type i bile (Bilirubin that has passed through Kupffer cells only, but not through the liver cells) gives *indirect reaction*.

When both Type i and Type ii bile get into circulation, the reaction will be positive for both the tests.

VARIETIES OF JAUNDICE.

(1) *Obstructive Jaundice*.—Where there is partial obstruction to the flow of fully formed bile through the natural passages, it gets into circulation and gives direct Vanden Bergh reaction. If the obstruction is complete no bile gets into the intestines, resulting in clay-coloured stools, and absence of formation of urobilinogen. As such after a time, the urine fails to show even a trace of urobilinogen. If the obstruction is not relieved in time, the liver cells which were healthy when the obstruction has set in get damaged, resulting in inability to deal with all the bilirubin that has passed through the Kupffer cells. Thus type i bile also gets into circulation, and gives a positive indirect reaction in addition.

(2) *Haemolytic Jaundice*:—When excessive haemolysis occurs due to any cause, Type i bilirubin is formed in large quantities, which the liver cells cannot excrete fully. So type i bilirubin remains excess in circulation and gives a positive indirect Vanden Bergh reaction. Type i bilirubin is not excreted by the kidney unless it reaches about 4 to 5 times the kidney threshold value of Type ii bile. So it is known as *Acholic Jaundice* and the icteric tinge is not very intense.

Haemolytic jaundice occurs in

1. Acholic jaundice (Familial).
2. In all conditions where excess of blood destruction occurs as in (a) snake bite (b) intravisceral haemorrhages (c) blood infection with haemolytic streptococci.

3. Pernicious anaemia:

In pernicious anaemia, the bilirubin content of blood is generally above normal as shown by the icterus index, but below the amount necessary to produce clinical jaundice. This is known as *latent jaundice*.

In the above conditions though urobilinogen is formed in excess, very little is re synthesized into bile by the liver cells, as they are partially damaged. So excess of urobilin is found in the urine.

(3) *Toxic jaundice*:—Here the liver cells are either partially or completely damaged. The earliest effect of such a damage will be a certain amount of ina-

bility to reconvert urobilinogen into bile resulting in increased amount of urobilin in the urine. Soon there will be accumulation of Type i bile (bilirubin) in the blood, giving a positive indirect Vanden Bergh reaction. With continued action of toxin, the hepatic cells get badly damaged and swollen causing obstruction to the flow of bile, in the fine bile canaliculi. Type ii bile gets into circulation and gives direct Vanden Bergh reaction. The blood now contains both forms of bilirubin. The more severe the injury to liver cells, the more complete is the retention of bilirubin and higher the urobilinogen content in urine. In extreme forms as acute yellow atrophy of liver, very little bile gains entrance into the intestines, with the result that little urobilinogen is formed. So the urobilin content of the urine will be markedly reduced.

(4) *Catarrhal Jaundice*.—The time honoured view is that catarrhal jaundice is due to obstruction of common bile duct, resulting from spread of inflammation from gastro-intestinal tract. Though this is true in a few cases, one has to remember the present day conception that in catarrhal jaundice there is mild hepatitis or toxic necrosis of liver cells. Due to obstruction to the flow of bile, type ii bile gets into circulation and gives direct Vanden Bergh reaction. At the same time as the liver cells are partly damaged, a portion of Type i bile, (bilirubin) gets into circulation. Thus both direct and indirect reactions are positive. The urobilinogen content of

Jaundice

urine first increases, and when complete obstruction occurs it disappears from the urine.

QUANTITATIVE VANDEN BERGH REACTION.

The normal bilirubin content of blood varies from 1 in 1,000,000 to 1 in 400,000. When it reaches 1 in 80,000 the sclera and the skin show the jaundiced colour (Clinical jaundice). The bile gets excreted in the urine when the bilirubin content of the blood has reached 1 in 50,000. In practice cobalt sulphate solution is used as a standard to measure the bile content of the blood serum.

The quantitative estimation of bilirubinaemia by Vanden Bergh's method is found to be not very satisfactory in clinical work. In its place, icterus index has come into vogue, and this is found to be simple and fairly reliable.

The Icterus Index.—The serum has to be very carefully separated preventing any trace of haemolysis. The best time

to collect the blood is 3 to 4 hours after a meal. A freshly prepared 1 in 10,000 dilution of potassium bichromate solution is used as the standard. The blood serum is diluted till it almost matches the colour of the standard bichromate solution. The comparison is done in a colorimeter. For dilution of serum, normal saline is used instead of water, as the latter precipitates the globulins of the serum giving an opalescence. The number of times the serum is diluted denotes the *icterus index*.

The normal icterus index varies from 4 to 6. No clinical symptoms will be noticed, when it is between 6 and 15. (Latent jaundice). When the index is above 16, it will never fail to show the clinical symptoms. It also furnishes a simple method of determining, whether the jaundice is increasing, decreasing or stationary. It is very useful in differentiation of some of the anaemias. In pernicious anaemia and anaemias of haemolytic origin, the icterus index is high while in secondary anaemias, it is generally low.

A Case of Aneurysm of the Abdominal Aorta

From Captain Minchin's Wards

REPORTED BY

MISS A. SAMUEL, M. B., B. S.

An ill nourished woman of 28 years was admitted on 10-8-'36 under the care of Captain R. L. H. Minchin, I.M.S., General Hospital, for pain in the lumbar and epigastric regions, of ten months' duration. The pain has become severe since 15 days.

Previous History.—Nil of importance. She had treatment at Tirupathi hospital with no benefit. For relief of pain she was taking country liquor and opium.

Family History.—She is married and has no children.

At the time of admission the patient's condition was miserable. She was screaming with pain and was lying curled up with her thighs bent over the abdomen. Her spinal movements were limited and there was tenderness over the lower thoracic and upper lumbar vertebrae. The spinal muscles were kept rigid, but there was no deformity of the spinal column.

Alimentary system.—There was no alteration in the shape of the abdomen. No visible pulsation could be seen. The upper portion of the abdomen was rigid and the deeper organs could not be palpated easily. The liver and spleen were not enlarged. There was marked tender-

ness in the epigastric region and around the umbilicus.

Respiratory system.—Nil abnormal.

Circulatory system.—Heart boundaries normal. Heart sounds normal.

Blood pressure.—
Right hand 130·85.
Left hand 125·85. Right leg 125·80.
Left leg 120·80.

Pulse.—80 per minute, regular and volume, tension good.

Central nervous system.—Cranial nerves normal. Knee Jerks normal. Plantar reflex—flexor. No sensory changes.

INVESTIGATIONS:—

Urine.—Nil abnormal. Culture sterile.

Faeces.—No helmenthic ova.

Blood.—Unfortunately the specimen of blood sent for Wasserman reaction was lost during transit.

Pelvic examination.—Uterus and adnexa normal. Cervical smear—no gonococci.

Lumbar puncture.—C. S. F. clear and not under pressure.

A Case of Aneurysm of the Abdominal Aorta

119

Albumin 30 mgms.

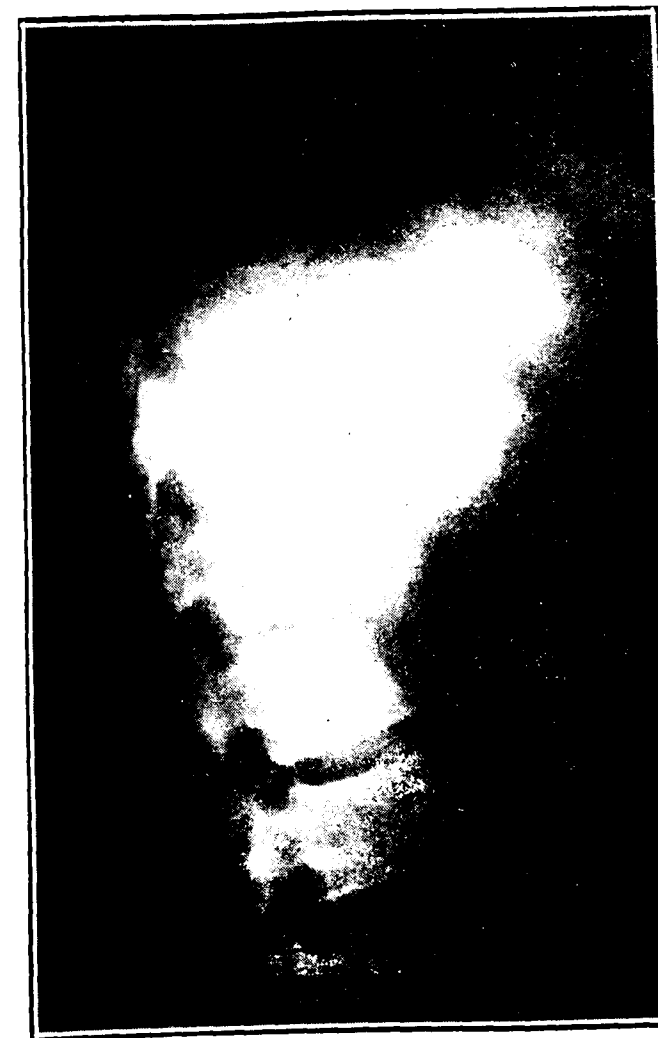
Globulin—Nil

Sugar 003 mgms.

W. R. ?

more involved than the second. Except the area involved there was no other rarefactive changes of the vertebrae concerned.

Examination of patient under choloro-



Skiagram of Spine.

X-Ray of Spine.—Lateral view. The first and second lumbar vertebral showed evidence of rarefactive changes, noted on the anterior aspect, the convexity being directed towards the back, the first being

form revealed a pulsating tumour in the upper portion of the epigastrum in the region of the aorta. The pulsation was expansile and a systolic bruit was heard over the area.

From the above clinical findings the case was diagnosed as one of aneurysm of the abdominal aorta near the coeliac axis causing erosion of the vertebrae.

Differential diagnosis.—Various causes of chronic pain in the lumbar and epigastric regions are.

(1) *Extra abdominal causes.*—Like spinal caries, metastasis in the vertebral column, epigastric hernia of small size.

(2) *Intra abdominal causes.*—connected with

(a) *Stomach.*—Ulcer, hyperchlorhydria, carcinoma, visceroptosis, gastralgia gastric crises of tabes, perigastric adhesions.

(b) *Duodenum.*—Duodenal ulcer.

(c) *Liver and gall bladder.*

Liver:—Congestion, Tropical and pyaemic abscesses, carcinoma,

Gall bladder.—Cholecystitis and cholelithiasis.

(d) *Pancreas.*—Calculi, chronic pancreatitis and new growths.

(e) *Abdominal aorta.*—Aneurysm may cause pain in the epigastrium but it is more marked in the back. The patient is usually a man, with syphilitic history with an expansile pulsating tumour in the line of the aorta.

(f) *Angina of the abdominal type.*

(g) *Colon.* Spasmodic contractions of the intestine.

Medical College Magazine

(h) Renal colic.

(i) Spondylitis of the vertebral column.

(i) Rheumatoid type often associated with rheumatoid arthritis elsewhere

(ii) Osteo-arthritic type.

(iii) Ankylopoietica with bony ankylosis of joints.

(j) Para metritis, pyosalpina, various ovarian causes, extrauterine pregnancy.

Aneurysm of the abdominal aorta is very rare. The incidence in men is decidedly greater than in women, and the majority of patients are usually young. The upper portion of the abdominal aorta, near the coeliac axis is the usual seat of affection. The aneurysm is usually of the saccular type. Syphilis is one of the chief aetiological factors. Trauma may occasionally produce a dissecting type.

Symptoms.—Symptoms manifested by an aneurysm are protein in character. As such the diagnosis is not easily reached. This is well brought out by Bryant in the analysis of the Guy's hospital statistics. "A correct conclusion as to the nature of the disease was arrived at in 18 only, out of the 54 cases, on which this lecture is based, an analysis showing that an abdominal tumour was detected in 31, pulsation in 35, expansile pulsation in 8 only and in 26 a systolic murmur. Incorrect diagnosis of a variety of diseases were made including malign-

nant tumours, lying in front of the aorta, renal calculus, lead colic, spinal caries, sarcoma of kidney, nephritis, peri nephritis, pneumothorax, pleuritic effusions, carcinoma, of oesophagus, chronic intestinal obstruction and malingering."

Pain is a constant feature and becomes unbearable with the progress of the disease. It is usually of a constant dull boring character especially when the aneurysm is eroding the vertebrae. It may be referred to other portions of the abdomen, and back of loins. It may simulate hip or sacro-iliac disease. When the nerve roots are compressed, girdle pain or pain radiating into the lower limbs may be observed. Finally when the intestines are pressed, symptoms suggesting chronic intestinal obstruction may be manifested.

Osler reports in his experience, that four cases were operated as for appendicitis.

On palpation of the abdomen, a circumscribed mass or swelling, with definite expansile pulsation will be noticed only in a few cases. The palpable diffuse throbbing of the abdominal aorta, especially in thin individuals, should not be mistaken for an aneurysm. When in doubt it is always advisable to examine the case under anaesthesia. A systolic bruit is more often heard over the aneurysmal dilatation. Rarely the inferior vena cava may be pressed, resulting in cedema of the lower extremities and effusion into the peritoneal cavity.

Course of abdominal aneurysms.—The aneurysm enlarges very gradually, and terminates fatally after some years. More than half of the cases die of heart failure or of intercurrent diseases, and not due to rupture of the aneurysm. Rupture when it occurs is usually into the retro-peritoneal tissues, and blood that has leaked forms a diffuse or false aneurysm. Rarely it may rupture into the peritoneum, gastro-intestinal tract or pleural space.

Investigations.—Wherever there are facilities, X-Ray examination of the vertebral column has to be done. Lateral view is more important than the antero-posterior. Tuberculosis of the spine, sarcoma, rheumatoid arthritis of the vertebrae have to be eliminated.

Prognosis of aneurysm of the abdominal aorta is in no way better than aneurysms in other situations.

Treatment.—The general lines of treatment are the same as for aneurysms in other situations. Potassium iodide and mercury have to be tried in every case. Rest and diet restrictions, are very essential. The fluid intake should be restricted. Calcium salts are useless in increasing the coagulability of blood and thereby promoting thrombosis in the aneurysmal sac.

Results of surgical treatment, such as the introduction of wire, (Colt's wire) electrolysis, needling, with the hope of formation of thrombi within the sac have almost invariably been disappointing. In aneurysm of the lower portion of the abdominal aorta improvement has been

occasionally reported by means of compression applied proximally to the sac. Compression may be applied with digital pressure or a tourniquet. If necessary chloroform may be administered.

William Murray of New Castle on Tyne cured a man aged 26, by digital Compression, as early as 1891, who had a pulsating tumour to the left of and above the umbilicus. Between the sac and the free border of the rib there was room enough to permit one part of a tourniquet, to press on the spine and control the pulsation. The patient was put under chloroform for two hours during which time the pulsation was arrested. On removal of the pressure there was no effect. Three days later the pressure was again applied for five hours under anaesthesia. In the last hour, the pulsation was no longer evident, when the tourniquet was released, the extremities were cold and the femorals could not be felt. The patient got perfectly well and lived six years, when another aneurysm occurred at the coeliac axis. From that time till

to-day, a number of successful cases have been reported.

