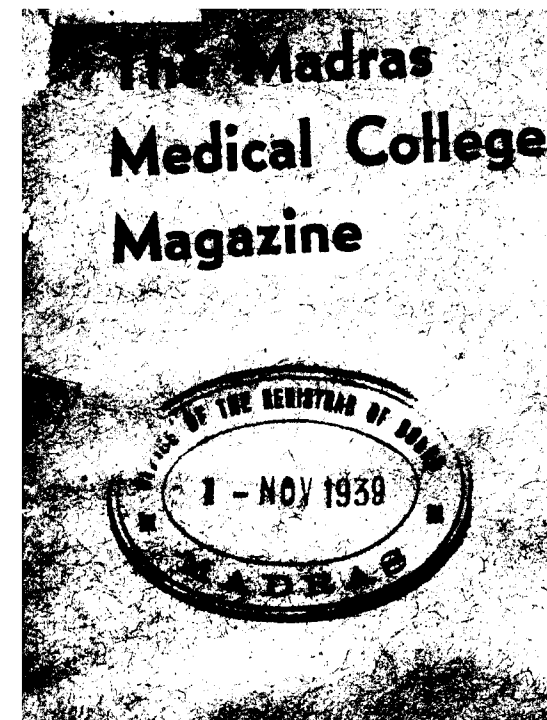


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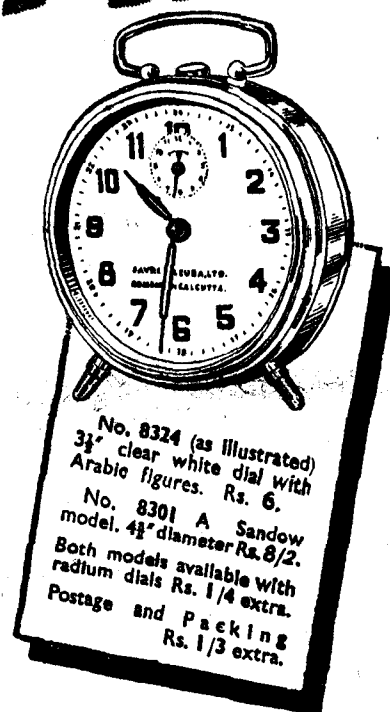
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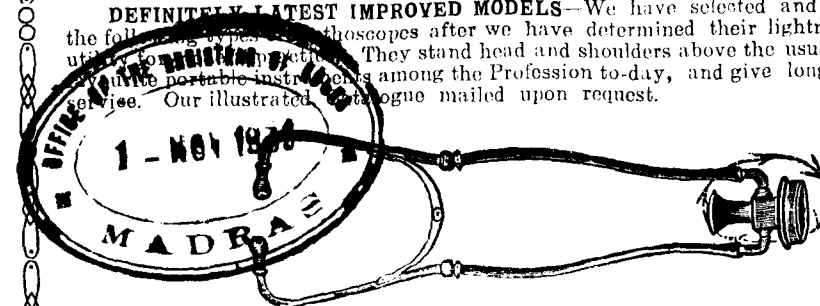


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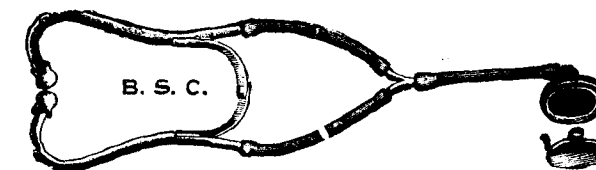


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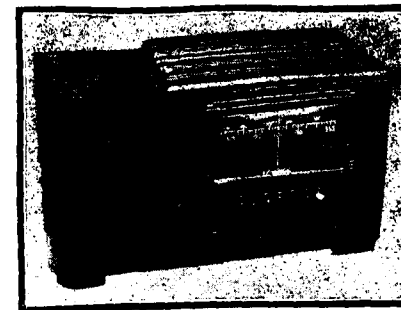
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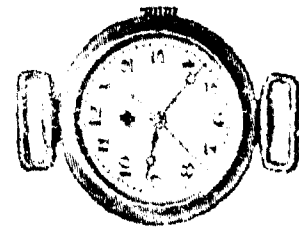
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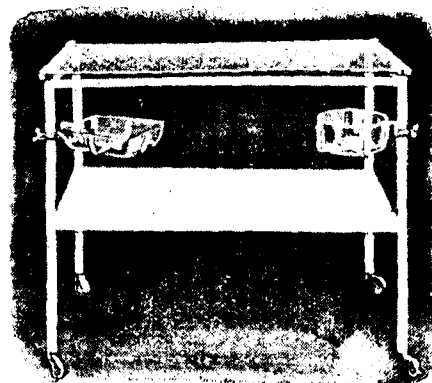
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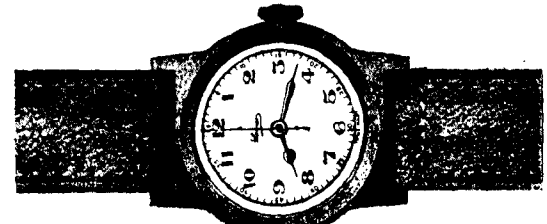
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Hepatology through the Ages.

(A HISTORICAL NOTE)

By P. RAMACHANDRA RAO, M.B., Ph.D. (LOND.),

Professor of Pathology, Medical College, Madras.

It is but natural that in the long march through the ages, the course of progress in Hepatology—the branch of medicine dealing with the knowledge of the liver in health and disease—should have run closely parallel to that of medicine in general. As in medicine so in Hepatology, the underlying current of thought was theurgic in the early (primitive) ancient, speculative and metaphysical in the later ancient, stagnant in the mediæval, and rational and scientific in the modern, periods.

Hepatology of the Prehistoric Ancient Period.—In the medical lore of the great prehistoric ancient civilizations, the liver occupied an exalted position along with the heart and brain as one of the "Triads of life". In the theurgic medicine of the ancient Babylonians (2000 B.C.) the temple schools use discribed clay models of sheep's

liver as omen texts for instruction in divinations and prognostications based on peculiarities of the surface markings and lobular conformations of the organ. The hierarchical physiology of the ancient Chinese (Neiching, 1000 B.C.) conceived of the liver as the storer of blood which contained the soul and as such the father and general of the heart—the king and director of the body. The Talmud of the Hebrews also attributed the formation of blood to the liver. The ancient Hindu medical writers (1000 to 600 B.C.), nearly two millenniums ago, recognised a close functional association between the liver and spleen in the circulation of body fluids. *Charaka* mentions these organs as the root of the ducts that bear the blood. Both *Charaka* and *Susruta* maintained that it was in these organs that the 'tejas' part of the circulating fluid 'rasa' derived from the finer part (sukshma

bhaga) of the chyme (rasa) of the small intestine, driven thither through the heart by the 'prana vayu' through a 'dhamani' trunk, became purified and coloured red by bile through the agency of 'ranjakagni' and emerged from them as blood to nourish and build all tissues (dhatus) of the body. Bile, which is described as a pungent fluid with fetid smell, yellowish blue colour, an acrid taste when fresh and acid after digestion, is identified by *Susruta* with the digestive fire (pachakagni) which digested the four kinds of foods. It is, however, apparent from their location of the point of entrance of this bile into the digestive tract, in the part between the stomach (amasaya) and intestines (pakvasaya) that it is the combined hepatic-pancreatic secretion which is referred to. In spite of the definite notions on hepatic function which the ancient Hindu writers had, they recorded very little on the subject of Hepatic Pathology as their conception of disease was not organic but humoral in its basis. The 'Siddha Vaidya' of the South of India, claiming common origin with Ayurveda from the Asvins, and having a physiology and pathology identical with that of the latter, needs no special mention here.

Hepatology of the Ancient Greeks and Romans.—The early Grecian school of Hippocrates of Cos (460 to 370 B.C.) viewed the liver and spleen as the seats of origin of the two important humours:—(1) the warm and dry yellow bile, and (2) the cold and dry black bile, respectively. The liver was besides, looked upon by Hippocrates as the producer of the blood from which all organs were built. The Aristotelean physiology (384 to 322 B.C.) which couples the two organs into a functional unity, however, views them as hot organs mainly with a digestive

role, furnishing the heat with special powers to the contiguous organ—the stomach where the concoction of food takes place. Aristotle classed bile with urine and faeces as a bitter waste product of the tissues. To Herophilus of this school, the liver was an extension of the digestive tract, as a seat of nourishment. Erasistratos, also of this school, who originated the theory of plethora attributed the ascites of cirrhosis to the condition of plethora in the liver.

The eclectic physiology of Galen (130 to 200 A.D.) gave the liver a place with the heart and brain as the source of the natural spirits (vital and animal) which flowed thence to the rest of the body. That part of the food which is absorbed from the alimentary canal is carried by the portal vein to the liver where it is converted into crude blood (natural spirits) endowed with nutritive properties and passed on through the inferior vena cava to the heart. The close analogy between the Galenic and ancient Hindu conception of the hepatic function appears more than a mere accidental coincidence and strongly suggests whether the "Prince of Medicine" had not drawn his inspiration from the teachings of the ancient Hindus.

The Hepatology of the Dark Middle Ages.—During the long and unproductive period of nearly thirteen centuries, "when reason and enquiry were abandoned and dogma and blind authority ruled" the Galenic doctrines held uncontested sway in Europe. They went into cold storage with the Arabs. The Byzantine civilization added little of importance to it.

Hepatology of European Renaissance.—While the theories of ancient

medicine continued to be transmitted with slavish fidelity in the "unchanging" East even till modern times, the progressive West saw about the middle of the 15th century (1440 to 1541 A.D.) a revolt led by such intrepid seekers after truth as Antonio-Bennivini, Alasandro Benedetti, Paracelsus and others against the tyranny of Galenic dogmas and textual sanctions. The overthrow of humoral pathology and dawn of rational medicine that followed, led to a transition period when the conception of disease became grossly anatomical and the position of the liver ultimately sank to that of a more excretor of the waste product—bile. During this period although Paracelsus (1493 to 1541) and Van Helmont (1577 to 1644) vaguely forestalled the future Biochemical era, by drawing attention to the chemical nature of the changes occurring in tissues and organs in health and disease and shrewdly compared the enzymatic tissue reactions to the fermenting action of yeast in the production of wine from grape juice, yet the contributions to the hepatology were mainly anatomical.

The classical description of the distribution and arrangement of the vessels and their fibrous sheaths in the liver by Glisson (1654), was the result of a naked eye study of the scraped framework of macerated specimens of liver and hence necessarily missed the significance of the parenchyma. The study of comparative anatomy, however, enabled the great Malpighi (1655) to conceive of the liver as a conglomerate gland with conical lobules enclosing closely set hexagonal or polygonal labile glandular acini, linked together by their investing membranes and drained by an excretory duct, from analogy to the hepatic structure in the lower and simpler order of animals

such as snails, fishes and reptiles. He, besides, correctly concluded that the portal vein played an arterial role with regard to the liver. To him was also left the distinction of correcting the earlier misconceptions of Wepfer regarding the locus of the secretion of bile and the direction of its flow, and clearly establishing by vivisection in kittens that the bile secreted in the acini of the liver was carried down the ducts from the liver to the gall bladder and not *vice versa*. In the theory of the mechanism of secretion of bile, both Glisson and Malpighi, however shared the "Vasalian mixture of Galenic doctrines and physico-chemical conceptions" which the 17th century Physiologists preached. To them the hepatic parenchyma served as a combination of the fermenting vat and a filter in which the nutritive material carried by the portal blood was fermented and separated, by a process of selective attraction to parts either connected with the inferior vena cava or with the bile capillaries, into the purified blood which ascends to the heart and the impurities—the lighter yellow and the heavier black bile—respectively. The lighter yellow bile collected in the gall bladder and flowed into the duodenum for aiding the digestive process as required. The course of the black bile, through venous connections to the spleen and thence after alteration, to the cardiac end of the stomach for aiding in digestion and final discharge outside through the faeces was vaguely understood. The faith in the law of morphological similarity in function, however, impelled Malpighi to view, the liver as only a secreting gland like the pancreas, salivary and sweat glands, and the bile as its secretion.