However one has to bear in mind that after compression, complications like peritonitis, or obstruction to the bowel may develop.

Symptomatic treatment—For relief of pain all varieties of analgesic remedies may be tried, but iodides when used in large quantities give the best result. In later stages, morphia is the only drug that gives relief.

My thanks are due to the Superintendent, General Hospital, for permitting me to report the case, and to Captain R. L. H. Minchin, I.M.S. and Dr. D. Govinda Reddy, M.D., for the help given to me in getting up the report of this case.

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"A case of Amyotonia Congenita"

(From the Wards of Dr. P. S. Varadarajan.)

REPORTED BY
DR. R. D. VAIDYA.

Myatonia Congenita. Oppenheim's Disease.

It is customary to spring an excuse when a case is reported. In this case its rarity is a sufficient plea for publishing it. On the morning of 8th September 1936 Baby R (girl) aged 18 months was admitted in Hobart Ward under Dr. P. S. Varadarajan for inability of the child to use her legs properly.

Previous illness.—When the child was four months it had fever with convulsions. Fever passed off normally.

Family History.—Her (child's) brothers and sisters normal. No history of any similar complaint in the family.

Present illness.—Parents noticed her queer way of progression "rowing with heels", which I shall describe later on in detail, for last nine months. They also noticed that the child could not stand on her legs by herself; *i. e.*, she needed another person to support her by her shoulder.

General condition.—Child intelligent. Has a congenital squint. She moves her legs in the bed while lying down. On making her stand, legs bend at knee. Genu-recurvatum and inversion of feet. When made to sit she drops her head on the chest showing weakness of neck muscles.

Neck muscles weak (hypotonic), muscles of upper extremities and trunk, normal. She has ten teeth now. She cut her first teeth at age of 8 months.

Nervous system.—Intelligence good. Speech not affected. She uses her little vocabulary well.

Cranial nerves.—Nil abnormal.

Motor system.—Child does not hold her legs up as other children do and does not move her legs as much as other babies do. Has the look of a 'Frog-Child' (Batten's) when lifted by arms.

Power.—Less than normal.

Tonus.—Hypotonia in neck muscles and muscles of lower extremities. No wasting.

Sensory functions.—Not impaired.

Superficial reflexes.—Present.

Deep reflexes.—Ankle jerk and knee jerk-present but weak.

Sphincters normal, No trophic changes. Spine and cranium normal. Joints—Hip, Knee, Ankle normal. When shaken they are very flail. Muscle reaction—Faradic and Galvanic irritability present.

Other systems.—Nil abnormal.

This interesting disease was described and demonstrated by Oppenheim in 1900 who named it 'Myatonia Cogenita' which he attributed to delayed development of muscles and anterior horn cells. It develops during very early life. It is more a paresis than paralysis. Legs are more affected than arms. Back and neck are more rarely involved. Sensations are spared. Sphincters are normal. Knee jerks and ankle jerks are weak or absent. Disuse atrophy if any is marked by the increase in subcutaneous fat. Electrical tests are depressed throughout. Faradic excitability may be abolished. Galvanic response may be feeble.

In 1925 Faldine repropounded the old idea of Oppenheim that 'myatonia-congenita' was not the result of disease but only a developmental disturbance.

He emphasised the very fundamental difference between this disease and another disease, *viz.*, Wordning Hoffman's paralysis wherein the essential lesion is in the anterior horn cells unlike Oppenheim's which is a true muscular dystrophy.

This view is now not tenable as it is thought that the morbid change is in the muscle itself. Unfortunately the cases recover and hence the cord changes cannot be studied in great detail.

Pathology.—In 1929 on the basis of 5 cases studied by the most careful anatomical technique Bielchowsky came

to the conclusion that 'Myatonia Cogenita' represented an anomaly or developmental retardation in which motor innervation remains qualitatively or quantitatively insufficient.

Anatomical basis being primarily agenesis and dysplasia of anterior horn cells. Secondly in a defective extension of the axons from malformed anterior horn cells and finally in defective development of the endorgans.

Collier and Adie give three most striking conditions:—

(1) The minute size of the majority of muscle fibres from 7 μ to 12 μ .

(2) The presence of a few very large original fibres reaching 140 μ larger than those occurring in a normal muscle.

(3) Marked regressive changes are seen in the giant fibres. Reduction in number of the ventral horn cells of Sp. cord occurs and ventral roots are poorly myelinated.

Diagnosis.—Other diseases which are likely to simulate it or are required to be eliminated are No. 1. Wordning Hoffman's paralysis. Peterman gives the following points differentiating between the two:—

A. (1) Absence of familial occurrence in 'amyotonia congenita'.

(2) Diffuse Symmetrical paralysis in "amyotonia congenita".

(3) Absence of localised atrophy of definite muscle groups.

"A case of Amyotonia Congenita"

(4) Absence of reaction of degeneration and vaso-motor disturbances.

(5) More important than all above is absence of progression; in contrast to quite definite improvement of the muscular function in those children who survive first month of life.

(6) Fibrillation is present.

Above points are present in Wordning Hoffman's spinal muscular atrophy. The disease is only one form of progressive muscular atrophy with progressive atrophy of anterior horn cells.

B. Atonic, Astatic, Cerebral paralysis. In this there is usually idiocy.

C. Rickets. This will not be present from birth. It was unfortunate that blood Calcium Phosphorous, and Phosphatase could not be done. Rickets should have caused general hypotonia and not only of legs and neck. Moreover it would have caused bony changes.

D. Mongoloid Idiocy. The term is self explanatory.

E. Obstetrical paralysis. This is not strictly symmetrical and there is usually history of instrumental delivery.

F. Polio myelites. Lack of acute stage and paralysis is a symmetrical.

G. Progressive muscular atrophy. Only a distinct improvement favours diagnosis of Amyotonia congenita. There would be marked reaction of degeneration. Fibrillary twitchings and progressive increase.

Many more can be added *e.g.*, Friedreich's Diphtheritic-paralysis, etc.

Let me mention the most striking feature which because of want of camera I have to describe. Whenever the child was placed on ground it used to sit with head sunk on the chest, *i.e.*, chin touching the sternum. When she was induced to move, she placed her hands just by the side of buttocks and rested her weight on them. She then rowed with her heels. History of absence of quickening in the mother during the intrauterine term of the child could not be elicited.

Uptill now only 150 cases are reported. Many of them die of intercurrent infection. Only 14 cases are traced who are well after puberty. Czerny believes that there are many a mild case that go unnoticed and Peterman endorses the idea.

I thank the Superintendent of the General Hospital for his kind permission to publish the case, and Dr. P. S. Varadarajan for all his help.

I also thank my student friends (including ladies)* in the ward for the help in obtaining the data.

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* Did the writer derive any inspiration from them? Ed.—M. M. C. Magazine.

A case of Mediastinal New Growth

(From Dr. M. R. Gurusawmy Mudaliar's wards)

REPORTED BY
RATHNAVELU SUBRAMANIAM,
4TH YEAR.

On 19-8-'36 a patient named Munian (*alias* Muniswamy) aged about 70, was admitted in Maitland Ward, for pain in the chest and cough with expectoration, as also some amount of difficulty in swallowing, and in breathing.

Patient was a motor driver, and at the time of admission he was leading more or less a retired life, being a pensioner.

Previous illness with dates.—No history of venereal disease, or rheumatism. Two months back patient had a similar complaint, for which he was treated in this ward, relieved and discharged about a fortnight back.

Habits.—Non-vegetarian. Addicted to alcohol and chews tobacco.

Family history.—Nil particular.

History of present illness.—Three days back patient became breathless and then he had cough with frothy expectoration and was confined to bed. After the attack of breathlessness, he was not able to take his food. On the last occasion he had blood stained sputum.

Condition at the time of admission.

General condition.—Patient was a well nourished old man of 70 years. The central incisors had fallen away and the rest of the teeth were dirty. Pyorrhoea alveolaris was absent. Tongue was thickly coated. Patient was restless. The breath was foul. In the left anterior axillary line in the 6th space was a small lump which was freely movable over the ribs and not attached to the skin. (Lipoma?) Left lens was cataractous.

Cardiovascular system.—Apex beat was neither visible nor palpable. Heart boundaries.

Upper border of 2nd space

1½ inches lateral to the right sternal line	1 "external to the left nipple line in the 5th space.
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Heart sounds were well heard. The heart quickened now and again. There were no murmurs. On the last occasion when he was here at a time when he had no wheeze, it was noted, that the second sound in the aortic area, while metallic, had a loud rapping character; there was

A case of Mediastinal New Growth

also an impulse felt over the aortic area, not a thrill. The first sound in the aortic area appeared split (Replaced by a short murmur".)

Aortic arch: Width 3½".

Pulse: Regular. Rate 130, Volume and tension good. Vessel wall slightly thickened.

Respiratory system.—There was a slight bulge over the right costal margin. Patient was in respiratory distress, the breathing being mainly abdominal. Chest was uniformly warm. Percussion note was of normal resonance. V. F. was slightly increased. Breath sounds were bronchial in type. Cooing sounds were heard at the bases. V. R. was slightly increased. Patient's stridor (wheeze) was heard more over the open mouth than over the chest wall.

Respiration was periodic but not quite Cheyne-Stokes.

Alimentary system.—No pain or tenderness was felt. Liver palpable two fingers breadth below the costal margin. Appetite was poor. Bowels were constipated.

Nervous system.—Pupils were normal and reacted to light. Knee jerks were positive. Plantar reflex was 'flexor'.

Investigations done.

Laboratory reports.—Urine: Alkaline. No sugar. Albumin trace. A few epithelial casts.

Blood pressure On 16-8-'36 160-110 m. m. of Hg.

20-8-'36 140-90 m, m of Hg.

Blood urea 55 mg %.

X-ray chest.—A round smooth shadow in superior mediastinum. Looking like an aneurysmal dilatation of aorta. Suggestion of effusion in the left base.

Skagrams taken in the wards did not throw further light. Patient was screened. The swelling at the base did not pulsate. Aortic pulsation was visible inside the bigger swelling. In oblique views the swelling filled up the superior mediastinum and displaced the oesophagus backwards (Barium swallowed under the screen). In right oblique view the retrocardiac space was clear. In left oblique view the aortic arch was not appreciated. (Screening notes by Dr. S. K. Sundaram).

Treatment and progress:—

19-8. Atropine }
Strychnine } a a 1 c. c.

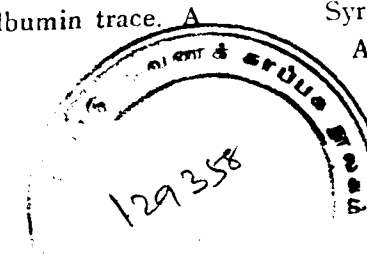
Camphor in oil 1 c. c. (intra muscular injection)

20 c c. of 20% glucose (by intravenous injection).

20-8. Inspiratory distress not marked, and the patient was quiet.

21-8. Since patient complained of sleeplessness he was given

Paraldehyde 3i } F. M. At
Syrupus Aurantii 3i } bed time to
Aqua ad 3i } be given.



A case of Mediastinal New Growth

22-8. Patient was better. Pulse regular, volume and tension good.

25-8. Patient looked normal and was put on

Mistura stimulans iii—3 1 t.d.s

26-8. A few rales were heard at the bases but there was no distress. 8-30 p. m Patient was very restless. Marked dyspnoea.

Atropine 1 c.c.

10 p. m Patient died.

On the last occasion when he was in this ward he was given deep X-ray therapy but on the present occasion as the patient was not in a fit condition to be carried from the wards to the X-ray department he could not be given X-ray treatment.

Discussion.—(1) Abscess or gangrene of the lung. The foul smell of the breath suggested the possibility of abscess or gangrene of the lung. But there was no circumscribed area of dullness anywhere in the chest and X-ray examination also did not bring out any cavity. The sputum was not purulent in character. The adventitious sounds were also of a bronchial rather than of a cavernous character.

(2) The chief feature in this patient was the wheezing respiration and this leads one at first sight to think of asthma.

(3) The next possibility was cardiac asthma. In this condition it is purely a left ventricular failure, whereas the

heart boundary both by percussion and screening showed an enlargement of the right side as well. Apart from this, that the wheeze (stridor) was better heard over the open mouth than over the chest showed that the wheeze was not due to any bronchial spasm as in asthma but due to some obstruction of the bronchus. Another feature noted was in spite of the extreme distress in respiration, there was expectoration of frothy sputum, whereas in asthma once the expectoration appears the spasm is relieved.

(4) Uraemia of the respiratory type: There was foul breath, but it was not urinous in character. The blood urea was only 55 mg %. Respiration was periodic, but not quite Cheyne-Stokes, but patient was restless. Other symptoms such as vomiting, cough, etc., were also lacking. Pupils were normal.

(5) Another possibility, that was suggested by the wide aortic arch as shown by percussion, was an aneurysm of the transverse arch of the aorta. The symptoms that were in favour were (a) pain over the praecordium which was of a dull aching character, (b) pressure on the bronchus as revealed by the wheeze, (c) no pressure symptoms, (i. e. the voice was normal, the sound of the cough was normal and not brassy, pupils were of equal size, etc.) and (d) no history of syphilis or rheumatism.

(6) The pain in the chest of a dull aching character, the paroxysmal dyspnoea, the dysphagia, the wheeze

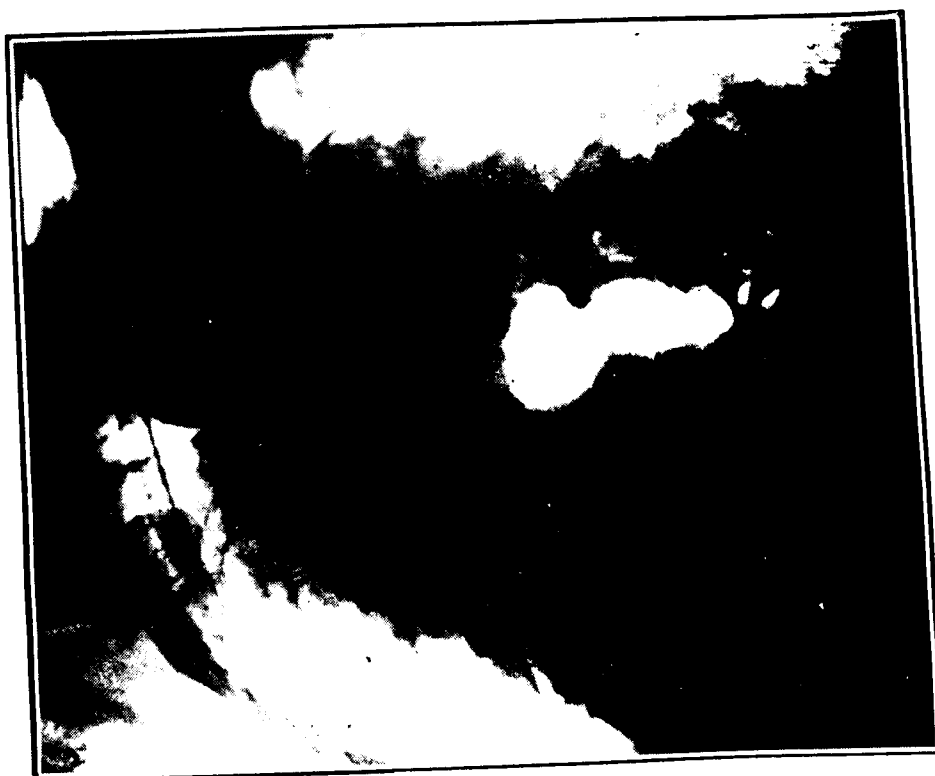


Fig. 2.