Franciscus Sylvius (1614-1672) completed the degradation of this large

organ by transferring the digestive and even sanguinifying roles, to the newly discovered salivary secretion, attributing to the bile only the supply of the bitter and volatile salts that effervesced with the pancreatic juice in the duodenum, which according to his pupil De Graaf, merely cleaned mechanically the lacteals of their mucus and promoted the absorption of chyle.

Thus we see that in this age of gross anatomy Van Helmont (1577 to 1644) was alone far ahead of his times, in fixing the level of his third stage of enzymatic digestion or sanguinification of the products absorbed from the intestines (second stage), in the liver, thereby forestalling the knowledge of the important metabolic functions of the liver which was to be harvested in the 20th century.

In the olden days to prove your love you had to fight an armoured knight, or spread your cloak down in the mud to catch her foot falls soft and light, or fight a dragon, scale a wall, or other stunts that maidens thrill. You need not do that now at all.

To make a hit—just pay her Bills;

"It is love that makes the world go round." But one should rather think that this is rather a foolish and costly way of keeping a sluggish earth on the move when a double whisky could do the same and much cheaper, too!

A Frenchman was invited for a drink. 'And what will you have' his friend asked him. 'I think I will have a contradiction' said the Frenchman. Rather surprised, his friend asked him what he meant by "contradiction." 'Why, it is this way' said the man from France. You add a little whisky to make it strong, add a little water to make it weak, then you put a little Lemon to make it sour and some sugar to make it sweet and say 'here is to you' and drink it all yourself.

Why be conceited? All that stands between you and idiocy is about five cents' worth of iodine in your thyroid gland, and any doctor could take that away from you.

DALE CERNEIGE.

A class had been instructed that the incident of burnt cakes was comparatively unimportant in King Alfred's life and should not be stressed. One child mentioned it thus: "It is also related that King Alfred once went to a certain lady's house, but perhaps the less said about it the better."

(MEN ONLY.)

Experience is not what happens to a man. It is what a man does with what happens to him.

ALDOUS HUXLEY.

A good woman inspires a man, a brilliant woman interests him, a beautiful woman fascinates him but the sympathetic woman gets him!

HELEN ROWLAND.

The Place of Physiology in General Education*

BY DR. B. T. KRISHNAN, B.A., M.B.B.S., M.Sc. (Mad.),

Professor, Medical College, Madras.

Religion and superstition were for a long time, both in the West and the East, hindrances to the acquisition of any detailed knowledge of the structure and functions of the human body. It was about the middle of the sixteenth century that there was a revolt, in the West, against religious authority, and Andreas Vesalius was able, by actual examination and dissection of human bodies, to publish in 1543 a book on the structure of the human body (*De corporis humani fabrica*) and thus lay the foundations of modern human anatomy. It was about three-quarters of a century later that William Harvey laid the foundations of modern physiology by his discovery of the circulation of blood.

Although marked progress was made in physiology by the middle of the nineteenth century, the general education imparted in Great Britain at that time ignored altogether instruction in natural science. The mistress of a ladies' seminary is said to have remarked that it was "not quite respectable for persons to know about their insides". It was considered then that "such gruesome details should be learnt only by the doctors". It was Professor Huxley who first criticised the educational policy of his day and it was largely due to his influence that the teaching of biology and with it that of human physiology was introduced into schools in Great Britain.

In India, physiology as a science was, I believe, very little heard of till the advent of English education. The ancient Hindu medical literature as embodied in 'Charaka' and 'Susruta' possibly contains some references to the normal functions of the human body. But, owing to the tendency in India of searching for things spiritual in the ages gone by and even at the present day amongst those who believe in and practise Ayurveda, the enquiry into biological and medical truths has been only by the application of spiritual knowledge and by mere interpretation of the works left by the ancient writers. There has never been any attempt to improve on the knowledge inherited by direct and practical investigation and to put forward any scientific publications for the information of those who seek enlightenment.

Even with the introduction of western scientific education in this country, owing to the periodical changes in the educational policy in different provinces, physiology as a science subject has not been regularly included in the curricula of studies either in the schools or colleges. At the Madras University, physiology was, about thirty years ago, a subject for compulsory study in the First in Arts course which corresponded to the present Intermediate standard but was not taught either in the lower or higher classes. At the present day, only such of the intermediates

* Paper read at the Indian Science Congress, Lahore, January 1939.

who study natural science as an optional subject get some acquaintance with the elements of physiology and these are very few indeed. Although very recently physiology has been included as one of the optional subjects for the B.Sc., only one science college at Madras has undertaken the teaching for the subsidiary standard. I believe, at other Indian Universities, physiology has been taught for the B.A., or B.Sc. standard for a longer period than at the Madras University. It is deplorable that, under the present scheme of education, specialisation in an optional subject commences very early in the school course and is carried on up to B.A. or M.A. in the same subject. The result of such specialisation is that majority of the graduates, undergraduates, and schoolfinals who are turned out year after year with history or philosophy as their optional subject are unacquainted with even the basic elements of physics, chemistry or natural science.

If the citizens of a country are to build up sound and healthy bodies, teaching in elementary biology and physiology should form an essential and important part of general education. It is the fashion in this country at the present day to form national health associations and to start maternity and child-welfare centres, ante-natal clinics, nutrition centres, cattle-breeding centres, etc., with the object of educating the public on problems of sanitation and personal hygiene and improving the health and nutrition of men and cattle. If the propaganda work carried out by these associations and centres is to be a success, if the citizens are to understand what is preached on the platform and published in magazines and newspapers, if the people are to learn the secrets

of perfect bodily health, it is imperative that the teaching of physiology should be a part of the general education imparted in the schools and colleges. Suitable health readers, such as those published by McDougall's Educational Co., Ltd., and Vincent T. Murchie's Science and Nature Knowledge Readers containing lessons on the elements of animal and human life, should be introduced in the lower standards of the schools and the knowledge of natural science should be gradually developed in the higher classes. In the college course, human physiology should be a subject for compulsory study and should not be one relegated to an optional group.

The aim of modern medicine and the declared ultimate goal of the medical profession is prevention of disease. Maintenance of sound and healthy bodies by preventing illness is certainly a better ideal than bringing about radical cures of illnesses already contracted. For the successful attainment of this goal, it is very necessary that there should be co-operation between the members of the medical profession and citizens of the country and an effective co-operation can only be expected when the citizens are equipped with a knowledge of the working of the human body and the laws of bodily health and personal hygiene. Such knowledge will also be of great value to the citizens to counteract the influence of, and to protect themselves from, becoming easy victims of unscrupulous quack-doctors and barber-surgeons. Charlatanism and witch-craft could be abolished and be given a decent burial more easily and more expeditiously with the help of such enlightened citizens. The public credulity in regard to advertised remedies can also be removed to a very large extent.

A knowledge of the working of the human body, apart from its usefulness in matters of health, nutrition, and prevention of disease, has also its influence on the moral conduct of individuals. The story of the human body is the "story of a great unity". In this sense, the functioning of the various parts of the body arouses a new interest. It is a remarkable example of a perfect society, where the component units, though they are divided in labour and appear to have different functions, all work in unison with one aim and purpose, i.e., the safety and well-being of the whole body. In a healthy body, there is co-operation, peace, and harmony instead of confusion and disorder. This knowledge ought to serve as a great lesson for the body-politic and is bound to have a great sobering influence on the minds of individuals who have a tendency to run riot. No one who has acquired a knowledge of this great unity and no one who has realised that the drama of human life ends with the dissolution of the physiological existence

of this unity, can be without a feeling of deep humility.

The story of the human body is also "a story of a great work of art". It is not a mere list of anatomical names. The more one comes to know of the exquisite beauty of its structure, the greater is the admiration and interest aroused. The finest work of art, however ingeniously it might have been carried out by a man, cannot excel this God's creation. Attempts have been made since the time of Hippocrates to learn the truth about its working, but Nature has been baffling mankind at every stage, however advanced the intellectual attainments and the scientific progress may be. The more is learnt of this marvel of Nature, the greater is the realisation of the limitations of man's intellect and capacity to unravel and explain more fully the varied complex activities of the human body. It is a great pity that majority of the so-called educated spend their life-time in this world in complete ignorance about this great work of art!

SMILE A WHILE.

Kittain :—Kittu, your wife was known to me even before you married her.

Kittu :—You are a lucky fellow. Only after my wedding I know her fully well.

Janaki :—My mother was well known for her beauty.

Her friend :—I see, therefore, you look like your father.

Boss of the Office :—Chengan (Clerk), how many days' leave you want for your honeymoon?

Chengan :—Sir, that is left to you.

Boss :—How can I decide that? I have not seen your wife!

Lover :—Won't you look at my face once more!

She :—No, if I look at your face, you will kiss me.

Lover :—Of course, I won't.

She :—Then, why should I look at your face?

Laboratory Diagnosis of Kala-Azar.

By DR. RATHNAVELU SUBRAMANIAM, M.B., B.S.

To the student in the Tropics the clinical diagnosis of kala-azar is a matter of considerable difficulty in view of its protean manifestation. A conclusive and clinching diagnosis of the disease may, however, be arrived at by a few laboratory tests.

Blood Picture in Kala-Azar.—Marked leucopenia is only a feature of the advanced disease. Predominance of the mononuclears occurs fairly early in the course of the disease and a count of over 15 per cent is a factor very much in favour of the case being one of kala-azar. Polynuclear leucopenia is not necessarily a feature though very often found, and I have frequently come across proved cases of kala-azar with polynuclear count of 60 to 65 per cent. Immature polynuclears occur in circulation the connecting link between the lobes of the nucleus instead of being fine strands are thickened and the lobes of the nucleus show budding.

In both kala-azar and malaria there is leucopenia with relative increase of the mononuclears and in both there is a destruction of the red blood cells. But this destruction of red blood cells is greater in malaria, as such the normal ratio of leucocytes to red blood cells of 1: 625 is altered (to 1: 2,000 to 1: 4,000) in kala-azar. Anæmia does not occur in the early cases of kala-azar.

Bio-Chemical Reactions.—About 5 c.c. of blood is drawn from the vein and centrifuged with a trace of citrate or oxalate. The serum is of a dull

opalescent colour in kala-azar whereas in chronic malaria it is yellow. The clear serum is taken in a small test-tube and the following tests are done:

(A) **Napier's Aldehyde Test.**—To 1 c.c. of clear serum one or two drops of 40 per cent commercial formaldehyde is added when the whole thing sets into an opaque white mass (jellification) almost at once in fairly advanced cases. This test is also obtained occasionally in certain other conditions such as chronic malaria, syphilis, etc. But opacity does not occur in these cases. For this test to be positive the fever must have lasted at least a period of three months.

(B) **Chopra Test — Antimony Test.**—About 0.2 c.c. of clear serum is taken and diluted ten times with normal saline and to this added one or two drops of 4 per cent solution of any pentavalent antimony preparation. In positive cases, a thick curdy white precipitate occurs. This occurs much earlier than the aldehyde test, and for a positive test to occur it is enough even when the fever has lasted only for 6 to 8 weeks; but the test by itself should not be taken as diagnostic of kala-azar, since this occurs positive in a number of other conditions—especially chronic malaria. This has been a common experience in the wards.