Fig. 1.

Skia gram of Thorax.
A CASE OF MEDIASTINAL NEW GROWTH.

being better heard over the open mouth than over the chest, all these without any pressure symptoms naturally caused a difficulty in distinguishing a new growth from aortic aneurysm. But the screening revealed a clear aorta. This in conjunction with absence of history of syphilis or rheumatism and a negative Kahn reaction puts out the possibility of aortic aneurysm and the quickening of the heart now and again was in favour of the new growth of the mediastinum. It is regretted that no post mortem examination was available.

Rationale of the treatment adopted. In spite of the increased blood pressure, atropine was administered to counteract the oedema of the lungs. Strychnine, and camphor in oil were given to stimulate the respiratory centre. In addition to this, glucose 20 c. c. of 20 per cent solution was administered by intravenous injection to reduce the oedema of the lungs that had already set in.

My thanks are due to Dr. M. R. Guruswamy Mudaliar for permission to report this case and to Dr. S. K. Sundaram for his help in preparing the report.

The Madras Medical College Magazine.



WE offer our heartfelt congratulations to Major-General E. W. C. Bradfield, M.S. (Lond.), F.R.C.S. (Edin.), C.I.E., O.B.E., K.H.S., I.M.S., on his elevation to the post of the Director-General of the Indian Medical Service. It is in the fitness of things that he should have been selected for the post. The Madras Medical College and the General Hospital, should particularly feel proud over his appointment, as Major-General Bradfield was connected with these institutions, during the best part of his career in various capacities as Principal, Medical College, First Surgeon, General Hospital, Professor of Surgery, Medical College, and Superintendent of the Hospital. In the various capacities he has left a brilliant record of achievement unequalled by any other officer. The pile of new stately buildings, and the reorganisation of the whole of the General Hospital, bear testimony to his genius and initiative. A consummate surgeon, with a flair for the scientific aspect of it, an impressive teacher, and brilliant organiser

and administrator. We wish him God speed in his new appointment.

Lord Moynihan is dead. In his death, Surgery has lost a brilliant exponent and a master craftsman, and the medical profession a magnificent orator. Many of his addresses and oratories, are full of scintillating aphorisms, which will last as long as the English language lasts. He was the first to raise the status of the Surgeon from a mere operator to that of a "physician who is doomed to the practice of Surgery". He was the first to introduce, the now famous expression 'Pathology of the living', and reiterated in his addresses and writings, the importance of studying by direct observation, the morbid changes in living tissues and organs while they are submitted for operation. He was the founder of the British Journal of Surgery, and was instrumental in raising it to the standard of a first class journal. He died full of honours, mourned by the whole world of the Medical Profession.

Dr. H. S. Hensman, M.R.C.S., L.R.C.P., M.P.C., Superintendent

of the Mental Hospital and Professor of Mental Diseases, Medical College, Madras, has just retired from service. During the twelve years of his stewardship he has done his duty honestly and unostentatiously. We wish him long life and happiness in his retirement. We welcome his successor Dr. S. Venkatasubba Rao, M.D., D.P.M.

We regret very much to learn that Dr. M. K. Sambasivan of Kumbakonam is dead. He was formerly a Secretary of the Madras Medical College Association. He was a well known figure in South India, both due to his professional abilities, as well as to his public work.

While welcoming back Lt. Col. G. R. MacRobert, I.M.S., to our midst, we congratulate him on his

promotion to the next higher rank in the Army.

The Magazine Committee has instituted three prizes, *viz.*, (1) one for the best case report, (2) one for the best general article, (3) one for most humorous article, especially caricature. The value of each prize is Rs. 20 and the contributor should be a student. The prizes for last year have been awarded to Messrs. N. Ramanathan, S. Balakrishnan, and A. W. Maduram Sandosham respectively. We trust this would give the needed fillip to the students to contribute more and better articles to the magazine.

Readers of the journal will notice that the design of the cover page of the journal has been changed in keeping with the college colours.

College Comments.

The Graduates Reception started this year's social season of the college. We wish the newly hatched eggs of the *alma mater* pots of luck and the best of life. The ladies' interest in this year's function has been very unique. Their contribution towards its success was by no means meagre. Will they continue in the same strain? Another unusual feature this year was the party given by the Secretary and his colleagues to the volunteers who helped to entertain the graduates. It was really thoughtful of the hosts to have recognised the services rendered by their guests.

"Consider the ravens; ..which neither have store house nor barn .. how much more are ye better than the fowls?" proclaimed Jesus from the mountain top. In fact, when the problem of the hostel comes, how much more are the male students better than the fowls? "Sufferance is the badge of 'their' tribe." The other day at the Prize distribution, the Hon. Mr. P. T. Rajan, the Minister, said if the Principal forwarded a scheme for a hostel for men students, he would deem it a pleasure to push it through. Many a time and oft, promises to more or less the same extent have been made, by a number of responsible men, from Lord Willingdon the former Governor and ex-Viceroy downwards. Yet the hostel is on its way. And the Hon. Mr. P. T. Rajan's name now foots the list. We suggest

that the Principal takes the Honourable Minister at his word and send a scheme. As for a scheme it would not be very impractical to acquire some of the private property on the Poonamallee Road in Vepery, and build a good hostel. Where there is will there is a way. If the authorities really believe in giving us a hostel, we dare say that would not be a very difficult affair. The need for a hostel for the men students cannot be too highly emphasised. May we expect that the new Minister Rajkumar The Hon. M. A. Muthiah Chettiar of Chettinad's regime, at least, would be more fruitful to us?

Perhaps Jaya Mansions might be the red herring drawn across the trail of those who consider the scheme for a hostel. To them, we say that if at all Jaya Mansions is a hostel, it is only the half a loaf that is supposed to be better than no bread. It has its own existing handicaps, and it awaits further trials and tribulations. Everything considered Jaya Mansions is an one-man's show. It is high time that we remember that the present warden Mr. K. N. Alva is in the fourth year, and his services at the most will be available for only a couple of years, unless he decides to choose the wardenship as his career for life! Will any student after him, have the courage to run such a stupendous show? We are almost sure that with the

close of Mr. Alva's studies, the Jaya Mansions Hostel will also end. This grave situation, though fortunately not an immediate complication, is yet not far off in the horizon. It behoves us to arrange for the continuance of this make-shift hostel, if a Government hostel is not forthcoming.

We welcome back to our midst E. G. Cullen the Olympic hockey player. Cullen comes back covered with honour and glory. But how many are aware of the sacrifices he had to undergo? His stipends are stopped, after the end of this year and he cannot appear for his examination in November.

This year—once again it is unique—our sportsmen have been denied a tour. In certain circles there is a tendency to haul the Sports Secretary over the coals for this, but we understand that years of experiment and experience show that tours like the ill wind blow nobody good. But the enterprising Mr. T. K. Thomas however seems to believe in more stable things. He is arranging to run a boxing club and is trying for a pavillion also. We wish him all success in his endeavours.

Elsewhere will be found the Annual Report of the Women Medico's Club which should have been published a long while ago. Any way better late than never. The Club—on outstanding accomplishment of the ladies, certainly reveals what they are actually capable of. We learn that their efforts to secure a bus are successful, and it would not be long be-

fore the incomes of the S. I. Ry. and the Amjikalai fleet of buses suffer. The Women Medico's should indeed be thankful to Mrs. Nimbkar for her efforts in this direction.

The separtist tendency among the students to form several cliques on basis of religion, sex, etc., is really to be deprecated. We are medicos just, and the present Medical College Association offers sufficient scope for everybody to co-operate, and work for the common good of all.

Contributions to the magazine this time are generally encouraging, and those students who have promised, will, we hope, send us their contribution before the next issue comes out. It should be realised that the Medical College Magazine is a purely student's affair, depending for its success, on the initiative, interest, and enthusiasm of the students the college. It is felt there is plenty merit and talent among the students and it only requires a little effort for them to be brought out.

We congratulate Mr. S. G. Rajagopalan on his promotion as Under-officer of the U T C. His merits, indeed, have been fittingly recognised. His interest towards the Corps cannot be over estimated. We trust he will do his best to maintain the honour and prestige of the 'A' Coy (Med) which we hope under his guidance will win fresh laurels.

May we kindly point out to the college authorities that fans in dining halls are essential?

THE STUDENT EDITORS.

LEST WE FORGET



Dr. MONKAMBU KRISHNAIYER SAMBASIVAN, M.B., B.S.

It is indeed with the profoundest regret that we record the death, at Madras, on Monday the 12th October 1936, of Dr. M. K. Sambasivan of Kumbakonam, the General Secretary of the Medical College Association in 1922. Dr. Sambasivan's term of office of Secretaryship was remarkable. The financial state of our Magazine then was not so rosy as it is now. It was only due to Dr. Sambasivan's untiring efforts that the Magazine survived the series of rainy days it had to face.

Born in December 1898, at Monkambu in Travancore State, the late Dr. Sambasivan was first educated at the

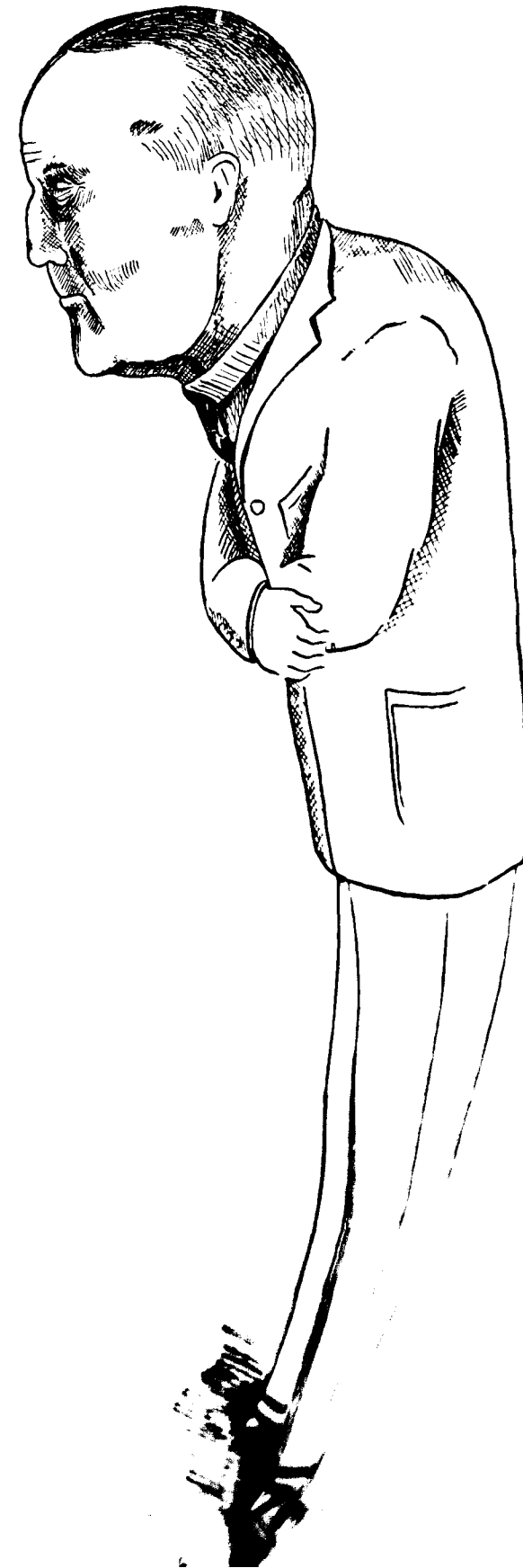
Santhana Dharma Vidyalaya at Aleppey. He next studied at the Basel Mission College, Calicut and joined the Madras Medical College. Later after graduating from our *Alma mater*, he served as a house surgeon under Lt.-Col. (then Major) Pandalai, I.M.S. He settled at Kumbakonam in 1926 and soon earned a name as an able medical man and commanded extensive practice. He founded a nursing home in the town of his adoption, and equipped it with all modern conveniences including an X-ray plant. In 1933 he went to Vienna for higher studies and returned after an year's stay there.

A man of multifarious activities, he was elected as Chairman, Municipal Council, Kumbakonam, once in 1929, and again in 1934 which office he held till his death. He was very much interested in improving the town and developing the civic conscience of the citizens.

A staunch patriot, a great friend of the sick and suffering, and a mighty prop of the poor, he devoted a part of his large earnings to support worthy causes.

Dr. Sambasivan leaves behind him his wife, three boys, and a daughter, besides a large number of friends and ardent admirers to bemoan his loss. Though he died young, yet his whole life has been one of useful activity and ceaseless toil for bettering the lot of mankind. We offer the members of the bereaved family our heartfelt condolences.

“ Our loss is great, but Thy will be done.”



Personal Notes

Dr. A. Lakshmanaswami Mudaliar after acting for over three months as the Vice Chancellor of the University has rejoined his appointment. Dr E. Atchuta Menon was transferred to Vizag as Professor of Midwifery.

Dr. P. V. Cherian has returned after a holiday in Europe.

Dr. S. Venkatasubba Rao is posted as Professor of Mental Diseases vice Dr. H. S. Hensman retired.

Dr. U. V. Nayak, Assistant to the Professor of Anatomy is back from leave.

Lt.-Col. G. R. MacRobert, I.M.S., has resumed the Professorship of Medicine and Dr. M. R. Guruswami Mudaliar that of Therapeutics.

The Model Scientific Article.

BY CAPT. C. S. S. SARMA.
Assistant, Surgeon, Pollachi.

It is a pity, that scientific journals are not supplied with a regular flow of original articles. Often the management selects a very busy and highly intelligent person, almost an authority on his speciality, but forgets to put more hours in the twenty-four, in which he is literally swallowed up. The result is very embarrassing to the editor and the subscriber. I intend devoting the resources of my slender intellect in writing an article on "How to write to journals", especially, medical journals. It is not out of the superior claim of having written a goodly number, nor out of the well acknowledged position of the ubiquitous contributor, sought after by Editors and paid handsomely and advertised in the front pages, that this duty has devolved upon me. It is a self appointed, holy mission. It will cure the vanity of many a would be contributor and add fresh laurels to those whose brows are cumbered with faded ones.