At best the tests enumerated above are only presumptive and to establish the diagnosis. The parasite has to be demonstrated in: (1) Spleen

puncture, (2) Sternal puncture, (3) Liver puncture, and (4) Blood culture.

Spleen Puncture.—Patient is given the previous day and on the day of the puncture, 10 c.c. of 10 per cent calcium gluconate intravenously. The splenic area is cleaned well with alcohol and painted with tincture of iodine. When the spleen is felt by having a grasp on the skin adjacent to the free margin of the spleen and the skin pulled away from the spleen with left hand. A 2 c.c. record syringe fitted with an ordinary sterilised hypodermic needle is used. The perfectly dry syringe is plunged into the spleen upwards, backwards and outwards, so that the direction of the needle is in the long axis of the spleen. If the spleen has been well fixed, as the needle enters the skin the patient automatically holds his breath. But a fussy patient in whom this cannot be confidently expected may be asked to hold the breath after the needle enters the skin and before it plunges into the spleen. The advantage claimed for this method is that even if the patient breathes while the needle is in the spleen it does not tear or cut through the spleen as it may when the needle's entry into the viscus is from some other direction. After the needle enters the spleen the piston is drawn up and held relaxed. If no material is drawn into the barrel the process is repeated once or twice and then the instrument is withdrawn. Even though no material is drawn into the barrel, 'blood' present in the needle is enough. This is spread as thin smears and stained with Leishman's stain. After the spleen puncture a tight abdominal binder is applied. In our experience in the ward it is easy to demonstrate the parasite by this method. We got the intracellular form frequently and

also this is positive at the end of four weeks of fever. But in view of the danger to the patient due to the possible hæmorrhage, this is not attempted as a routine method of diagnosis. It is the last resort of the clinician, when the other methods fail, and yet he does not wish to fall back upon the therapeutic test, when even after treatment there is an element of doubt whether the malady was really kala-azar.

Sternal Puncture.—This is done with a special needle (Salah's). It has an adjustable stop so that the depth of the needle penetrating the sternum can be adjusted. The needle carries a stillette.

The patient's sternum is prepared as for an operation after the skin over the sternum, if it is hairy, is shaved. Sterilised novocaine 2 per cent solution is infiltrated over the sternum opposite to the third intercostal space; special precaution is taken to infiltrate the periosteum to avoid pain. After allowing three minutes for the novocaine to act, the sternum is punctured with the needle. The needle is driven in as a screw with slight twists. When the needle enters the sternum it is distinctly felt that the bone gives way and the needle remains firm. The stillette is withdrawn. A 2 c.c. syringe is fitted to the needle and the marrow aspirated so that it is just seen inside the barrel of the syringe and no more.

Excess of marrow, if drawn, dilutes it with excess of blood. While being aspirated, the patient experiences pain as if being caught in a vice. The needle and the syringe are simultaneously removed and then the syringe detached (otherwise the marrow in the needle will flow back into the sternum). The material in the needle

is spread out evenly on slides, dried and stained with Leishman's stain just as any blood smear.

The precautions to be observed in this are: the sternal puncture needle and syringe used for aspiration should be completely dry, for even a trace of moisture distorts the parasite and distinction of the same from a platelet made difficult. Hence to sterilise the needle, dry sterilisation by flaming it with alcohol is the method of choice.

The advantages with this method are: (1) There is no risk to the patient. (2) It can be done as a routine measure since the only special instrument required is the sternal puncture needle. (3) Neither requires any elaborate paraphernalia as an operation theatre nor does it require general anaesthesia. For patients who are not nervous even local anaesthetic can be dispensed with.

The disadvantages are: (1) Unless the parasites are in abundance one has to search for a long time. (2) The occasional failure to aspirate the marrow. (3) It is very difficult to come across intracellular form.

Liver Puncture.—This has not been done for any case in the wards. The

technique is as for spleen puncture. The advantage claimed for this is the lesser risk compared to spleen puncture. But discovery of the parasite is rare with the liver puncture.

Blood Culture.—10 c.c. of peripheral blood from a vein is citrated, put into N.N.N. medium, and incubated for some days the finding of mircercidia clinches the diagnosis. This is not adopted as a routine on account of the elaborate technique and the time taken to arrive at the diagnosis—a fortnight at the earliest. The only advantage with this method is: this becomes positive early in the course of the fever. The other methods are omitted since they require cumbersome laboratory equipments, and specialists to man them.

My thanks are due to Dr. D. Govinda Reddy for going through the manuscript.

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VIRTUE AND SIN.

As a woman, I would like to hit out at man. A man is brought into the world without being asked; he is taken out when he doesn't want to. When he is little, all the big girls want to kiss him, and when he is big, only the little girls want to. He uses his health to make his wealth, and then uses his wealth to regain his health.

COUNTESS OF MAYO.

In men whom men condemn as ill,

I find so much of goodness still;

In men whom men pronounce divine,

I find so much of sin and blot,

I do not dare to draw a line

Between the two, where God has not.

JOAQUIN MILLER.

Prophylaxis in Diseases of the Heart.*

BY DR. P. S. VARADARAJAN, M.D., M.R.C.P.

The word 'prophylaxis' used in conjunction with diseases of the heart sounds somewhat incongruous; for, the application of the word has hitherto been mostly limited to Public Health. However, in a venturesome world, it is unwise to stick to conventions too closely so as to limit progress. Hence I propose that we shall to-day think together and see how far prophylaxis is possible in diseases of the heart.

The word prophylaxis has a Greek origin meaning "to guard against". That then clips our wings a bit in our flight of thought. I plead, therefore, for a more "catholic" view of the subject and that the term be made applicable in a slightly restricted or modified sense as illustrated below:—

Congenital Disease of the Heart.

The term prophylaxis is only applicable in a very restricted sense as no option is available for preventing the inception of the morbid processes. It is true that congenital defects, including congenital *Morbus cordis*, are said to be more common in multiparity, interbreeding with or without consanguinity, abiotrophies, and agenesis of neurological origin and in infants born towards the lag end of sexual life as in Mongolism. These instances can be multiplied *ad lib ad nauseam* but the process is neither constant nor definite. What we are concerned in practice is that we should guard an infant born with *Morbus ceruleus* against an onset of heart failure—simple or with

congestion. "The patient's activities are to be guided by the simple but sound principle that he lives within the limit of his exercise tolerance" (Lewis). A shielded life, resting during an attack of cold, prevention against exposure to infection of the epidemic varieties, and also Koch's bacillus infection, etc., are some of the measures suggested within practical limits.

Rheumatic Infections.

This subject is the one most pertinent to the day's lecture; for, it is the criminal negligence in failing to rest a patient adequately during an attack of juvenile or infantile rheumatism that leads to valvular lesions of the heart. The periods of rest suggested vary greatly from type to type of an attack, and from patient to patient. Two or four months should be the average period. The second effective measure is to look for an offending focus such as an infected tonsil on the hypothesis that infection plays an important, though indirect, part in the production of the morbid process, and to eradicate such a focus.

Syphilis of the Heart.

Considering that chronic disease processes of syphilis such as meso aortitis, and aneurysm, manifest themselves about 10 to 15 years after the infection, prophylaxis can hardly be thought of. It is wise, however, to remember that syphilis is best treated in the early hours and days of exposure to infection rather than in the weeks and months to come.

* Lecture given under the auspices of the M. M. C. A. on the 7th September 1939.



Case of infantile enlargement of liver.

A Case of Infantile Hepatic Cirrhosis

BY A. V. S. SARMA, M.B.B.S., D.Ch. (Eng.).

Baby Raman. Male. Two years and three months old.

with barley water and tapioca rice conjee.

Family History.—Mother and her sister are asthmatics. Six children older to the patient died of infantile liver. The patient has now a little sister about two months old.

During the first year the child had suffered from diarrhoea or constipation, one alternating with the other.

Previous History.—The patient has been watched till the time of report by the writer except during February to October 1938 when Dr. V. V. Shenai observed the case with no eventful history. The baby was not breast-fed, but was brought up on Allenbury's till nine months age; later weaned

In April 1939 the child had virulent small pox. In May and June 1939 the child had careless feeding and was allowed dosai, iddli, muruku and vadai. Thereafter the liver was felt enlarging more and more.

In the first half of June 1939 the child had no ascites or jaundice, but was observed to lose fat.

Clinical Condition, Treatment and Progress:

CLINICAL CONDITION.	TREATMENT.	PROGRESS.
30th July 1939.—Abdomen bloated. Ascites present. Abdominal veins prominent. No jaundice. Constipation and scanty urine present. Oedema of feet present.	Cirolysin—one teaspoon thrice a day before feed. Diuretin 3 grains per day. Feeds.—Barley water and milk in equal parts with Dextrosol, Vitamin C (Redoxon tablets 3 per day). Euphyllin $\frac{1}{2}$ c.c. given intramuscularly.	30th July 1939 to 1st August 1939.—Satisfactory bowel action and urinary output. Oedema of feet decreased.
1st August 1939.—Ascites present Abdominal circumference at umbilicus 20". Liver 1" and spleen 1" enlarged and both hard. Liver-right lobe more enlarged. Axillary temperature in the morning 99°F. Urine scanty.	Euphyllin 1 c.c. given intramuscularly.	...
4th August 1939.—Weight of the child is 22 lbs. Abdominal circumference at umbilicus 20$\frac{1}{4}$". Flow of blood in abdominal veins is upwards.	Theocin (Bayer) one tablet per day.	...

The Madras Medical College Magazine.

WAR SERVICE.



WE are at war and under that prime necessity every one in this country has to accommodate himself to a new environment quickly. The staff and students of this College rendered willing service during the Great War, 1914-19.

We understand a large number of our graduates have applied for the utilisation of their services and are waiting for the call of duty.

The Red Cross, the St. John Ambulance, the A. R. P. Committees are organisations that require support and demand spirit of sacrifice.

WE offer our hearty congratulations to Rao Bahadur Dr. A. Lakshmanaswami Mudaliar, B.A., M.D., F.R.C.O.G., on his appointment as the Superintendent of the

Government Hospital for Women and Children. This is the first time a former student of the College is appointed permanently to the post.

Personal.

Rao Bahadur Dr. A. Lakshmanaswami Mudaliar, to act as Superintendent and First Obstetric Physician and Gynaecologist, Government Hospital for Women and Children, and Principal and Professor of Midwifery, Medical College, Madras, *vice* Lt.-Col. W. C. Paton.

Lt.-Col. W. C. Paton, M.B., F.R.C.S.E., left Madras as Inspector-General of Hospitals, N.-W.F. Province.

Dr. A. P. Kuriappan to act as Second Obstetric Physician and Gynaecologist, Government Hospital for Women and Children, and Professor of Clinical Obstetrics, Medical College, Madras, *vice* Dr. A. Lakshmanaswami Mudaliar.

Captain C. B. Thomas, to act as Specialist in Obstetrics and Gynaeco-

logy, Government Hospital for Women and Children, Madras.

Lt.-Col. M. M. Cruickshank, I.M.S., to rejoin his appointment as Senior Specialist in Surgery, Superintendent and Surgeon, Government General Hospital, Madras, and Professor of Surgery, Madras Medical College, *vice* Lt.-Col. V. Mahadevan.

Lt.-Col. V. Mahadevan, to be Acting Professor of Operative Surgery, Medical College, and Surgeon, Government General Hospital, Madras, *vice* Major F. M. Collins.

Major F. M. Collins, to act as District Medical Officer, North Arcot, and Superintendent, Government Headquarters Hospital, Vellore.

The Graduates' Reception.

Dewan Bahadur S. E. Runganadhan, Vice-Chancellor of the Madras University, addressed this year's medical graduates at a reception given to them by the Madras Medical College Association yesterday at the College. Dr. A. Lakshmanaswami Mudaliar, Principal, presided.

Mr. Runganadhan expressed gratification at the large number of medical graduates who had taken their degrees this year, and said that when the Stanley Medical College, which had been the nursery for about fifty years as a Medical School, began to add its quota, it was reasonable to expect that the annual output of medical graduates in this Province would be well over a hundred. If all these men and women were inspired by the ideals of an institution like the Madras Medical College with its long history and traditions, a great deal of good could be done to the people. Mr. Runganadhan referred to a paper contributed by Dr. Lakshmanaswami Mudaliar to the Madras Tercentenary Commemoration Volume which pointed out, among other things, that the admission of women into the Medical College dated back to a time when the admission of women to medical colleges even in Great Britain was a matter of controversy.

Large Scope for Public Service

Mr. Runganadhan then dwelt on the advantages accruing from University education, namely a disciplined and cultured mind and a philosophy of life apart from the sartorial accomplishment which was undoubtedly

theirs (laughter). If they were leaving the College equipped in this manner, said Mr. Runganadhan, it was scarcely necessary to say there were vast opportunities before them for rendering service to their fellow-men. A great deal remained to be done for removing the appalling conditions of existence in this country. If, as was likely, in the case of many of them, they were called upon to carry out the periodical medical inspection of school-children, it was essential that they should do that work most conscientiously and well, for the health of its school-children was very important to the country. They could get school clinics to be established at any rate for groups of schools in particular areas, and could ensure that some provision was made for the follow-up treatment of the children wherever necessary. Rural sanitation and child welfare were other spheres in which, if they took special interest, they could do something to improve present conditions. They should not imagine that these problems were too vast and difficult to tackle. If only they were animated by a sincere desire, they could accomplish a great deal even within the limited sphere in which they had to live and work.

Mr. Runganadhan added that what could not be done by individuals could be done by co-operation with others, co-operation not only among medical men themselves but of medical men with other public agencies. This was absolutely necessary if anything effective was to be done in regard to the improvement of public health. Nations were at the present day

feverishly preparing for war and were mobilising all available resources for national service. But did they realise that a great and ceaseless warfare was going on silently in their very midst—the warfare against ignorance and superstition, against disease and suffering? Was it not necessary that they should mobilise their forces just as they did for war? In public health work, medical men would need the co-operation of the school teacher, the Government official and the educated citizen. It was because the various agencies for uplift had been working in isolation hitherto that the work had been so little effective. What was wanted was that they should organise their forces on the basis of war for the purposes of peace, building up a new nation, healthy, educated and physically fit.

On behalf of the graduates, Dr. P. Ramachandran replied.

Future of the Profession in the Melting Pot.

Dr. Lakshmanaswami Mudaliar said that the future of the medical profession was in the melting pot. Great changes were taking place and were likely to take place. None of them could visualise what these changes

would ultimately result in. But they did hope that whatever was done would be first for the good of the country and secondly to help the medical profession to play its proper role in the national welfare and the nation-building programme of the country and that, thirdly, it would bring about a satisfactory sense of security which was essential in a liberal profession such as theirs.

Referring to the present tutorial system of instruction in the College, Dr. Lakshmanaswami Mudaliar added that he felt that the system was not quite satisfactory. The tutorial system, not only in the Medical College but in many others, required to be put on a satisfactory basis. He was sure the Vice-Chancellor would look into the matter and do what was necessary. Dr. Lakshmanaswami Mudaliar said that with the co-operation of his colleagues and the staff of the College, he would find out how far it was possible for them to come into personal touch with the students and give them that help and guidance which some of them at any rate stood in need of. Dr. Lakshmanaswami Mudaliar exhorted the graduates to "be prepared for the opportunities that might come their way".

—The Hindu, August 8, 1939.

The Prize Distribution.

The Hundred and fourth Anniversary of the Madras Medical College and Prize Distribution was held last evening in the College hall with the Hon'ble Mr. C. Rajagopalachariar, Prime Minister, in the Chair. The function was attended by a large number of doctors—both official and non-official.

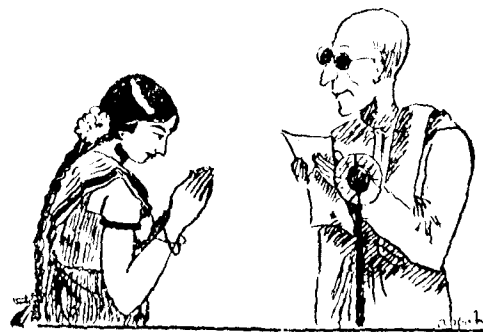
As the Premier came to the Hall, the students received him with deafening cheers and applause.

Dr. A. Lakshmanaswami Mudaliar, Principal, welcomed the Premier and presented the report of the College for the year 1938-39.

The report stated that the percentage of passes at the final medical examinations during 1936-37 was 33.2 per cent, during 1937-38 37 per cent, and during 1938-39 41.85 per cent. There were 979 students in the College during the year, including 276 newly admitted. Of these 757 were regular M.B.B.S. students of whom 124 were women, 52 military medical pupils and the rest of other classes. It was gratifying to note that the College was maintaining its high standard in sports. The College had won the Inter-Collegiate (Travancore Shield) for the fourth year in succession. The College contingent of the University Training Corps was proud to record the selection of Mr. K. Sundaram to the Indian Military Academy, Dehra Dun. Several old students of the College had distinguished themselves in the academic field and had been recipients of higher qualifications in various subjects. Mr. U. Mohan Rao, son of Dr. U. Rama Rao and Johnstone Gold Medalist in 1937-38, left for England in 1938 and obtained the

F.R.C.S. (England). He was the youngest Indian to get this qualification. He was among the youngest in the Register of Fellows of the Colleges. Dr. P. T. Madhavamma who was the Johnstone Gold Medalist in 1935, took her M.R.C.P. (London) and qualified for M.D. Honours, she being the first woman student of the College to get this distinction.

The Principal thanked his colleagues for their hearty co-operation and said that the students had conducted themselves in an exemplary manner and made it easy for the Principal to ensure the smooth and efficient working of the Institution.



Orchids to the Ladies!

The Premier rising amidst cheers said that it was his first duty, before thanking the Principal for inviting him to preside on the occasion, to congratulate the boys and girls who had won prizes. He had no idea before distributing the prizes that very many lady students would carry the palm in open competition. He wondered if there was favouritism (laughter). But he could not safely believe that, for it must be taken for granted that, in a modern academy

The Prize Distribution

like that, there was no room for any favouritism. Perhaps women were better doctors than men. He had been assured by the Surgeon-General that it was an open competition and that there was no reservation for women (renewed laughter). It was but right that girls should succeed in the competition, because, he thought that most of the boys spent away their energies in the boisterous exuberance of animal spirits whereas girls by their natural reserve had saved their energy for their studies and success. He wished the ladies, who had taken away the prizes and honours, continued success.

The Premier congratulated the boys also who had won prizes, because he knew how difficult it was to pass examinations, not to speak of winning prizes. He knew also how easy it was to make mistakes and how difficult it was to cure diseases, even if they correctly diagnosed them. He knew the pace at which the modern medical knowledge was galloping and the varieties of duties the professors had to discharge. The professors had to satisfy the students, who were hard task-masters, by having their knowledge up-to-date and at the same time by their habit of sociability, kindness and strictness.

"Don't Mind Your Fees."

As he was going to the meeting, the Premier observed, that he noticed the boisterous hilarity that marked the students' company which was common with the medical students all over the world. It was easy for the professors of any other department of University education to deal with their students. But it was only given to medical professors to deal with a difficult body of students. He, however, hoped that the students would not make the position difficult for

professors and particularly for Dr. A. Lakshmanaswami Mudaliar, who was a 'good and very quiet soul' and who was not made by nature to deal with mischievous elements. For the last 100 years it had been the lot of students in the Medical College to live under European Principals. Now they had the special advantage of being under an Indian Principal. He hoped, therefore, that they would not make it hard for him. It was only when they treated their professors well that they would be able to learn well. If they had affection for their professors, the knowledge would flow easily. In his experience he had known that there were many doctors who diagnosed the ailment by their intuition and with the help of their instruments. It was only when they were affectionate to their professors that they would be able to deal with patients properly when they entered on their professional life. They should not look upon their patients as subjects of torture or as instruments of making money. They should look upon them with love, which was the universal instrument and without which they could not cure their patients. They should look upon their patients as their blood relatives and they should even forget asking payment of fees.

Doctors and Doctors.

There were some doctors who, from the time they saw a patient and till he was sent away, kept their vigilant eyes on their pockets. How much was he worth, who was he, wherefrom he came, how much land and liquid property he possessed, was he in debt or could he pay cash easily—were some of the things they were anxious to know. There were others who absolutely forgot the monetary point of view. The same was the case with lawyers. If they wished to be good

doctors, they should forget the money aspect. Then alone would they be able to diagnose the disease and treat patients properly. Many doctors were in difficulties because they did not know how to deal with patients committed to their care. They were so much remembering *their* difficulties that they were not able to diagnose the difficulties and ailments of patients.

Now that war had come there was chance for any number of doctors being absorbed provided they were fit for service. There would not be much competition hereafter. When dealing with the human body in surgery and the like, they were apt to forget the human element and to get hardened in heart. It was specially necessary for doctors, when they dealt with patients, to remember that they were dealing not only with the subjects for treatment but with sensitive people. Madras had earned a good name in the department of healing. Madras doctors were thought off well in the whole of India (cheers). They should try to maintain that reputation which Madras had deservedly earned. He had learnt that one of the books given as prize was written by their Principal, Dr. A. Lakshmanaswami Mudaliar. It was a first class book which had gained reputation throughout the world.

Chain of Knowledge.

It was not enough to practise medicine, to earn money or to cure. They should add to the knowledge by making researches and leave their mark behind in the unbroken line of knowledge. They should be able to see that even Modern India had a place in the history of knowledge. They should not allow their experiences to go unrecorded. They should

note down their experiences even from the very beginning of their career. It was not necessary that they should go to foreign countries for making researches. If they were determined, if they were honest and earnest, they could add to the knowledge of the world wherever they might be. He was not against medical students going to foreign countries. But for those who could not go there was enough scope in India to work.

Speaking about the financial help to the Medical College, the Premier said that if there was money he would not shirk spending it on the College. But they should not think that there were inexhaustible funds with the Government for expenditure on any particular institution. They should not be angry with the authorities if they were not able to give funds. He would plead with them that, before they were dissatisfied with the administration with regard to grants and finances, they should try to diagnose the disease properly.

Dr. Lakshmanaswami Mudaliar thanked the Premier for the readiness and kindness with which he accepted the invitation and exhorted the students to follow the valuable advice given by him. The students of the College, he said, had cordial affection to their professors and sometimes a little too much and forgot their shortcomings. He had not doubt that with that spirit in evidence they would be able to carry on the work of the College in the tradition left to them by their predecessors who had outstanding rank and reputation in the medical world. They should also remember their duty towards the public and the Government.

—*The Indian Express*, Sept 5, 1939.

The Ætiology and Pathology of Gall Stone Formation.

BY S. RAMALINGAM, M.B.B.S., AND V. HARIHARAN, M.B.B.S.