Before writing about anything, be sure to give it a modest but nevertheless an exhaustive title. It may be "*a few notes*," "*some observations*" or "*further results*," etc. But they wont read well unless you style them. "A few preliminary notes regarding the much

disputed but nevertheless long suspected existence of ticks in the street dog" by Iyer, Nair and Chetty of the "Central Ticksonian Institute" Doglands, Kusapet. You may have to call another by a more humble and highly differential title "Some recent observations on the relative Disproportion as applied to Boots and Corn" being the annual report of the "Podometric association of the United leather workers". "Further results of the third thirst survey with the Soda fountain apparatus in the eradication of the crown cork nuisance by the Cool Drinks Syndicate" may be an apt heading for a really brainy and original article. You will have to know before hand what you have got to say on the subject and let it out at the end of your article as a "Summary" for that is the portion that busy people will be anxious to look into, in sheer despair, and there you should not disappoint them but shorn of all periphrasis and bombast must confess that :—

Summary (1) Dogs have ticks (2) feet have corns (3) have a cool drink. But this should not blind you to the obvious necessity of following the well known research methods in the most up to date scientific spirit. Find out who discovered the first tick on the first dog.

Be indefatigable. Learn a few foreign languages. Give the names of especially two simultaneous discoverers and decide how hard it is to give priority to any. Be impartial and couple the names of both; collect the varieties of ticks existent, if you found one on the mummified dog of Tut-ankh-Amen. Go for it without any delay and upset all the current hypothesis that there were no ticks in Ancient Egypt. State the important variations of the Continental ticks from the ticks of the new world and take for your special diatribe the importance of the terminal hair of the first glosso labial fold; it is good to start a controversy over such trifles, the more trivial it is, the more contentious you should become. You should support it by microphotographs, line drawings, colour plates, and what not until in dis-

gust, somebody concedes you the terminal hair or says "Go Hang" about it.

It is also a wise proceeding to make your things look as though they were the crumbs you picked from the lavish table of clinical material at which your chief or boss or unit Director or whatever he or she may be. You should never strut in the role of an original author yourself for some time at least unless you carry on your back like Sindbad some old man of the sea namely your Boss. You may collaborate with him, provided you feel eternally grateful for being permitted in the interests of pure science, to twist the ears of timorous rabbits and meddle with the peace and domestic happiness of untold monkeys in captivity. All this is the accepted position amongst the front rank research workers.

The Puff that Cheers.

BY NIVIS.

The History of Tobacco.—By the word "tobacco" to-day is meant the leaves of certain 'species' of *Nicotiana* (natural order—*Solanaceae*), but the origin of the word "tocacco", though not exactly wrapped in obscurity, is certainly somewhat vague.

Several hundreds of years ago it was the custom among the inhabitants of San Domingo to inhale tobacco fumes through an instrument of queer shape, which they called the "tobacco". The instrument consisted of 'y' shaped wooden tube; one end of this was placed in the fumes arising from the fire which had been kindled from tobacco leaves, and the other two extremities were inserted into the nostrils of the inhaler. Thus it would seem that the word owes its origin to the apparatus used for the inhalation of its fumes. On the other hand reliable record leads us to believe that the Mexican name for the herb has always been "tobacco".

The scientific name of the genus, *i.e.*, "*Nicotiana*" was established in commemoration of Jean Nicot. This man was at one time the French Ambassador to Portugal. He is supposed to have carried out some botanical investigations in connection with the plant, and to have sent a large quantity of tobacco seeds to Catherine de Medici, because they were

accredited with miraculous healing powers, so much so that the tobacco plant in ancient times was known as the "Herba panacea" and the "Herba Sancta". The immortal Spenser in his writings even went so far as to use the adjective 'divine' in describing the plant.

It is common knowledge that the home of tobacco is America. In 1492 the followers of Columbus, at Cuba, noticed the natives carrying lighted firebrands which gave forth large volumes of smoke, and it was observed that the natives were in the habit of perfuming themselves with the same herb, moreover the inhalation of the fumes was part of the most solemn tribal ceremonies, and had considerable religious significance.

The tobacco plant itself was first brought to Europe in 1558 by Francisco Fernandez, who was a physician to Phillip II of Spain. He had been sent to Mexico to investigate the medicinal products of that country.

Although the credit for the introduction of the plant into Europe goes to Spain nevertheless the habit of smoking was neither initiated nor propagated by the Spanish people. It was through the example of Englishmen that the practice of smoking spread rapidly throughout Europe.

Probably the first habitual smoker was an Englishman named Ralph Lane, who was the Governor of Virginia. However it was not Ralph Lane but Sir Walter Raleigh who was responsible for the inculcation of the habit among the Elizabethian courtiers. In the popularisation of the habit in England Sir Walter Raleigh was assisted by other famous people, chief among whom were Sir John Hawkins and Sir Francis Drake. With so many renowned sailors as parents of the habit it does not seem extraordinary why almost every sailor to-day says that his best friend is his pipe!

The implements and materials for 'tobacco smoking' were brought to England in 1586 by Ralph Lane and Sir Francis Drake, and these were first handed over to Sir Walter Raleigh, whose servant had to douse him with water when he first attempted to smoke!

From the very first the use of tobacco was bitterly opposed by both statesmen and priests. Popes issued edicts against smoking; in Turkey and Russia it was made a punishable offence and in England James I was constrained to issue his "counterblaste to tobacco" in which he described smoking as 'a custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs,.....resembling the horrible Stygian smoke of the pit that is bottomless'. Nevertheless the most resolute opposition failed to suppress the practice in its initial stages, and the habit spread with amazing rapidity throughout all nations and countries, until to-day the

habit is more or less worldwide. Notwithstanding the fact that three centuries of experience have, since that time, shown the comparative harmlessness of tobacco when used in moderation, equally violent diatribes are still occasionally directed against smoking by that estimable band of people who call themselves 'Temperance workers', but who too in reality are guilty of intemperance; for are they not intemperate in their temperance?

The acquirement of the habit and its maintenance.—An investigation into the acquirement of the habit of smoking in modern young men cannot fail to be of interest. The process of maturation of the normal human male is marked by physiological phenomena such as the appearance of hair upon the upper lip, the development of a deeper tone of voice, and by certain psychological changes; among these latter is included a desire to put away childish things and to take unto oneself the deportment, the habit, and the hall mark of a full grown man. This may appropriately be termed a stage of precocity, during which there develops a seemingly unnatural tendency towards habits generally considered to be typically masculine, some of which however have, in truth, nothing to commend them. At no other time in the life of a man is the fact that he is a 'creature of habit' more evident. At no other time is he more liable to acquire habits which are harmful to himself.

The sex instinct is undoubtedly associated with the acquirement of these so

called masculine habits. It is the desire to appear in the light of a seasoned man of the world before the eyes of the opposite sex, that is in no small measure responsible for the practices of smoking and drinking among modern youth. Women does not judge man by breadth of shoulder and depth of voice alone, but by his habits and deportment as well. There is a fair majority of women who look askance at men who do not smoke, or drink, or do things generally considered to be typically masculine. A 'he-man' who is too temperate ceases to be considered a 'he-man'.

A factor of equal importance in the acquirement of habits detrimental to one's well-being is a dread of being considered a masculine by one's own fellow-men. Thus the probable explanation of the origin and establishment of the habit of smoking in the young man of to-day lies in the desire to appear fashionable and up-to-date, the dread of being considered under-sexed and amasculine, but certainly not in the desire to experience any pleasurable effects. Perhaps the acquirement of the habit is due in some measure to a sense of curiosity. It is a well acknowledged fact that the first taste of tobacco is decidedly nauseating, so nauseating in fact that in many cases it is sufficient to last the would-be smoker for the rest of his natural life. Almost everyone knows this, and yet the potential smoker deliberately seeks the experience. Having survived the unpleasant experience of the first inhalation and still being intent upon smoking, the

individual learns to avoid any unpleasant sensations by inhaling at first very small but later gradually increasing quantities of tobacco smoke, until ultimately he is able to inspire the fumes of an entire cigarette without experiencing any uncomfortable subjective symptoms. The amount of tobacco consumed by the individual gradually increases until there comes a time when he is capable of smoking just as much tobacco as the next man. Social intercourse aggravates the desire to smoke but is not responsible for the maintenance of the habit. A habitual smoker, having been cut off entirely from civilisation still experiences the desire to smoke, and there are many lonely men who find tobacco indispensable. From this fact it may be gathered that some kind of enjoyment must be derived from the use of tobacco, by the habitual smoker at any rate. Habitual smokers continue to smoke not because they have become the slaves of a habit but because they have learnt to appreciate smoking and to derive some pleasure therefrom. There are many strong willed men who are capable of giving up the habit at a moments notice but who do not do so because they do not desire to do so. It would seem ridiculous to compare tobacco addiction with morphine addiction or even with the alcohol habit, for although a desire, which in some cases almost amounts to a craving is experienced when habitual smokers suddenly obtain from tobacco, set this craving is not attributable to any definitely stimulant or depressant effect such as is the case with morphine and alcohol.

It has been suggested that the establishment of the habit has nothing whatever to do with the effects of tobacco itself but is merely due to the development of a complicated system of conditioned reflex arising out of a series of movements such as the following:—insert hand in pocket—remove cigarette—place cigarette between lips—extract match box from pocket—remove match stick—strike match—flick burnt out match away—return match box to pocket—remove cigarette from mouth—inhalate deeply—return cigarette to mouth, etc. Whether or not this theory is the sole explanation is certainly open to question but conditioned reflexes probably have something to do with the continuance of the practice.

A curious but very significant fact is that blind men hardly ever smoke. Moreover the enjoyment derived out of smoking is greatly reduced when the subject blindfolds himself.

The most probable explanation of the maintenance of the habit seems to be the pleasureable sedative influence of tobacco experienced by habitual smokers, the sense of mild intoxication that overcomes nervous irritability, and the feeling of well being and contentment.

Chemical composition tobacco.

Water	23.5 %
Ash	14.9 %
Nicotine	2.5 %
Nitric acid	1.9 %
Ammonia	.7 %
Other nitrogenous matters	12.2 %

Fibre	8 %
Starch	3.2 %
Nitrogen free extract	29.4 %
Ether extract	3.9 %

Chemical composition of tobacco smoke.—Tobacco smoke is a very complex mixture; it contains among other things:—

Carbon monoxide.
Prussic acid.
Ammonia.
Nicotine, .57 %
Tar.
Pyrocin and its derivatives.
Resinous compounds.

There is a retention of about 66 % in 'puffing' and 88 % in inhaling.

The action of Tobacco.—The enjoyment derived out of the use of tobacco has never been adequately explained. It has not yet been proved that nicotine is responsible for the pleasurable effects experienced by the habitual smoker. The vomiting, giddiness, faintness, and other unpleasant sensations experienced as a result of the inhalation of the concentrated fumes in an individual unaccustomed to tobacco, are in all probability reflex phenomena and are the result of irritation of the bronchial and laryngeal mucosa, and perhaps of gastric irritation too because the novice, in addition to inhaling the fumes, swallows a good deal as well. The effects could not possibly be due to the absorption of noxious substances in tobacco smoke because the effects are almost instantaneous; but at

the same time they might be due to the action of nicotine on the ganglia of the gastrointestinal musculature.

With the habitual smoker the picture is a very different one. The first few inhalations of the first cigarette of the day, especially if postponed until three or four hours have elapsed since awakening from sleep, induce a pleasurable sense of intoxication. A certain definite interval elapses before this sense of intoxication is experienced and it seems indisputable that some substance or substances, which are constituents of tobacco smoke, are absorbed, conveyed to the brain via the blood stream and affect the former in some obscure way. The initial sensation is one of exhilaration, followed by a care free lethargy and a feeling of peace and contentment, and a desire for complete relaxation. Only the action of a drug or a drug like substance would transform a normally energetic individual into the laziest of men. Moreover the sensation of exhilaration and well being is very similar to that experienced as a result of the inhalation of fumes of 'cannabis indica' though with this latter drug the effects are far more pronounced, the duration of the sensations just described seldom exceeds twenty seconds, and cannot be elicited again, until a lapse of about fifteen hours has been permitted, since the previous cigarette was smoked. This latter period therefore seems to indicate the time taken for the intoxicating substances to be eliminated from the brain.

It has been suggested that smoking gives repose and thereby facilitates intel-

lectual work because repose aids coherence of thought, but this effect is denied by quite a few habitual smokers. Other people describe a constant stimulation of mental activities which greatly increases mental acuteness but this too is uncertain.

The action of tobacco depends largely upon

- (1) the constitution of the smoker,
- (2) his habituation to the drug,
- (3) the circumstances under which he smokes.

Whether or not the action of tobacco is the action of its contained nicotine is still a disputed fact. Nevertheless it is known that a very small amount of nicotine, e.g., that contained in a single cigarette, has a definitely stimulating effect on the mental and bodily powers. In larger amount the action is a depressant and narcotic one, which in habitual smokers is modified to a sedative effect upon the central nervous system without much depression of the heart.

The most suitable time for smoking is generally admitted to be after meals, and especially in the evening after a day's work, when the sedative action is most beneficial to the nervous system.

Susceptibility to the action of tobacco is very different in different people. In some, and particularly in young persons, very small quantities suffice to cause depression and irritability of the nervous system, the heart, and the digestive

organs; while others, specially those who lead an open-air life, are not in the least affected by very large amounts.

Continued and excessive smoking are definitely harmful. The pipe, cigar, and cigarette in this order are methods of smoking by which increasing amounts of nicotine are taken into the system from a given weight of tobacco. As a cigar or cigarette is smoked, the nicotine and other volatile products retreat before the heat, so that the stump or butt becomes very highly charged with them and is therefore the most active part of the cigar. Excessive smoking is most harmful in young people. A healthy full grown man should not consume more than four ounces per week. Symptoms of excessive smoking include palpitation and cardiac irregularity, giddiness, and a tendency to syncope ("Tobacco Heart"). Other symptoms are fatigue on slight exertion, dyspepsia, and dimness of vision, associated with disturbances of colour vision. ocular derangements are particularly liable to occur when excessive smoking is associated with excessive indulgence in alcohol. So called "tobacco Amblyopia" is the commonest eye symptom. Tobacco heart and tobacco Amblyopia however are really not so common as people are apt to make out. What is a very much commoner result of tobacco over indulgence is what is known as "Smoker's throat" or "Smoker's cough", which is a chronic laryngitis associated with distressing cough and aphonia; this is obviously due, not to a specific action of nicotine, but to the constant application of an irritant alkaline vapour to the throat. It

is particularly liable to occur when the brand of cigarette smoked is suddenly changed, but on the whole seems to be more common in pipe smokers than in cigarette smokers. "Smoker's cancer" is another sequel to excessive smoking and was by no means uncommon in olden days when men were in the habit of using clay pipes. A similar chronic irritation of the tongue, which however very rarely develops into cancer, is fairly common among both pipe and cigar smokers nowadays.