[No originality is claimed for the following article, which is merely culled from various text-books on both Surgery and Pathology.]

Gall stones are concretions formed from the constituents of bile—chiefly cholesterol, bile pigments, and lime salts, in varying proportions with a certain amount of organic material, usually formed in the gall bladder—but may be formed in the bile passages, especially those within the liver. They may be single or multiple.

Structure:

Nucleus: Clump of bacteria mucus or blood clot.

Middle layer: Laminated layer.

External layer: Bile pigments and calcium carbonate.

Types.—Aschoff has applied the term "Inflammatory Stones" to the multiple mixed stones and the combination cholesterol stone and the term "Metabolic" to the solitary cholesterol stone and the bile pigment stones.

Metabolic Stone: (1) *Solitary Cholesterol Stone.*—Due essentially to a disturbance in cholesterol metabolism. Large, oval, white, usually single and of light weight. Cut surface shows characteristic radiate structure and glistening crystals of cholestrin. Factors which favour its formation are high bile cholesterol and stasis. It is a silent stone. Solitary cholesterol

stone forms in a sterile gall bladder with normal wall, and represents the crystallising out of cholesterol from bile containing it in excess, this of course being favoured by stagnation of the bile and absorption of water (Aschoff).

(2) *Bile Pigment Stones.*—Multiple, very small, black in colour, friable and consist of bilirubin. They contain no cholesterol; when very small and numerous they constitute biliary gravel. They are often met with in acholuric (hæmolytic) jaundice and are apparently due to excess of bile pigment in the bile.

Inflammatory Stones.—A solitary cholesterol stone predisposes to secondary bacterial invasion. Two things may then happen:—

(1) Cholesterol and bile pigment may separate out along with lime salts and form a laminated crust on the surface of the cholesterol stone, producing the *compound* (or *combination*) cholesterol stone;

OR

(2) The separation may occur in various independent foci, giving rise to *multiple mixed stones*. Of course the latter may form in a catarrhal gall bladder without the presence of a solitary stone, but this probably does

not occur apart from the presence of bacteria. This explains the presence together of two so different types as a solitary cholesterol stone and multiple mixed stones. A mixed stone apparently starts, like concretions elsewhere, around some clump of catarrhal cells or debris as a nucleus and the presence of bacteria may often be demonstrated in the centre. Hence infective or septic or inflammatory.

These mixed stones are the commonest type, are multiple, and composed of cholesterol, bilirubin and calcium. The colour is yellow or brown and the stones are faceted, polished and irregular. The pigment and cholesterol are laid down in alternate layers, so that the cut surface presents a concentric arrangement of laminae dark brown (bile pigment) and paler layers (cholesterol), alternating, both containing an admixture of calcium salts.

Ætiology.—Commonest in late adult life, especially in those of obese nature, and much commoner in women than in men; further they occur much more frequently in women who have borne children than in nulliparæ. The three chief factors are: (1) Infection; (2) Stasis; and (3) High bile cholesterol. It does not follow that all three need be present in any given case.

(1) *Infection.*—This is the principal factor. All the infective or mixed

stones are associated with cholecystitis. The cholecystitis causes the calculi, and not *vice versa*. Cholesterol is held in solution in the bile in a series of loose chemical complexes with bile salts. These may easily be broken up, *e.g.*, by dialysis. When the bile salts are removed, the cholesterol is precipitated.

The diminution in the capacity of bile to hold a normal amount of cholesterol in solution is due to a reduced bile salt content due in turn to (a) deficient excretion by the liver, and (b) differential absorption by the diseased gall bladder (Garrod). There is no differential absorption of cholesterol and bile salts by the normal gall bladder. The infected gall bladder, on the other hand, absorbs the bile salts rapidly but cholesterol very slowly, so that the latter tends to be precipitated. When a nucleus of cholesterol is established, bilirubin is laid down around it to form a mixed stone.

(2) *Stasis* or stagnation of the bile produced by an atonic condition of the gall bladder, occurring in association with constipation and obesity, is favoured by conditions causing pressure on the gall bladder.

(3) *High bile cholesterol* associated in turn with high blood cholesterol is a probable factor, as in pregnancy and typhoid fever. Deposits of cholesterol in the mucosa may become pedunculated, detached and form the starting point of calculi.

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Muir—*Text-book of Pathology*.

Boyd—*Ibid*.

Garrod—*Recent Advances in Pathology*.

Gastric Analysis

(Continued)

BY DR. A. S. MANNADI NAIR, M.B.B.S., Ph.D. (Edin.),

AND

DR. M. RAJAH, M.B.B.S.

Evidence of Pathology.

When disease alters the function of the stomach, this alteration ought to be revealed by a carefully performed gastric analysis. When the fractional test-meal analysis was first introduced, the exponents of the test expected much help in the diagnosis of the diseases of the stomach from fractional test-meal analyses. But accumulated experience has convinced them of the serious limitations the test has in this matter, and the necessity of careful consideration of each case from all points of view before any inference is drawn; yet some useful points of information are obtained from a fractional test-meal analysis regarding the pathology of the stomach.

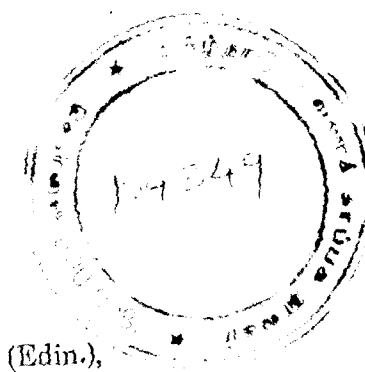
Evidence of pathology of the stomach may be shown in one of three ways:—

- (1) Alteration in the response of the mucous membrane or in other words 'change in the nature of the secretion'; or
- (2) a disturbance in the motor function of the stomach which depends on the muscular efficiency and efficiency of the sphincters; or
- (3) evidence of pathological elements in the gastric secretion: (i) Mucus, (ii) Pus, (iii) Blood, and (iv) Bile.

(1) The condition of the mucous membrane is perhaps an important factor in the production of gastric secretion and therefore a low acid response may be considered a significant sign of disease. A low acid response may be due to an inefficient mucous membrane or a mucous membrane altered by disease. Congestion, inflammation, toxæmia or infection can reduce the functional efficiency of the mucous membrane. Hence low acid response is met with in the following pathological conditions:—

1. Gastritis.
2. Severe toxæmias.
3. Acute infections.
4. Chronic kidney disease.
5. Chronic gall bladder disease.
6. Exophthalmic goitre.
7. Addison's disease.
8. Pernicious anæmia.
9. Pellagra.
10. Gout.
11. Syphilis.
12. Infiltrating growths.

Excessive regurgitation of duodenal fluids, commonly seen in biliary and duodenal conditions, can also reduce the acid output. The rate of evacuation may also play a part. The combination of acid with



mucus during a slow transit and the neutralizing and dilution factors of the meal itself can reduce the acidity of the secretion. It is also well known that different foods evoke different responses from the same gastric mucous membrane, proteins stimulating the secretion and fats depressing it.

A disturbance in the motor mechanism is revealed either in increased motility and premature evacuation or decreased motility and delayed evacuation. Increased motility and premature evacuation are met with in sub-acidities and anacidities. Relaxation of pyloric sphincter with diminished peristalsis can produce early evacuation. Chronic inflammation of the mucous membrane can lower the tonus of the pyloric sphincter and so also infiltration of the pylorus, as in diffuse scirrhus carcinoma, can render the sphincter patent and produce early evacuation. Increased peristalsis—whether functional or organic as in duodenal ulcers—can produce early evacuation. Early evacuation is also naturally common in Gastro-enterostomies. On the other hand, lowered motility and delayed evacuation are seen in Atony of the stomach where there is weakness of gastric musculature. Delayed evacuation is also met with in pathological conditions producing increase in the tonus of pylorus as, for example, in chronic infection in some other part of the digestive system as in duodenum, gall bladder, pancreas, intestines or appendix. But in these conditions the increased tonus of pylorus quickly disappears under anti-spasmodic and sedative treatment. A third possibility for delayed evacuation is obstruction at or near the pylorus which may be intragastric or extragastric obstructions as in the following conditions:—

(a) *Intragastric obstruction:*

- (1) Stenosing ulcer.
- (2) Carcinoma of the pyloric antrum.
- (3) Syphilis.
- (4) Hypertrophic pylorus.
- (5) Benign growths.
- (6) Duodenal stenosis.

(b) *Extragastric obstruction:*

- (1) Adhesions between gall bladder and pylorus.
- (2) Cancer of the head of the pancreas.
- (3) Diffuse inflammations.

The significance of the presence of pathological elements may now be considered.

(i) *Mucus*.—Mucus is found normally in traces, but presence of large amount of mucus is due to irritation to the mucous membrane and is generally found in chronic gastritis.

(ii) *Pus*.—Inflammation and infection can give rise to intragastric pus which is generally found in (i) ulcerating carcinoma, (ii) gastric syphilis, and (iii) infected gastritis; but it should not be forgotten that extragastric sources of pus from nose, throat or even from lungs can give rise to pus in the gastric content, and so care must be taken to exclude these possibilities by a careful examination of the patient before its possible significance is considered.

(iii) *Blood*.—Presence of blood in more than one specimen is significant, especially when the technique of the

examination is not faulty and possibility of trauma can be avoided. Here again extragastric sources of swallowed blood from gingival, tonsillar, post nasal, œsophageal, or even pulmonary sources must be carefully excluded before the real significance of its presence is considered. Regarding intragastric sources of blood, in 80 per cent of cases it is due to malignant disease of stomach, other conditions being infected gastritis, hæmorrhagic erosions, simple oozing from passive congestion, gastric syphilis and gastric and duodenal ulcers.

Bile.—Presence of bile indicates duodenal regurgitation.

Before we consider the gastric analysis in definite pathological entities, a word may be said of pathological variations in resting juice. The volume of resting juice is an important factor. Normally it varies between 20 and 100 c.c., 50 c.c. being the average. Any volume above 100 c.c. may be considered abnormal. Increase of volume in resting juice may occur with or without retention of food. To note food retention, administration of a charcoal biscuit after previous nights' supper is a valuable method, food retention being indicated by the presence of charcoal in the resting juice. *Increased volume without food retention* is met with in the following conditions:—

1. Normal hypersecreting persons (8 per cent of normal).
2. Tobacco hypersecretion.
3. Psychic vagotonia.

Pathologically, mostly in duodenal ulcers, less frequently in chronic appendicitis and still rarely in uncomplicated cholelithiasis, retention of food

and increased volume are noteworthy findings. Twelve hours' retention in the great majority of cases indicates organic lesion in or near the stomach; but it should not be forgotten that habitual over-indulgence in alcohol and over-eating can produce 12 hours' retention. Retention of food, however, may be due to—

(a) *Muscular Defect:*

- (i) Atony;
- (ii) Dilatation;

or

(b) *Obstruction:*

(i) *INTRAGASTRIC*—

- (1) Cancer 50 per cent.
- (2) Gastric ulcer 50 per cent.
- (3) Duodenal ulcer 20 per cent.
- (4) Gastric syphilis 40 per cent.
- (5) Benign tumors
- (6) Hypertrophic pylorus

(ii) *EXTRAGASTRIC*—

- (1) Cancer of the head of pancreas
- (2) Adhesions from gall bladder
- (3) Inflammatory processes involving pylorus.

The following characteristic features are generally found in the pathological conditions noted below. A characteristic curve is also shown wherever possible.