Diabetics and pellagrous subjects are believed to be unduly susceptible to the ill effects of over indulgence in tobacco, an increased liability to Vincents' Angina is also believed to be the result of over indulgence.

To set a common standard we may take four ounces as the maximum permissible tobacco consumption per week for the normal healthy adult. Nevertheless it is a well known fact that certain individuals are capable of consuming quantities greatly in excess of this, for long periods, without much apparent harm to themselves. For instance it was recently reported that a certain officer in the British army was in the habit of smoking no less than one hundred and thirty cigarettes per day for years. An equally astonishing story is one of a woman who smokes a hundred and twenty cigarettes a day.* How on earth these people ever find time to eat or

* The late M. Briand, the French politician smoked, it appears 100 cigarettes a day.

think or sleep is a mystery; perhaps they smoke even in their sleep! when one recollects that the average time taken to smoke a single cigarette is about six minutes, it hardly seems possible that these extraordinary people can consume so much tobacco within the short space of time between waking and sleeping. These performances, if authentic, may obviously be accepted as records in the smoking world!

Withdrawal symptoms. — When a 'seasoned' smoker endeavours to rid himself of the habit suddenly various symptoms, which depend to a large extent upon the constitution of the smoker and his habituation to tobacco, manifest themselves. These symptoms range from a slight restlessness or irritability on the one hand to severe muscular twitchings and nervous derangements on the other. The most constant withdrawal symptoms appear to be:—

- (1) Insomnia.
- (2) Indigestion.
- (3) Irritability.
- (4) Restlessness.

The more serious symptoms are exceedingly rare. They include:—

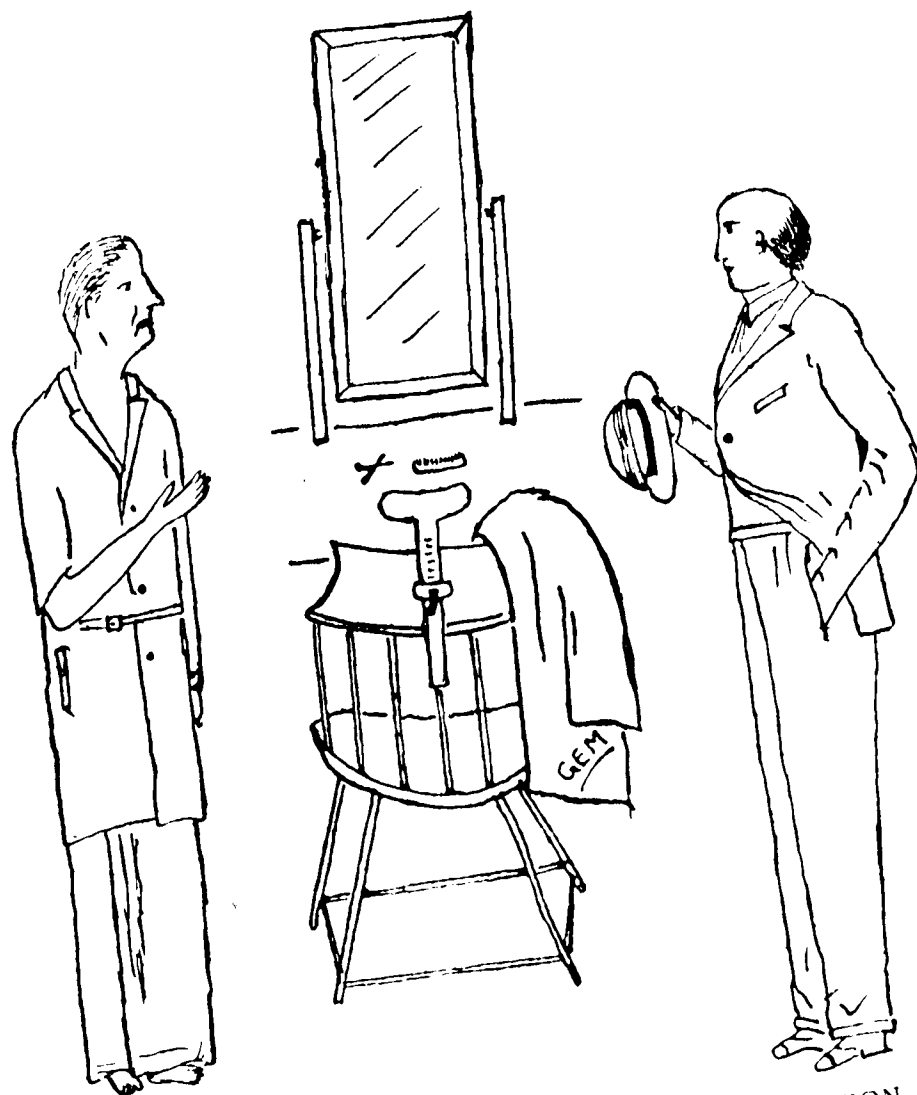
- (1) Dyspnoea.

(2) Involuntary movements of the tongue, lips, and cheeks-tremors and slight twitchings.

(3) Twitching of the muscles in the right arm.

(4) Giddiness and syncope.

While remembering that allowances must be made for the peculiarities of the individual yet it may be taken as the general rule that smokers below the age of forty are hardly if at all affected by sudden stoppage. It is in older men and especially those of neurotic temperament, in whom great care must be exercised in the breaking off of the habit. Moreover this should not be attempted while the subject is under any kind of nervous strain such as anxiety or worry or overwork. It should be done very gradually and over a very protracted period of time, depending upon the response of the individual, months if necessary. At first sight it would appear that such assiduous supervision is quite unnecessary owing to the rarity of alarming symptoms, but on the other hand it must be remembered that a good deal of domestic friction is liable to arise when the man of the house is restless and illtempered, and the avoidance of this is of course very desirable.



SIR ARCHIBALD DE ALMA MATER AT THE SALOON.

Sir Archie :—I want a hair-cut. Can I have the coat on.

Barbar :—Sir you can have the hat too.

Our Personalities.

MADURAM SANDOSHAM.

BY

N. MONEY.

It was at a College Sports day some two or three years back. I heard the familiar old ditty "Keep young and beautiful if you want to be loved". It was so perfect in every detail that I had a notion that Eddie Cantor must have eloped from Hollywood, for the Medical College is not totally devoid of attractions. But, instead of Eddie Cantor, I saw an antithesis of the famous personality. The only similarity was the lips, painted that too. This is one phase.

Another phase was at the reception to the graduates last year. Maduram had hell to pay with a class of rebellious ruffians.

"There, in his noisy mansion, skilled to rule.

The village master taught his little school."

He wore the sacred thread.

"With eyes severe.....

Full of wise saws and modern instances.

.....

With spectacles on nose, pouch on side.

And so he played his part."

The thread he wore seemed to send a challenge to the religion which he had assumed for the moment. "Orthodox of all religions! Beware!".

Our idol is a very good entertainer. He can keep audiences spell bound, with his oddities. The art of mimicry, I think, has seen no better exponent than Maduram. Only in the course of his mimicking performances he has been a terror to the staff of the Medical College. He considered none too great to be left out. Reverence and awe were tucked away for the moment, and full justice was done to every individual and department.

Caricatures too, are not beyond him. His clever exposition of a clinic in progress drew all round praises.

A caricature should have a certain amount of satire in it. And if Maduram's had more than enough of it, it might be ventured, that,

"E'en his failings lean'd to virtue's side"

for if in his caricatures and mimicries, he had some noble end, some fleeting good in view, I think, it must have been to better the social life of the college.

This is not all. Sandosham has been something of a composer too, what his songs lacked in metre or rhyme were compensated by their popularity. The song about the Medical College and its Annammas, Ponnammamas, and Thangam-



Mr. Maduram Sandosham as he sees himself.

mas, became the rage everywhere. I would not be surprised if you tell me that with its advent the popular 'Marc Mowlabula' went the way of its predecessors. Maduram boasts, and that rightly too, that his full name, Abraham William Maduram Sandosham, is a line of a verse, and that he himself has rather a close resemblance to the celebrated Paul Robeson!

If you begin wondering at this long

repertoire of Maduram's I can only tell you

"That still you can gaze and still the wonder grows,

That one small head can carry all he knows."

I have many convictions and this is one of them—I apologise for troubling you with my convictions. I hold that a man without mischief is worse than a man that has no music in himself. Our idol has the mischievous element in him and I like him all the better for it. Once, at the I. C. C. lodge, a neighbour, who had offended Maduram in some way or other returned late at night, to find in his room, a ghost, in the shape of a donkey. I do not know what happened immediately but only this much I know that in the end he had to clear all that which the poor animal was pleased to deposit in his room. Our hero's words that night were to the effect.

"Mischief thou art afoot
Take thou what course thou wilt."

It is said that the poor man, in spite of the stink, slept none the worse. Only the incidence of the retaliation was shifted on to the donkey.

To the consternation of one of the lecturers, he went on imitating him in the class. That proved too much for the gent to bear. Maduram knew he was skating on thin ice. The lecturer thought that by asking Sandosham to take the class he might prove himself, equal to the occasion. But Maduram is one of

those eternal boys whom nothing less than a ton weight would pin to the earth. He went to the platform and began explaining the intricacies of the three way tap exactly as the other man did. Fretting and fuming are things for which Maduram cares little, and the lecturer had to abandon him as one of those incorrigible wags who will never reform. An exhibitionist to the tips of his ears, funny items come to him as mosquitoes to an 'Ento-Ray' lamp.

Men of his sort have always some yarn or other to tell us, and Maduram has a pretty good stock. Once he received a letter addressed to Miss Maduram Sandosham, from the College Office asking him why he avoided admission to the lady student's hostel. Maduram replied that if the Principal did not mind, he would certainly join!

That reminds me of another one, of his far off Pre-reg. days, when one of the lecturers whom he hailed early

morning from a tree top, told him that short as he was he was not expected to fall short of the good manners expected from a gentleman. If people mistake his bluff and breezy way we can only be sorry for their incapacity to enjoy a joke.

But Maduram cannot be taken too lightly always. In his case "Rira bien qui rira la dernière"* is the best policy, for the subtly camouflaged joke may be on you for all you know. A Puck grown big he can knock you down with a feather.

Almost every college function owes its success to Maduram. You bet, he can set the tune for the rejoicings, as he knows how. There is not a glum face in the audience when he is on.

You can miss Naples but not Maduram.

Commend me to Maduram for an entertainment!

* "Rira bien qui rira la dernière" he laughs best who laughs last.

THE HYGIENE EXCURSION TO THE KILPAUK WATER WORKS.



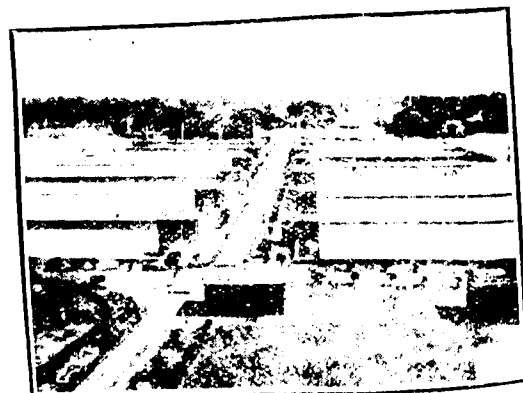
[Photo C. S. R.]

The fourth year students who went for the Excursion.



Photo L. R. M.]

The Kilpauk Water Works.



[Photo L. R. M.]

On Purgatives.

By "N".

If you want to purge a fellow,
There are no rigid rules to follow :
Broad principles bear in mind,
And favourable results, you find.

In ordinary constipation
Only of some short duration
Drugs to produce mild purgation
Is always the indication.

Castor oil, sulphur or senna,
Rhubarb, aloes or frangula,
In small doses are laxatives,
Larger ones more productive.

Aloes has the bad tendency
To abort in pregnancy ;
Through its excretion in the milk
In the child, senna does the trick.

Rhubarb tends, after purgation
To produce some constipation
Some colour in the urine is seen,
After action of this anthracene.

Prescribe in all chornic cases,
Habits, and hygienic measures ;
Failing which, it is always best
Saline cathartics have stood the test.

Experience has now us taught,
As also some authorities thought,
Agar in paraffin oil base
Is beneficial in a chronic case.

Constipation that is obstinate,
By milder drugs will not terminate.
So jalap, colocynth or croton oil,
Give, with a carminative oil.

Or add extract of atropine
To prevent any griping,
Also compound infusion of senna
And, with advantage give enema.

Purgatives in cases of typhoid,
Beware ! you should always avoid.
A glycerine enema is indicated,
Of course, if the patient is constipated.

In post-operative atony
Of intestines, 'twill be moony
To administer but anything,
Than physostigmine or pituitrine.

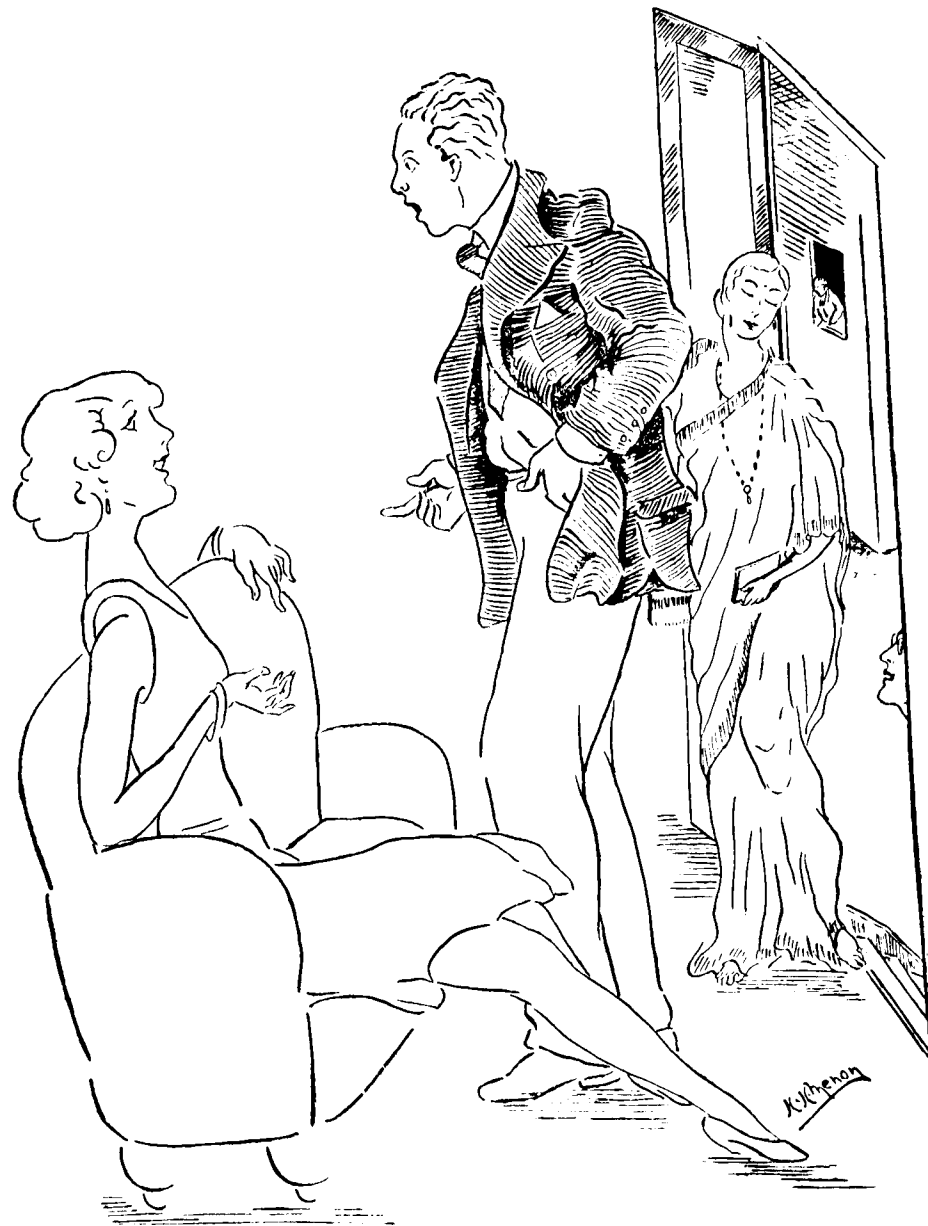
If a person is getting fat,
There's nothing like mineral salt.
Kruschen and Epsom have a name,
To reduce to fashion's fame.

Purgatives should not be given
In acute intestinal irritation,
Or even in obstruction,—
Not to speak of menstruation.

Always ! in the case of a relative
That is not at all remunerative,
Give croton oil with scammony—
A large dose without ceremony !

If there's any other condition
That's not dealt in this edition,
There is nothing to bother—
You can consult the Author !

THE GRADUATES' RECEPTION.



Secretary :— Hn— Hr— Cēn you— hm— hr— dc— rr— something for— rr— the— mn— graduates' reception.

Newcomer :— Why ! Of course show them in.

Teasers.

CONDUCTED BY
THE B IN BONNET.

1. What is an Aphorism ?

2. (a) Which is the oldest recorded case of sunstroke ?

(b) On whom was an attempt to produce leprosy by experimental means, successful ?

(c) Which disease was known as the King's Evil ? Which King touched for it first ?

3. What is meant by

- (a) Bed-lam.
- (b) Ichor.
- (c) Robot.
- (d) Sarcophagus.

4. Who invented.

- (a) The stethoscope.
- (b) The opthalmoscope.

5. Which medical man

(a) Is a member of the British Cabinet ?

(b) Wrote a series of books on character building ?

(c) Introduced a new universal language ?

6. Who are the following :—

(1) Galen (2) Lord Horder (3) Tom Thumb (4) Serge Voronhoff (5) Sir Aldo Castellani.

7. Whence are the following characters obtained :

- (a) Mr. Hyde.
- (b) Count Dracula.
- (c) Dr. Fu Manchu.
- (d) Dr. Pangloss.

8. Who was known as the " Lady of the lamp ?"

(Answers on page 164.)

My Pursuit.

By T. K. N.

Late in July a Nurse I met
Working in Orthopoedic ward;
So off my guard I promptly, got
And broke one leg—Surely 'twas hard.

But She went to Medical side,
And my hope too, then nearly died.
Quickly I got my bone mended;
With fever and cold it ended.

When I went there with my fever
Her term there too was then over.
She's transferred to Surgical side,
And so there came my pain inside!

Operated—
For appendicular abscess!
I progressed without relapses;
But ere I could my passion say
Terminated her term's last day.

And now I am in a bad fix,
Not that I lost my appendix;
For this time She's gone to a place,
Shall I go there?—to win her grace?

I've followed her with all my heart,
Now, Reader! Should I cry the halt?
Of your advice I'm so needy
For she's gone to work in V. D.*

* The Venereal Specialist would not mind
lending a bed for a few days, to help a
good cause.—ED., M. M. C. Magazine.

THE LATEST CRAZE OF LADIES.



The Golfer who forgot herself.

"Leaves in the Wind"

BY BOILER.

"God created man in his own image, in the image of God created he him..... And the Lord God caused a deep sleep to fall upon Adam and he slept, and he took one of his ribs, and closed up the flesh instead thereof. And the rib which the Lord God had taken from man made he a woman." But it fell to the lot of the staff of the Hygiene Museum at Dresden to create the first 'transparent' man and the first 'transparent' woman. The transparent man was shown in the Chicago Century of Progress Exhibition of 1933. The world's first 'transparent' woman is now exhibited at the Museum of Science and Industry at New York. She is sculptured in glassy material with all the vital organs visible. All the bones, viscera, the brain, the arteries and larger veins are made in imitation of natural colour inside the woman's statue. They can be illuminated by concealed lights. It is said that over twenty years' laboratory research was needed for the correct placing of the organs. This recalls to my mind our own Centenary celebrations, the exhibition, the lorry drives, duckings and what not. Our Anatomy department, on the other hand, in its own humble way, has erected models for the study of cutaneous nerve distributions, and surface anatomy. Will it attempt anything on the Dresden scale, at the next exhibition, probably when the college cele-

brates her second Centenary? Anyway you and I—I dare say—would not be alive then to witness any such grand affair, and so let us not bother our heads about the next Centenary, but mind our own present business. Sufficient unto the day is the evil thereof.

The famous Surgeon, Lord Moynihan of Leeds who died quite recently, had a fine stock of yarns. At the Royal College of Surgeons, the other day he told one about his student days. He was undergoing an oral examination when the examiner, an old man told that one of his answers was wrong. "Well sir," said Berkely Moynihan, "I may be wrong but the answer I have given is in the book." "Whose Book"? "I am afraid it is yours, sir." A copy was fetched from the college library. "I could never have believed I had written that" was all that the examiner said. "I told the story to a friend of mine, the same night," the surgeon added "and his comment was: 'No wonder the old buffer had forgotten it. I don't suppose he wrote a word of it.' History repeats itself and it repeated many years ago, it appears, at a Biology examination. A student's answer was found correct in the book but the examiner told him 'we will meet at Pompeii'. They met anyway at Pompeii at the next university examination. I refrain from further comment as it is always unpleasant to tread on other

Leaves in the Wind

people's corns, especially if they happen to be in plenty on an examiner's feet.

The late Sir Alfred Yarrow, the ship builder, many years ago arranged a yachting trip for his daughter whose health was causing anxiety. A young doctor Bertrand Dawson was recommended to him as the medical adviser to take during the voyage. Miss Yarrow recovered her health. Dr. Dawson lost his heart. And some one put it "the girl regained her health, the doctor succumbed." This might remind you of the man in Islington 'whose dog to gain some private ends went mad and bit the man.'

"The man recovered of the bite
The dog it was that died."

The voyage ended, the romance continued. Dr. Bertrand Dawson to-day is Lord Dawson of Penn, P.R.C.P. and Miss Yarrow, Lady Dawson. Well, it is quite in order when Bertrand Dawson starts making love to a patient, and he makes a bee line for a peerage. If reader, you and I try the stunt in the hospital, you will find the S.A.S. & Co, close at your heels to drag you by the ear to the Superintendent, unless you make a bee line for the gate.

Bhaskar is the boy for bright ideas. The other day he had a brain wave for taking a photograph of the moon. "Set

the camera ready, light a piece of magnesium ribbon, and click the shutter. You get a jolly good flash light photograph of the moon, in fact as good as any that you get about dances and dinners." How about a flash light photograph of your brain, Bhaskar?

A former secretary approached a prominent lady student for some item by the girls for the College Graduates Reception. Yes, my masters, it is the same man who used to be the motor engine that misfired on all the cylinders, whenever he chose to speak on the platform. "What sort of thing do you need?" inquired the lady "Some dance." What sort of dance? "I would prefer something Indian say Krishna's dance" said the secretary "There are many of Krishna's dances. Which would you like." The gentleman had rather hazy notions about them all, and hazarded "Jalagreeda." I expected the lady to faint or do something worse but she gave sufficient allowance for our friend's superficial knowledge: You certainly don't mean "Jalagreeda" she said. "Yes, I do" said the secretary but words failed him afterwards, and with a few movements of his hand tried to show what he meant. Ignorance in his case at least was bliss when it would have been sheer folly to be otherwise.

Ethics of Election.

BY A. K. KRISHNASWAMI

The alumni of our college were exercising their minds over the selection of a proper candidate to the College Representative Council. Mr. Sanker, one of the aspirants, was a favourite horse. "I must get busy in nursing my constituency," he would say with his usual diffidence, "nothing must be left to chance. I must not rest on my oars now." And Mr Sanker got busy.

Some days passed. One evening, sitting on the sands of the Marina, Mr. Sanker brooded silently "yes," he said to himself, "there are several ways of getting into the public eye, and coming out of their mouths...I mean.. of becoming popular. Have I not read of the mediocre actress who attained stardom by advertising for her lost dog; and another who dropped herself down from the Thames Bridge just when the coronation procession was passing along. I must not lag behind, but hit upon something."

When a couple of days later the notice board announced that Mr. Sanker of the fourth year class would speak on "a missing link in the history of Medicine" both staff and students thought that Mr. Sanker had had what he wanted.

"Guess what he has in mind," said the student with the half consumed Icefrute in his hand, to his companion

in Hanava suit who stood, idly, smoking like a volcano in action, "Is it an easy task to plunge into the recesses of medical history and reclaim some bit of knowledge hitherto unknown to medical celebrities." "You don't know our Sanker," said the other, who obviously knew the aspirant better, "I am sure he will acquit himself quite O. K. on the platform, that day. Let us wait and see."

It was a long time before Sanker could conceive of a fit theme for the speech with which he could bring out his triple qualities of originality, courage and humour—qualities indispensable in a students' representative.

The idea of pulling Darwin by his beard on a point of order, anent his famous theory engaged his attention for some time. But, luckily for him wiser counsels prevailed. And Mr. Sanker gave the idea a go-by, "not because," (so ran his explanation), "I have no honest difference of opinion with Darwin, but because I have been told reliably that he had no beard to be pulled."

"How I wish either G. B. Shaw or Tagore with their long flowing beards were men of science," remarked a comrade, who had been busily biting his nails and spitting the fragments on the Tootal tie of another standing opposite. "Why, Sanker dear, the world of our

Ethics of Election

science has been big enough for other persons than Darwin to figure in. Why don't you have a fling at.....at... ..Pasteur for instance." This idea somehow did not appeal to Mr. Sanker.

* * *

Next day. Mr. Sanker pompously announced his new theme to a group of interested colleagues idly chatting over their cigarettes at our cafe. "I have a new recipe for climbing the Everest," he began, "no need for unwieldy Oxygen cylinders. Nor any need for a multitude of Tibetan coolies with their unpronounceable names, to carry all the cumbersome paraphernalia. All that you need" he proceeded scrupulously adjusting his tie-knot peeping from within the nicely polished fish-bone collar "All that you need is a bottle of Vapex to scare the cold and a couple of pints of Vichy water per head to restore energy." "Why, Sanker," interposed his chum always ready with his mite of advice, "don't you recommend Flex-shoes with antiflex soles for glacier walking?" The advice was drowned in a burst of laughter—And all that I know is that even this second idea proved abortive.

* * *

The day of the lecture. Friends, who that morning had seen Mr. Sanker draw out a bit of paper from his pocket and look at it constantly, conjectured that he had prepared notes for his speech, and was mugging it up.

The hall was crowded. The fairer sex were present in their full numbers.

Eminent Mr. Whimpole occupied the chair. Sanker was dressed in his best.

Mr. Sanker smiled ingratiatingly and with graceful bow began his theme:

"Mr. President, Ladies and Gentlemen,—I was ever of the honest opinion that a man who could wrest a single fact from the bosom of the past and secure for it the stamp of approval of the high priests of our honourable profession, did more service to the cause of medicine and mankind, than one who merely talked of curing sickmen and went about to give them Mixture Alba and Quinine."

The beginning was promising Supporters of the speaker cried, "yes," and "go-on" by way of encouragement. Interruptions, even by way of encouragement are to be deprecated, and staunch advocates of this school-of-thought began 'hissing' for silence. Even eminent Mr. Whimpole could not resist the temptation to participate in this laudable campaign for the suppression of noise. Amidst resumed silence, Sanker continued.

"The burden of my short speech this evening will be to bring out before the intelligent and critical audience such as it is now my pleasure to address, that Dr Johnson, the man of letters, was also a doctor of repute and an outstanding member of the profession to which we will have the honour to belong". The members of the audience, eyed one another for an indication of their respective states of mind, with reference to this new revelation, while the president

closed his eyes, and nodded non-committingly. "There is proof positive, Ladies and Gentlemen," continued Sanker, with the air of confidence of one who has the mastery of the situation," from Mr. Boswell himself that the great person had once stocked in his garret several cures for bald heads and grey hairs. The board over the doorway with "Dr. Johnson" in bold letters proclaimed the calling of the occupant

In spite of the dubious looks of several members of the audience Sanker continued undaunted. "No" you would say, Ladies and Gentlemen, but here is evidence from a contemporary document. Facts and figures can't lie; so also the news sheets which contain them." He pulled out from his waist-cast pocket a bit of newspaper cutting, and waived it before him like a magician his wand, he triumphantly yelled out, "This is the document, which set me thinking about Dr. Johnson. It says, though not in terms, that Dr. Johnson was a real doctor as much as you and I would be. It says: that Dr. Johnson had to sell his stock of chemicals and drugs out of sheer poverty. But he forgot to remove the board which continued to proclaim him as a doctor. One fine evening, Ladies and gentleman, here Mr. Sanker keyed his voice to its utmost pitch, "a venerable old lady came and stood below his garret, called aloud for the ex-doctor; the latter appeared on the balcony and respectfully demanded what she wanted. "Dear doctor," said the old lady. "I came to ask you if you have anything for grey hairs." As I already told you, the doctor's stock of

Medical College Magazine

Vitex or its eighteenth century equivalent was exhausted. The old lady repeated her question: "Doctor, have you anything for my grey hair?" "Yes, madame," answered the doctor bowing, "the utmost respect".

The hall resounded with a burst of laughter from end to end. Mr. Whimpole also succumbed to the contagion but tactfully resorted to his silk-kerchief to preserve the dignity of the chair.

That was how Sanker managed 'to get into people's eye and come out of their mouths'. "I might have told a conscious lie; might have seemed eccentric," Sanker would explain "but what does it all matter so long as I am sure of my election? Is my way of gaining my end more questionable than that of the actress who advertised for her lost dog when she had no dog at all to lose?" This convincing argument evoked a spontaneous nod of assent from his friends; but somebody interposed: "what about the 18th century newspaper which cited for support? It couldn't be true."