(c) *Chronic Gastritis*.—There are two types of gastritis met with: (1) *Acid gastritis*—gastritis in a hypersthenic individual, and (2) *Achlorhydric gastritis*—gastritis in a hyposthenic individual.

Acid gastritis may be attended with—

- (1) Typical symptoms of tenderness and rigidity.
- (2) Hyperchlorhydria.
- (3) Negative X-ray examination, i.e., no gastric or duodenal deformity.
- (4) Absence of mucus in the specimens—hypersthenic stomach is incapable of secreting much mucus.

Achlorhydric gastritis may be attended with—

1. Symptoms like nausea especially in the morning, anorexia discomfort after meals, heart-burn and acid regurgitation.
2. Sub-acidity or achlorhydria is present.
3. Mucus is present in most cases in the resting juice and in each fraction.
4. Total acidity remains moderately high above the base line.

Exception:

In advanced cases with atrophy of the superficial mucus-secreting cells, mucus is absent and total acidity is much reduced. Treatment in these cases rarely restores the power of secreting acid.

Gastric ulcer:

1. Burning pain after food in the middle line or to the left of epigastrium relieved by vomiting or administration of alkalies, tenderness and rigidity are present.

2. Occult-blood is almost always found in the stools and vomited material.

3. There may be some delay in evacuation due to reflex achalasia of pyloric sphincter.

4. There is no characteristic curve for gastric ulcer. Hyperchlorhydria is more common than in normal cases, but due to associated gastritis, hypochlorhydria and even achlorhydria are found.

5. Volume of the resting juice is usually normal but increases with pyloric stenosis.

Duodenal ulcer:

1. Pain or discomfort appears two to four hours after food and often called "hunger pain" being associated with a feeling of hunger and is relieved by food and alkalies.

2. The volume of resting juice is increased to 100 c.c. and more.

3. Hyperchlorhydria, often with a climbing curve, is found in 70 to 80 per cent of cases.

4. Occult-blood in later specimens of test-meal, with regurgitation, is a characteristic finding in the stools.

5. Occult-blood is found in a large majority of cases.

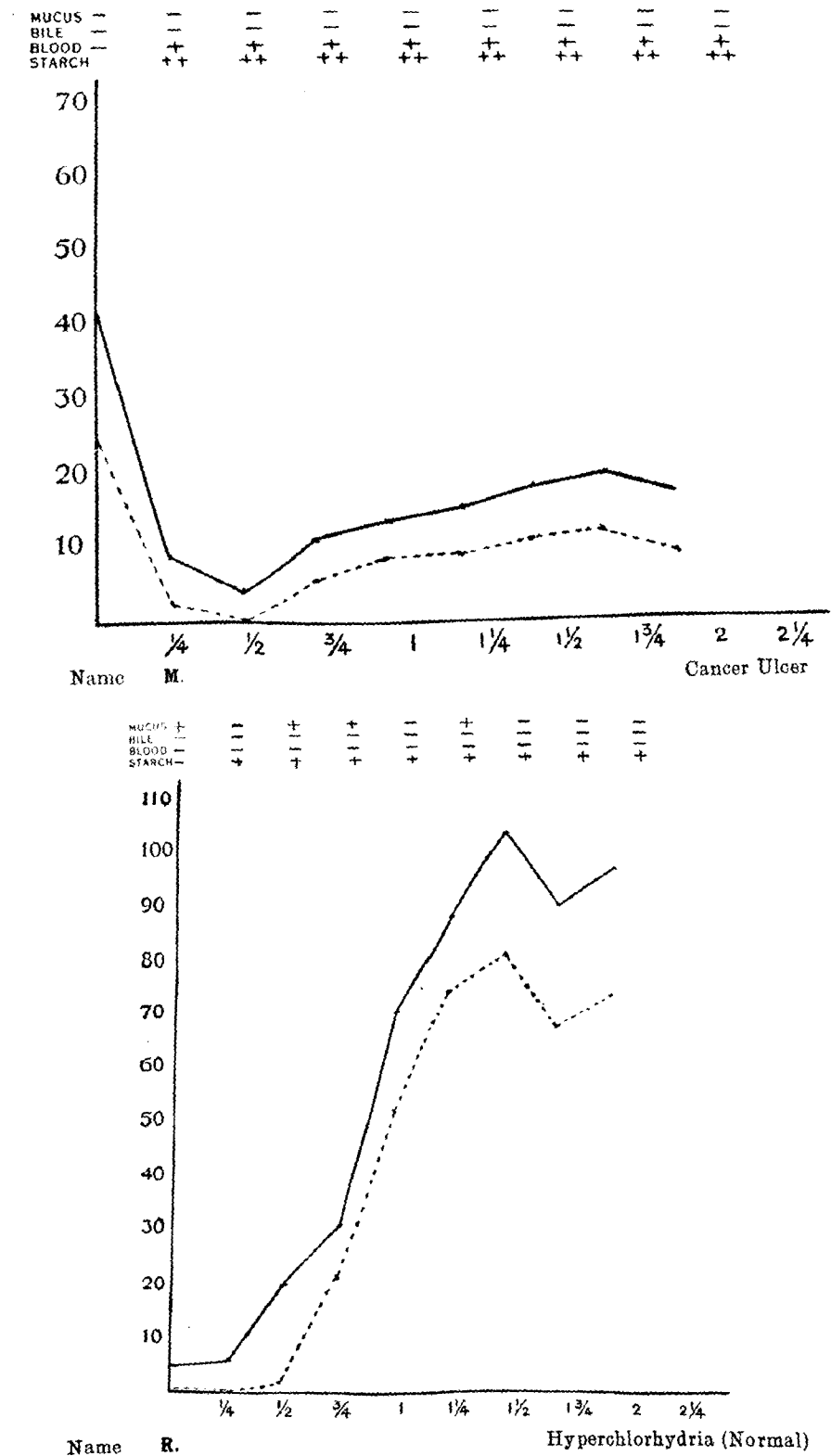
Cancer Stomach:

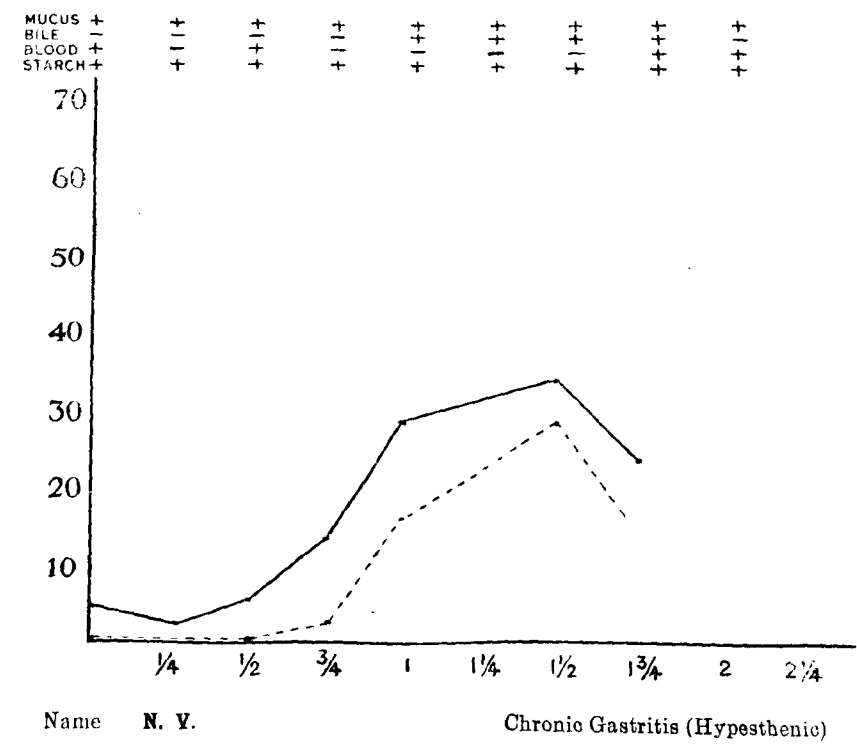
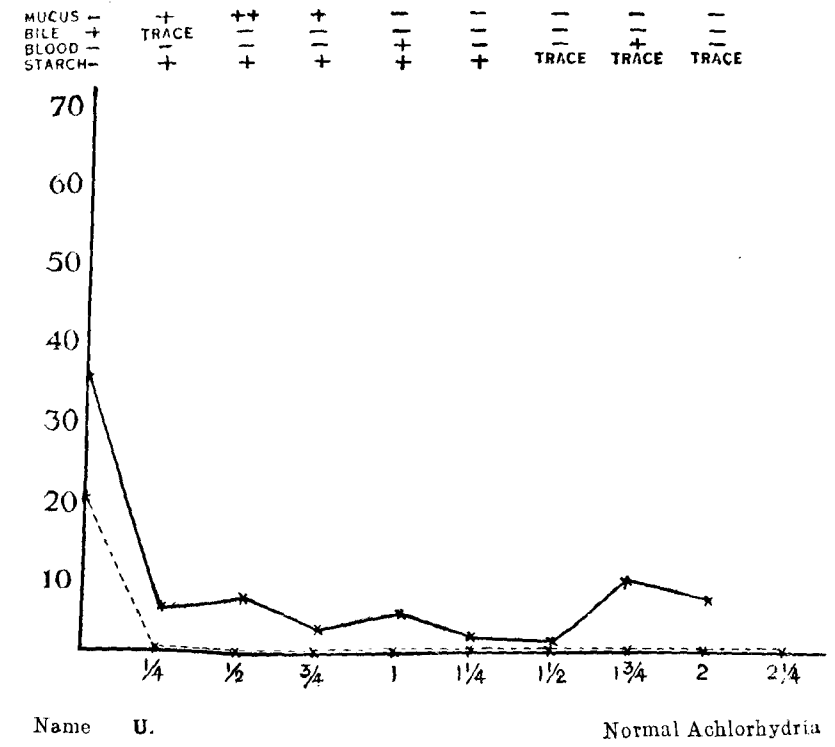
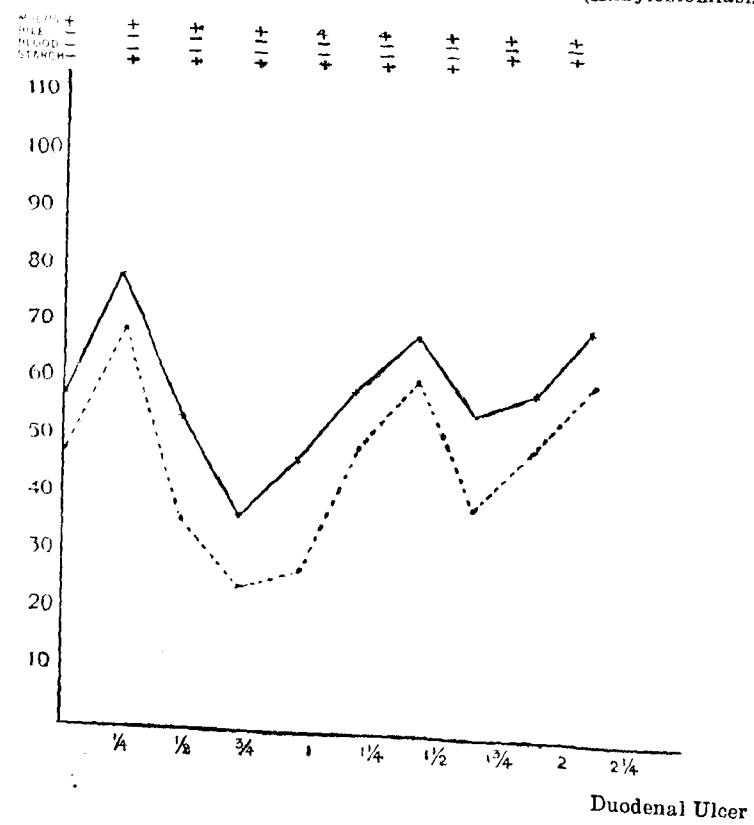
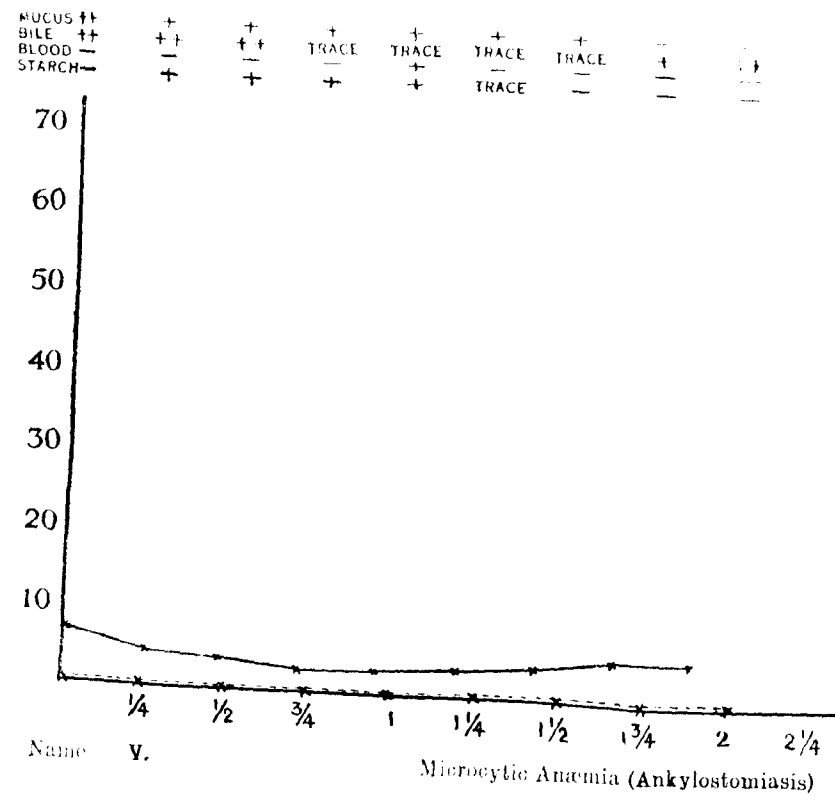
1. The resting juice often contains pus cells.