Sanker braced himself up to face this unexpected heckling. He turned towards the questioner in whom he recognised his rival candidate. "Well, as for that pertinent question I would say this you can't sufficiently appreciate what "snakes in Iceland" means unless you know a bit of geography. Nor can you know why I forged such an absurd missing link in medical history unless you know my only object was to stage an election stunt. There is practically no difference for me

Ethics of Election

between an 18th century paper and 'The Hindu' dated 12th November 1935. A tit bit appearing in the latter put the idea into my head, and I fabricated a story round about poor Dr. Johnson. May his soul rest in peace!"

Loud applause greeted this explanation. The rival candidate stood for a

while, a sorry figure, withdrew from this hostile circle and later from the election itself!

Reader if ever a bookish man should tell you that Boswell was the only man who became great by associating himself with Dr. Johnson, cut him short, pity his ignorance, and remind him of Mr. Sanker.

Our Bus.

It is learnt that the lady students of the college are buying a bus of their own out of the proceeds of the variety entertainment they put up some months ago, together with a grant from the Government. This is to depict their just feelings and enthusiasms.



Buses, buses, a bus our own !
No more for us to rush or groan ;
No more to wait, or else, go late ;
Nor to borrow money for the rate.

Our tender toes now untreaded
Those uncouth rudes ! how we dreaded.
No more for us to tuck our dress
For dirty passenger's egress.



We do not halt at standard stops ;
We have no luggage on the top.
Regulations? None we abide ;
To beach we can go for joy ride !

Buses, buses, a bus we own ;
It was not bought of any loan.
We made a hit and made a bit
How comfortably we now sit !

T. K. N.

Teasers (Answers.)

1. Aphorism is a concise sentence embodying an important truth. It seeks to systematise human experience. The word was first used for a collection of medical propositions made by Hippocrates which began with the words "Life is short, art is long." The best known collection of aphorisms is contained in the Book of Proverbs in the Bible. Another well known aphorism of Hippocrates is "experience is fallacious, and judgment difficult." In recent times Professor Gee is well known for teaching medicine by means of aphorisms.

2. (a) The case of the son of the Shunamite woman (2nd Book of Kings, chapter IV—the Bible) is perhaps the oldest on record. (Osler)

(b) An Hawaiian convict under sentence of death, who was inoculated on September 30, 1884, by Arning, four weeks later had rheumatoid pains and gradual painful swelling of the ulnar and median nerves. The neuritis gradually subsided, but a small lepra tubercle developed at the site of inoculation. In 1887 the disease was manifest and the man died of it six years after inoculation.

(c) Scrofula, tuberculosis of the lymph nodes was known as king's evil, since it was believed that the disease was healed by a King touching the affected person. In the early days the streets of London were crowded with scrofula patients whenever a King went out. Dr. Johnson the celebrated man of letters as a baby was carried to the royal palace for getting touched by the King for the evil.

The first monarch to touch, it is believed, was Edward the Confessor.

3. (a) Bedlam is a popular name for any mental hospital. The Bethlehem Hospital London was founded in 1247 as a religious house, and became a home for the insane, the first in the country in 1403. It came to be known as Bedlam, and from that Bedlam developed as the name for any mental hospital.

(b) The Greeks called the fluid that ran in the veins of gods, ichor, the equivalent of blood in human beings. The watery discharge from a wound or ulcer is also called ichor.

(c) Mechanical man. The term was first used by Karel Cipek in his play R. U. R. 1920 where it described a piece of mechanism extraordinarily efficient, but wholly without heart or soul. Robots of varying degree of efficiency have been invented.

(d) Stone coffin used especially in ancient Egypt as a receptacle for the mummified body. At first stone sarcophagi were reserved for Kings, but later came into more general use.

4. (a) Laennec.

(b) Helmholtz.

5. (a) The Rt. Hon. Walter Elliot, the Minister for Agriculture.

(b) Samuel Smiles, the author of *Thrift, Self-Help, Character*, etc.

(c) Esperanto, the universal language was invented by Dr. Zamenhof, a Warsaw medical man, in 1887.

6. (1) Galen—the Greek Physician was born about A. D. 130 at Pergamum and

Teasers

studied medicine in Greece and Egypt. He was physician to the Roman emperors Marcus Aurelius and Commodus, and to many eminent Romans. He died in A. D. 200. Galen wrote a great deal in medicine; though most of his writings have been lost, those that remain were studied by medical men for centuries, and proved him to have been after Hippocrates, the greatest of Greek physicians.

(2) Lord Horder K. C. V. O., M. D. is an English Physician, Thomas Horder born Jan 7, 1871, he received his medical training in St. Bartholomew's Hospital, London. He joined the staff there, and soon became known as a consultant, his patients including members of the royal family. He was raised to peerage in 1933 as Lord Horder of Ashford.

(3) Name given to an American dwarf whose real name was Charles Sherwood Stratton. He was 2 ft. 7 in height and was exhibited in London in 1844 and 1857. He married another dwarf Lavinia Warren.

(A fairy tale of the same name deals with the adventure of a child dwarf.)

(4) Russian Surgeon. Born July 10, 1866, studied medicine in Paris, becoming chief surgeon in the Russian Hospital, and the Military hospital there. He is best known for his method of preventing or delaying senility by grafting monkey glands into the human body. Among his publications are *Thyroid grafting and Life*, *The Study of Old Age*, and *My method of Rejuvenation*.

(5) Sir Aldo Castellani, the Director General of the Ross Institute and Hospital for Tropical Diseases, London, an Italian by birth, succeeded to that place after the death of Sir Ronald Ross. He has married an English lady. Sir Aldo was in charge of the medical attendance, etc., for the Italian troops in the recent Italo-Abyssinian war. One of the main reasons for the Italian victory, was, thanks to Sir Aldo Castellani's careful arrangements, the excellent health of its troops.

7. (a) The baser half of the dual personality of Dr. Jekyll. From R. L. Stevensons "The strange case of Dr. Jekyll and Mr. Hyde."

(b) Central figure of the novel *Dracula* by Bram Stoker. The chief of the vampires he sucks the blood of healthy human beings, who in turn become vampires.

(c) In Sax Rohmer's, *The Devil Doctor*, *The Mystery of Dr. Fumanchu*, etc. The doctor is depicted as a picturesque oriental criminal, with a subtle western polish and culture.

(d) There is one Dr. Pangloss in Voltaire's *Candide* and another in George Colman's comedy *The Heir at Law*. In the latter he is seen as a poor scholar full of learned quotations.

8. Florence Nightingale, the English nurse and hospital reformer, who was responsible for raising the standard of nursing to what it is to-day, and who rendered great service during the Crimean war, was known as the Lady of the Lamp.

Smile a while.

The skeleton, wrote the little boy in an essay, is a man with his inside out, and his outside off.

It was a very dull lunch party, and conversation languished. The little girl seized the opportunity to glean a little knowledge. "Mummy" she said, "if a lord marries a lady, and the lord dies, and then some years afterwards the lady has a son, is he a lord too?"

And general conversation buzzed in every direction.

A teacher told the class to compose a verse containing the words "analyse" and "anatomy."

A pupil with a romantic turn of mind wrote.

*"My Hannah lies over the deep blue ocean,
My Hannah lies over the sea of Galilee,*

*My Hannah lies in the land of Goschen,
Oh! Bring back my lovely Hannah to
me."*

Surgeon:—What are the tests for renal efficiency?

Student:—Sir, do a sigmoidoscopy and inject indigo carmine.

"How did you come to lose your job?" asked a friend of the young man who had just been dismissed at a moment's notice from the big store.

"Simply by misplacing a label," was the reply.

"What do you mean by that?"

"Well, I saw it on the floor where it had fallen from a pile of ladies' jumpers, and without looking at it, I put it back on a bath tub."

"That doesn't seem to be a very big mistake. What was the label?"

"How would you like to see your best girl in this for Rs. 7-8?" said the young man sadly.

A doctor, known for his parsimonious ways joined a golf club. He was told by the professional that if his name was on the golf balls, and if they were lost, they would be returned to him, when found.

"Good," said the doc, "put my name on this ball."

The pro did so.

"Would you also put M. D. after it?" said the new member. "I am a doctor."

The pro obeyed.

"There is just one more thing," went on the doc, "can you manage to paint 'Hours 7 A.M. to 10 A.M.' also?"

The Judge in the Dentist's chair:—"Do you swear to pull out the 'toot', the whole 'toot', and nothing but the 'toot'?"

The honorary asssistant physician was giving clinics about amoebic dysentery at

Smile a While

the O. P. "Have any of you seen a cyst?" the asked.

"Yes, Sir" said a lady student rather fresh to the hospital.

"What cyst have you seen?" he demanded.

"An ovarian cyst" said the girl meekly.

"You seem to be very bright this morning" he remarked.

"I thought all cysts were more or less the same" said the student.

"What is heridity."

"Something every man believes in, until his son begins to act like a fool."

167

"Did you sew the button on my coat, darling?" asked newly-married Raju.

"No, my sweet. I could'nt find a button, so I sewed up the button hole."

A street fruit seller was stopped by an old woman. She picked up a bunch of bananas. "They are not ripe" she sniffed.

"Not ripe" ejaculated the hawker. "Of course they are ripe!"

"I tell you they are not" persisted the old woman, "they are hard to skin."

The fruit seller gasped. "Grandma", he cried "What do you expect for ten for an anna—bananas with zip fasteners?"

Letters to the Editor.

To

The Editor,

THE MADRAS MEDICAL
COLLEGE, MAGAZINE,
Madras.

Sir,

I deplore, as I know many worthier people do, the growing demand on the part of our students for didactic lessons in the wards and the growing response to it. The following quotation from Osler's valedictory address at John Hopkins University (*J.A.M.A.* civil: 639, August 29, 1936) is therefore very opportune.

"...the amphitheatre clinic, the ward and dispensary classes, are but bastard substitutes for a system which makes the medical student himself help in the work of the hospital as part of its human machinery. He does not see the pneumonia case in the amphitheatre from the benches, but he follows it day by

day, hour by hour, and he has his time so arranged that he can follow it; he sees and studies similar cases, and the disease itself becomes his chief teacher, he learns its phases and variations as depicted in the living, and he knows under skilled direction when to act and when to refrain from action, he learns insensibly principles of practice, and he possibly escapes a nickel-in-the-slot attitude, which has been the curse of the profession in the treatment of disease.

And the same with the other branches of the art; he gets a first hand knowledge which, if he has any sense, may make him wise unto the salvation of his fellows....."

Substitute, Sir, the imperative for the indicate mood!

I am, Sir, yours etc.
S. K. SUNDARAM.

MADRAS,
22nd October 1936.

Association Notes.

The Graduates Reception Day came off on the 2nd of September 1936. This year there was an unprecedented enthusiasm among the students which began to be displayed long before this expected day. This 'Stir up' among the members was considered by many of us as the herald of the happy and successful termination of the function. Particular mention must be made of the great enthusiasm and co-operation of the military and lady students. The latter had been of late years reticent for some unknown reason. The disappearance of this reservedness on their part was mainly responsible for the great success with which the grand function ended. In this connection I have to thank especially Mrs. L. K. Nimbkar (Lady representative) for her sincere co operation and valuable suggestions.

The graduates and post-graduates of the year, the guests, the staff and students assembled in the College at 4-30 P.M. A group photo of the graduates and the distinguished President and the Lecturer was taken as usual. The guests and the graduates were then entertained to tea which was arranged in the open College maidan. The tea over, all adjourned to the beautifully and tastefully decorated College hall in the new Pathology block which was fitted with microphones. Lt.-Col. Cruickshank presided and after a short but humorous introductory speech by him, the learned

lecturer of the day, Rao Bahadur Dr. T. S. Tirumurthi delivered his interesting Speech. Dr. Iswaran then suitably replied to the advice given by the Speaker and for the first time we were struck by his oratory. The President then wound up the proceedings pointing out the salient features in Dr. Tirumurthi's lecture.

At the termination of this, the long awaited variety entertainment commenced which consisted of a good many interesting items some of the items were of a humorous nature and others were of immense educative value. Of these items perhaps, the most enjoyable were those given by Mr. M. Santhosham. My sincere thanks to him for his co-operation and the items he contributed, would not be out of place here. The Tamil Farce was appreciated much by the audience. The actors under the able guidance of our great actor, Mr. Venkatachari acquitted themselves remarkably well.

On behalf of the association the Secretary thanked the guests and graduates of the year who responded to the invitation and expressed gratitude towards all those who helped him to conduct the function. Amidst cheers the function came to an end.

Lastly I have to record here my great indebtedness to Rao Bahadur Dr. S. Ramakrishnan for his timely advice and

Cricket this Year.

REPORTED BY
G. ATMARAM RAO

The College Cricket season opened with regular practice at the nets for about a month. The usual sides game was played early in July and fifteen players were chosen from which the College XI for each match is selected.

The absence of Garson, Sivaraman D'Costa, Wilkinson, Pereira and Dr. Khote is keenly felt and it will be long before we can find real substitutes for the above mentioned players. The present team is a well balanced one with about seven batsmen and six bowlers. The problem of finding the opening batsmen has not been solved yet even though we are in the middle of the season. Madhava Rao has been doing well as an opening batsman, but his partner Muthukumaraswami has not been shaping well. The mantle of Garson has been taken over by Haridas who has been batting consistently for the college and has an average of 110! The other batsmen, are Hogg and A. V. Rajagopalan, who can be relied upon to score when runs are needed. The former has a century to his credit while the latter batted very well against the Presidency College, scoring forty runs (3 sixes). We have reached the 200 mark in two matches, i.e., against the Y.M.C.A. and the Law colleges. As in many cases we had to declare at the fall of the 4th or 5th wickets, the other batsmen had no chance of making any scores for the college.

The bowling this year has been consistent though not brilliant. D'Silva, our fast bowler has not been bowling well

this season and we hope he will regain his form shortly. H. Paul who bowls well at the nets is not quite successful in matches (perhaps due to nervousness). Thus the brunt of the bowling has been borne by Rama Rao and Rajagopalan who can keep the batsmen quiet though not run through the side. This year's new find is N. S. Mani a slow right arm spin bowler, who will shine better if he can command better length. With enough practice he is sure to be a match winner, one of these days. At the beginning of the season we had high hopes of H. Gnanavolivu a left arm bowler but he did not come up to the expectations.

Our fielding this year is good. A. V. Rajagopalan is particularly good in the slips. The fieldsmen who could be said to replace D'Costa is B. Mahadevan (who was "reserved for the future") a brilliant fieldsmen in all positions. But his abilities could not be taken advantage of as he is the under study to S. V. T. Chari who could not play this season regularly on account of unavoidable circumstances. Though it is difficult to replace S.V.T. Chari, we have in B. Mahadevan a safe pair of hands behind the wickets. The other candidate for this place is D. S. B. Stevens who is also a good fieldsmen. Hogg, Haridas and Muthukumaraswami have been doing some good work.

Lastly, till now we have played eight 1st Eleven matches, of which we have won four and lost four. The 2nd XI has played two matches and has won both of them.