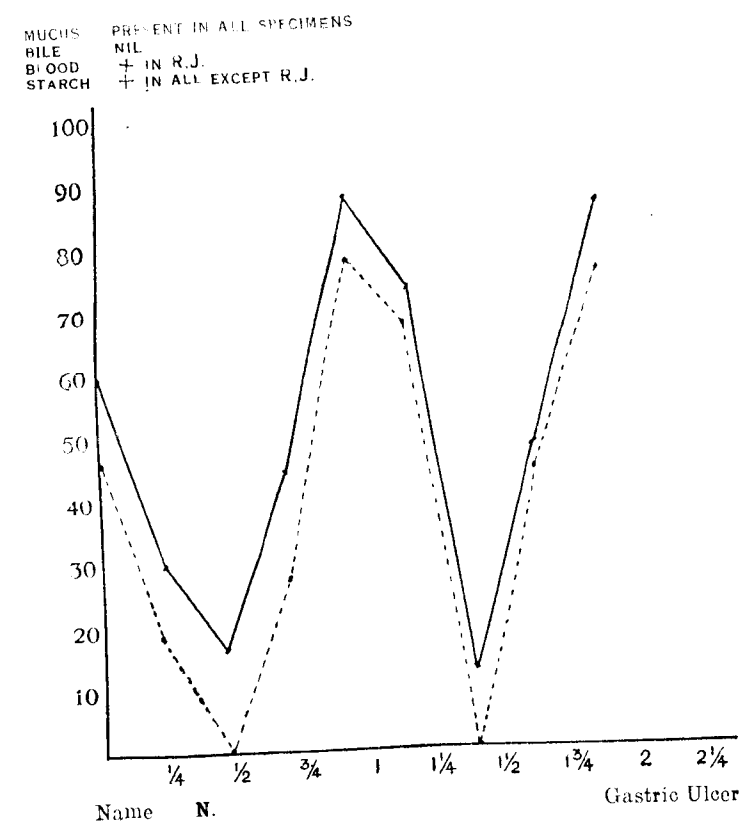
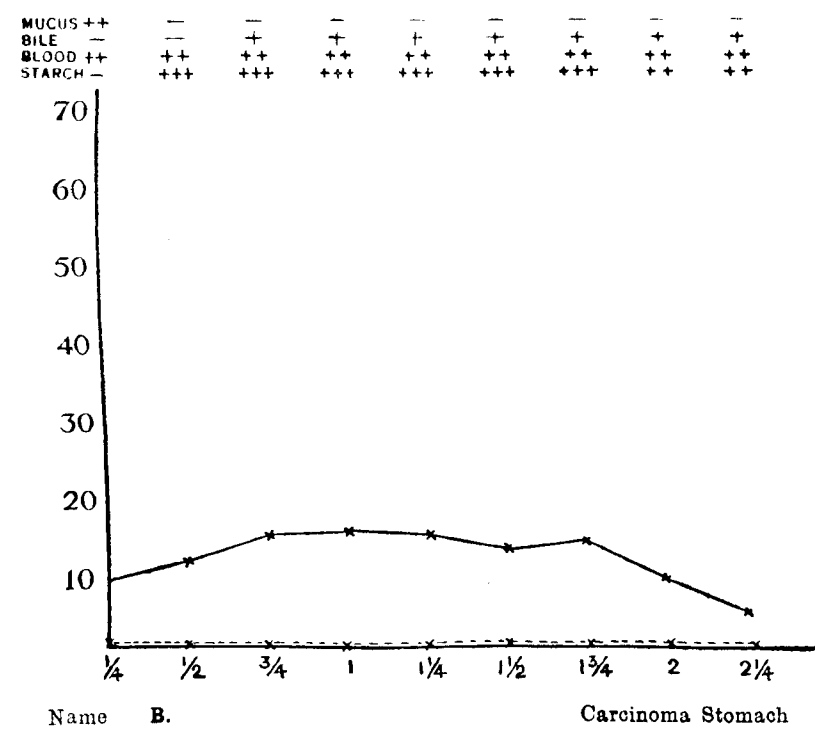
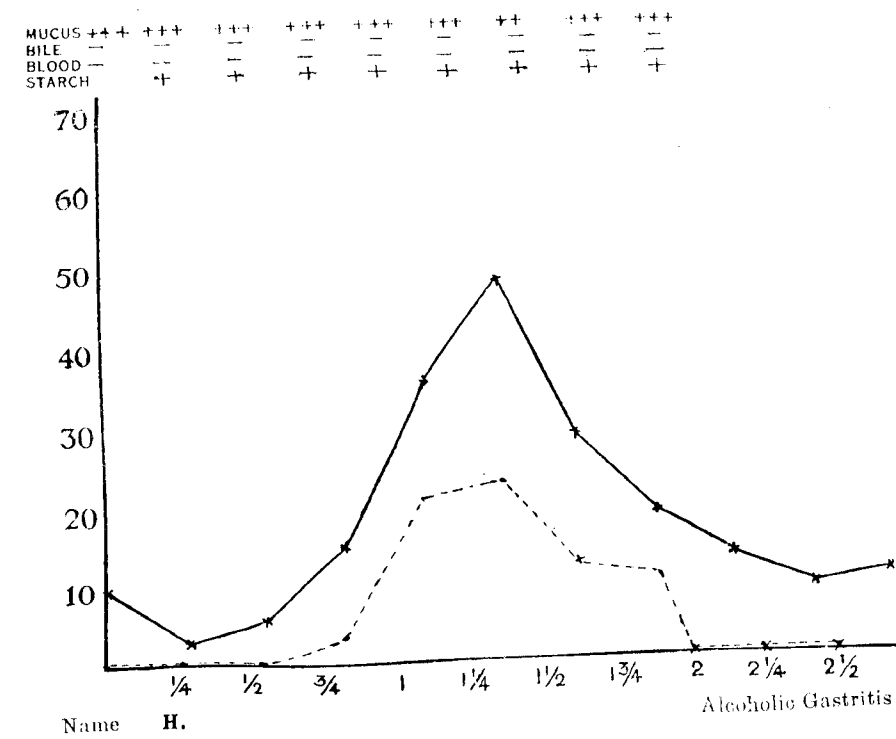
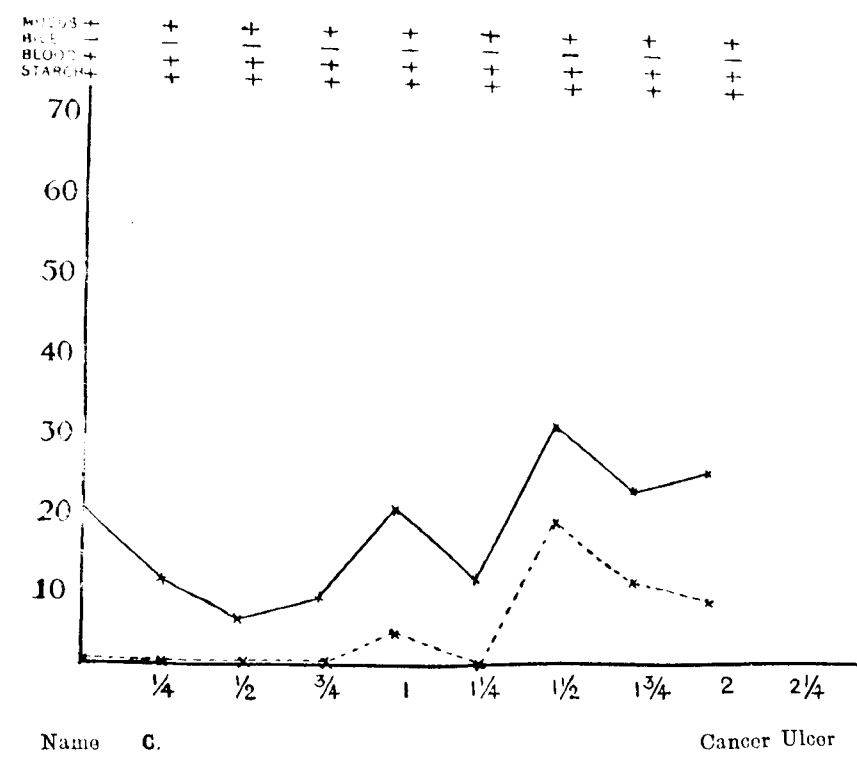
2. In 60 per cent of cases, achlorhydria is present and in 20 per cent hypochlorhydria is found. In ulcer-cancer cases, however, free acid is present and sometimes in excess.

3. Blood in all specimens of the test-meal is a common finding.

4. On account of associated gastritis, mucus is present in the specimens.







5. Occult-blood in the stools is present.

- (2) chronic hepatic disease, or
- (3) chronic nephritis.

6. As a result of pyloric stenosis—carcinoma involves pylorus in about 70 per cent—retention of food and large volume of resting juice often smelling foul from fermentative changes, are commonly found.

(iv) Anacidity with presence of blood and pus. Such curves are found in—

- (1) cancer stomach,
- (2) syphilis stomach, or
- (3) chronic infected gastritis.