The Women Medico's Club.

The Women Medico's Club celebrated its second anniversary on the 7th March 1936 at the Wallajah Bagh Hostel and combined with it the send off party to the Final Year Students. There was a large gathering of over eighty. The function began with a meeting when in the unavoidable absence of the President, Dr. Miss Kantamani was voted to the chair. The Secretary read the annual report including the Treasurer's statement of accounts. This meeting was followed by games and competitions held in moonlight in the compound of the Hostel. Nearly every one assembled took part in the games and the evening proved really enjoyable. We had a Boat Race on the Tennis court, Musical Balls on the Net Balls Court, Treasure Hunt all over the compound etc. etc. We had special items for the final year students too, and we bet they had a time of it in striving to be up to the mark with the rest of us.

At 8 p. m. we assembled for dinner under the trees. The spot was tastefully decorated and illuminated. Members of the Committee and others acting as hostesses waited personally upon the guests and made the whole scene look homely and bright. It was really a lesson to many of us as to what a little co-operation and good will could do. After dinner and distribution of Pansupari, flowers and sweets, we had a small ceremony of prize distribution to the

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Speaking generally of the experience gained by many of us in conducting the affairs of the Club, we have all along felt that a large amount of team spirit has been shown by members, but for which spirit the Club could never have accomplished much. Still I would say there are a great many things regarding the working and organisation of a club, that we have yet to learn and that leaves much to be wished for. It is very necessary for any successful institution that its members show a certain

guidance and Dr. Viswanathan our beloved treasurer for the great help he rendered to me in the management of the function.

* * * *

The Madras Medical College Association places on record its deep sense of sorrow at the untimely and premature death of Dr. Sambasivan who was a former General Secretary of the Association. The association offers its condolences to the bereaved family through the pages of this magazine.

The Association is extremely grateful to Rao Bhadur Dr. Ramakrishnan for the promptness with which he fulfilled many of the wishes of the students regarding the remodelling of tiffin room, etc. But there are some more minor changes and arrangements to be effected and we hope that our popular vice-principal will consider them soon and make especially our tiffin room the hygienic model for other colleges to copy.

Dr. E. Achuta Menon, our former lecturer in Ante natal care has been appointed as the Superintendent of King George Hospital and Professor of Midwifery of Vizag Medical College. He has been very popular with us and those of us who had the good fortune to attend his lectures and clinics were struck with his vast knowledge in the subject and the

good number of practical points he used to stress upon. What the Madras Medical College has lost the Vizagapatam College has gained. Our consolation is that she is our sister College. Dr. Dayanda Rao has taken charge of Dr. Menon's place here. His unassuming manner and his winning talk have already made him very popular among us even in such a short time.

* * * *

The retirement of Dr. Hensman is an irreparable loss to the College. He has been taking deep and sincere interest in the welfare of the students. He is never tired of giving advice to us and his fatherly affection and attitude towards us have made such an impression in us that we cannot think of his retirement without sorrow. We wish him a happy and long retired life.

Dr. Venketasubba Rao has taken Dr. Hensman's place. He is not new to us. He has been very popular with us when he was acting as physician of the General Hospital. We offer our hearty welcome to him and are sure that he will take sincere interest in our affairs as his illustrious predecessor.

BIJASKARA MENON AMBODY,
General Secretary,
Madras Medical College Association.

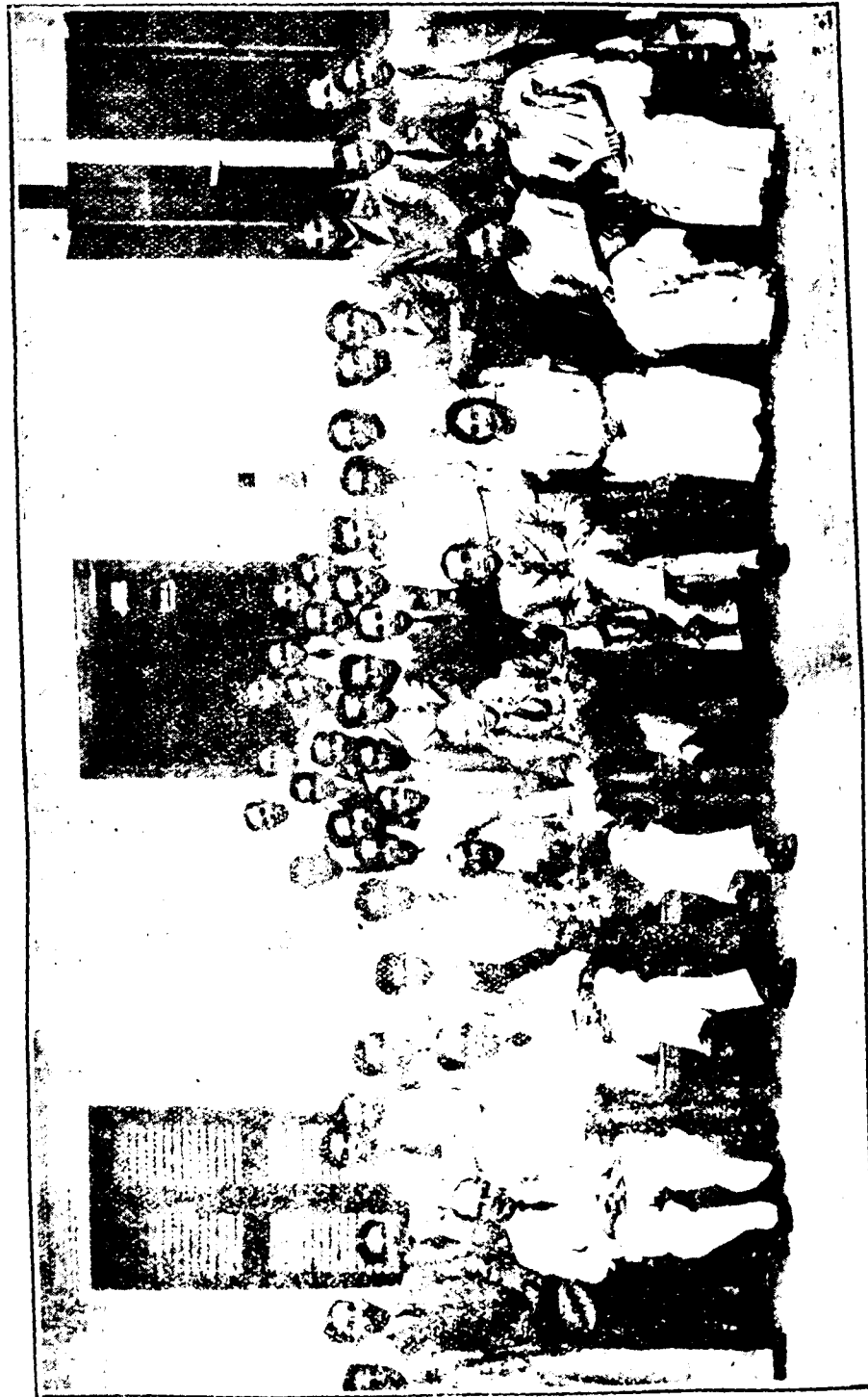


Photo taken at this year's Graduates' Reception.

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OUR EXCHANGES.

1. The Indian Medical Record—Sept. 1936.
2. The Journal of Indian Medical Association—Sept. 1936.
3. The Burman Medical Times—Aug. 1936.
4. The Indian Journal of Venereal Diseases—Sept. 1936.
5. The Medical Reporter—Sept. 1936.
6. The Medico-Surgical Suggestions—Aug. Sept. & Oct. 1936.

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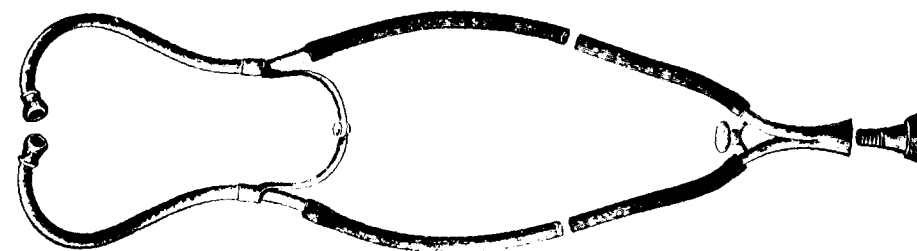
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EDITOR,

The Madras Medical College Magazine.

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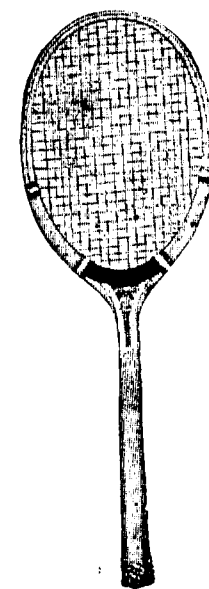
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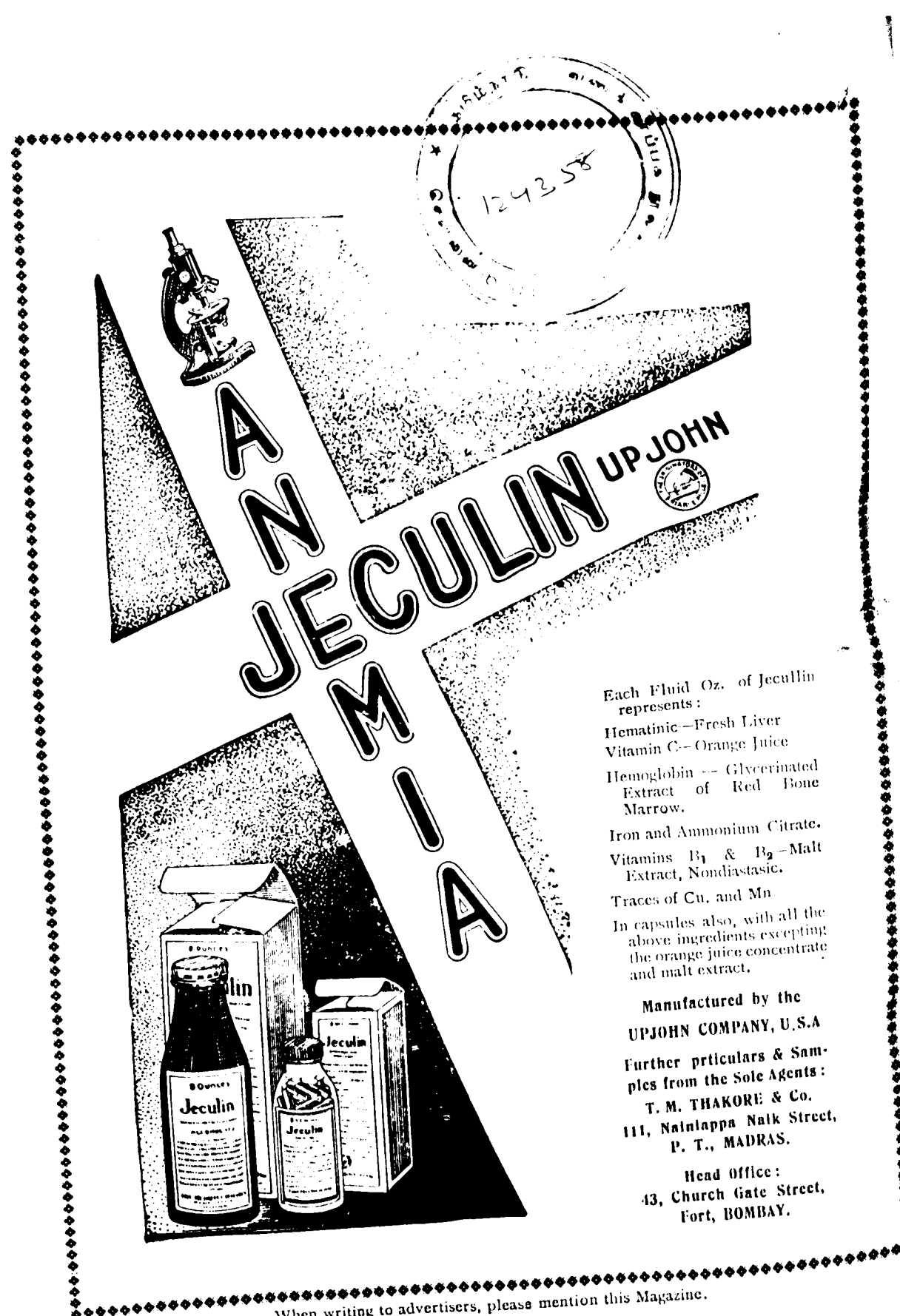
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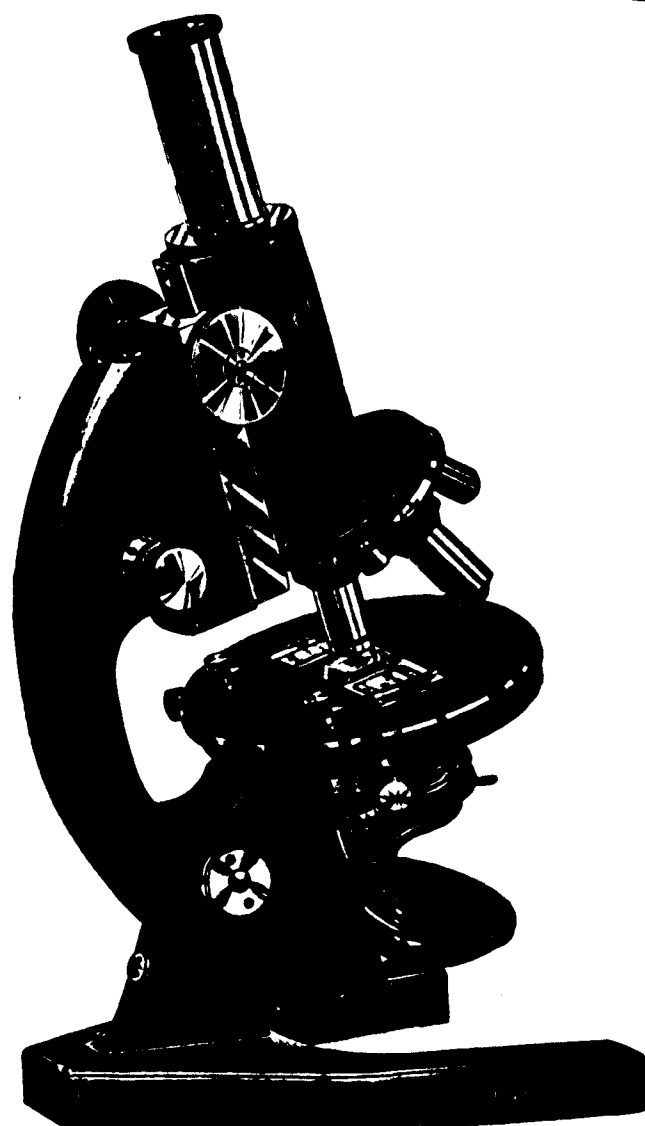
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