A word may be said in conclusion of anacid curves. These curves may be grouped under four categories:—

(i) Complete anacid curve with no pus, blood, nor mucus—may be due to—

- (1) severe anemias,
- (2) intestinal toxæmia,
- (3) diseases of kidney,
- (4) diseases of thyroid,
- (5) gout, or
- (6) pellagra.

(ii) 'Anacidity' with increased mucus may be due to gastritis.

(iii) Anacidity with presence of blood from passive congestion as in—

- (1) chronic heart disease,

In conclusion we may state again that it is absolutely incorrect to draw diagnostic inferences from fractional test-meal analysis alone. It may be supported by a detailed chemical examination, X-ray examination, blood examination and examination of stools for occult-blood. All types of curves found in pathological conditions are found also in normal persons. Hyperchlorhydria, hypochlorhydria and even achlohydria are present in normal persons without any evidence of pathology in the stomach; and pathological conditions in other parts of the digestive system—may in other parts of the body—have reflex effect on the gastric secretion, and consequently accumulated experience has convinced us of the limitations of fractional test-meal analyses.

A Case of Secondary Abdominal Pregnancy

(From the Government Hospital for Women and Children,
Egmore, Madras)

BY M. G. SHABARI,

Fifth Year, Medical College, Madras.

Alamelu, a Hindu, aged 28, got admitted on 17th July 1931 for bleeding per vaginum, pain and a lump in the abdomen. The duration of the complaint is ten months.

She is married, has two children, both naturally delivered and both alive and healthy. The second child is ten years old. Her periods were regular before and the flow was normal. According to the patient, the last date of her periods was seven months ago.

History of Present Illness:—Her periods stopped ten months ago. From the third month onwards she was attending a private hospital in Manargudi for pain in the abdomen and discharge of blood per vaginum lasting for a day. The discharge used to come on practically every fortnight. During the fifth month she had an acute attack of abdominal pain and began draining watery fluid which was blood-stained at first but later became clear. This lasted for two hours and so the doctor expected her to deliver within 24 hours at the latest. But she did not. She was given some injections at regular intervals for a few days and was told that the pregnancy was progressing normally. For the next three months she had no bleeding at all. Again from the ninth month onwards she began passing blood per vaginum and was having pain in the abdomen.

The doctor examined her again and said that the foetal parts could not be felt and that she should go over to Tanjore Hospital. The patient stayed in that Hospital for 21 days. An X-ray was taken and the patient was informed that the foetus was dead and was advised to go to Madras for an operative delivery.

Condition on Admission.—Anæmic; tongue coated but moist; appetite fair; bowels not constipated; passes urine freely; no back-ache.

On Examination:

Alimentary System.—A tumor in the middle line of the abdomen of the size of a 28 weeks' pregnant uterus is palpable. Slightly fixed. There is tenderness on the right side of the tumor.

Heart: Nil abnormal.

Lungs: Nil abnormal.

Blood Pressure: 100/70.

Hæmoglobin: 56 per cent.

Per Vaginum Examination.—Cervix soft, small, feels eroded, very freely movable; os closed; soft cystic tumor of about the size of a 28 weeks' pregnant uterus felt in the middle line; uterus normal in size and felt separately. No ballotment to be elicited. Fornices clear.

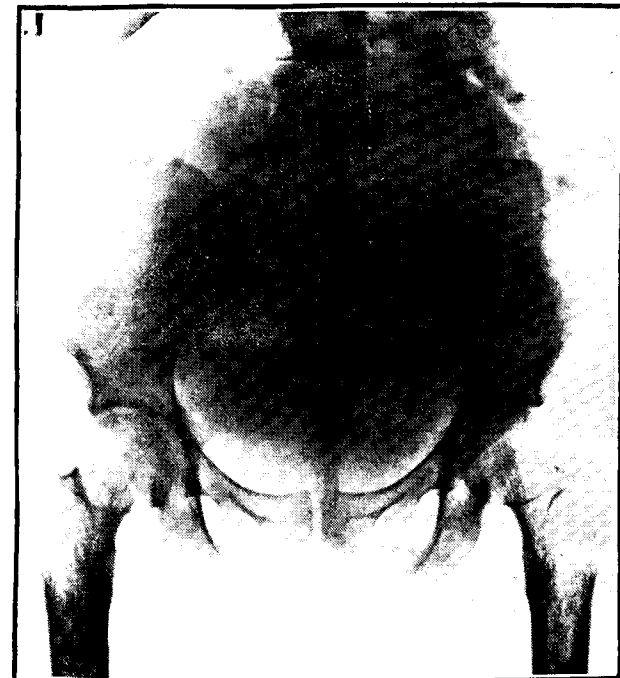


FIG. I.

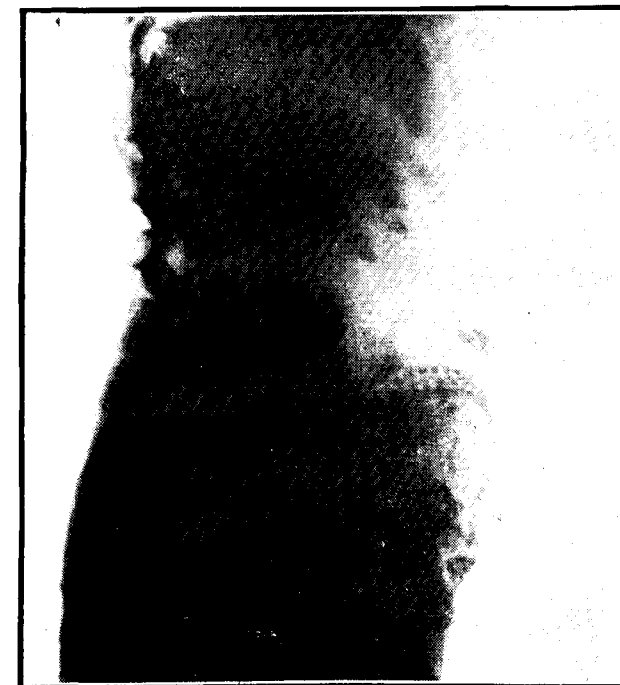


FIG. II.

Uterine pregnancy?

Secondary broad ligament pregnancy?

X-ray shows parts of a macerated foetus. Diagnosed as secondary abdominal pregnancy.

Operation.—On the 22nd, Col. Paton opened the abdomen by an incision from above the umbilicus to the symphysis pubis. There was oedema of the fascia of the anterior abdominal wall. On incising the peritoneum a layer which looked like an organising blood clot was encountered with. This proved to be the outer surface of the placenta. On incising it, membranes of the amniotic sac were reached. They were opened and a dirty blood-stained fluid was evacuated and foetus of seven months' size was extracted. The membranes and placenta were easily separated from the adventitious sac. There was

no bleeding. The sac shut off the uterus, tubes and bladder below and omentum and intestines above. The sac was lightly packed with gauze which was brought out at the lower end of the incision. The abdomen was closed in layers.

Progress and Treatment.—Patient had temperature for the first three days after the operation. By the seventh day the wound healed by first intention except at the lower part where the drainage tube was kept. A small drainage tube was kept till the discharge from the cavity of the sac stopped. The patient is making an uneventful recovery and expects to be discharged soon.

My thanks are due to Lt Col W. C. Paton for permitting me to report this interesting case and to Dr. M. G. Prabhu for correcting the same.

SMILE A WHILE.

Two fishermen went out for fishing in a hired boat. When they returned to the shore one man told the other:

"To-day is a lucky day for us. See our boat is full. We should go to the same place to-morrow also. Don't you remember the exact place in the river?"

Second Man :—O! Yes. I have even marked at the bottom of the boat with a chalk!

First Man :—You are a big fool. Suppose we don't get the same boat to-morrow?

Teacher :—In which battle did Nelson die?

Student :—In his last battle, Sir.

When the train stopped at a station, a fashionably dressed young man, came running up to get into a third class compartment. On seeing the compartment fully crowded, he said: "The Third Class is full."

Then a voice from inside the compartment said: "Yes; all but the Ass. Come right in."

Doctor :—Who is that knocking at the door at this late hour of the night?

Patient :—Sir, I am bitten by a dog just now.

Doctor :—Don't you know that my consulting hours are between 12 noon and 3 p.m.?

Patient :—Yes, Sir, I know; but the dog doesn't know that.

Extracts from the Annual Report of the Chemical Examiner's Department, Madras, for the year 1938.

BY DR. S. RAJAGOPAL NAIDU, B.A., M.B., M.C. (Lond.), D.I.C., F.I.C.

The total work of the Department shows an increase over last year. We had 1,781 cases with 8,913 articles in 1938 as compared with 1,670 cases with 8,227 articles in 1937. The increase is due mainly to the increase in medico-legal work.

Human Poisoning Cases.

The total number of human poisoning cases examined during the year was 467 with 2,485 articles as compared with 426 cases with 2,427 articles in 1937. Poison was detected in 241 cases or 51.6 per cent.

Datura heads the list this year with 36 cases followed by *oleander* with 30 cases and *opium* with 29 cases. There were 14 cases of *madar juice* poisoning. Cases of poisoning with organic poisons were nearly twice as frequent as those with inorganic poisons. Among the inorganic poisons, mercury claimed 21 cases, arsenic 20 cases, copper sulphate 12 cases, cyanide 10 cases and nitrite 9 cases. There was a marked increase in *datura* cases and nitrite cases.

The following are some of the cases amongst those selected as of interest:—

Mercury.—One night while a man was sleeping soundly, presumably with his mouth open, an unknown person put some powder into his mouth and ran away. The victim woke up a little later and tried to spit out the powder but could not do so as his tongue was stiff and swollen. He was removed by some persons to a hospital where

he died sixteen hours after the poisoning. The post-mortem examination revealed oedema of the glottis and congestion of the abdominal viscera. We detected in the viscera mercury in soluble form equivalent to about two and three-fourths grains of corrosive sublimate.

Potassium Bichromate.—There are certain mendicants in this country who go about trying to impress people with their supernatural powers by undertaking to swallow anything from prickly-pear to poison. A man, probably of this type, came to a village and in their presence swallowed daily for some days about an ounce of sulphur, drinking his own urine as "antidote". As the villagers did not seem impressed with this show, he swallowed one day in their presence a substance stated to be "red sulphur" and drank the usual "antidote". He collapsed and was removed to a hospital where he died an hour and a half after swallowing the poison. We detected in his viscera chromium equivalent to about three hundred and twenty-nine grains of potassium bichromate and we found the remnants of the "red sulphur" to be potassium bichromate weighing about three hundred and forty-two grains.

Nitrite.—A typical case of nitrite poisoning is given below:—

A man was seen alive and well, sitting on a bench at a railway station at three o'clock in the afternoon. Half-an-hour later he was found dead near the bench. Amongst

his possessions was found a bottle containing a white powder. The post-mortem examination revealed small serous effusions into the pleura, pericardium and peritoneum, dark fluid blood in the heart and the vessels, intense congestion of the lungs, liver, spleen and kidneys, congestion of the stomach and intestines in portions, and congestion of the membranes of the brain. We detected in the stomach and its contents nitrite equivalent to about nine and four-fifths grains of potassium nitrite, in the contents of the small intestines nitrite equivalent to about two grains of potassium nitrite and in the urine nitrite equivalent to about one-twentieth of a grain of potassium nitrite. We identified the white powder found with the deceased to be potassium nitrite weighing about three hundred and forty grains.

Powdered Glass.—A young newly married wife, very much upset that her husband was not home by half past eight, put powdered glass into her coffee and drank it off. She was removed by her maid to a hospital where her stomach was washed out and she recovered. We detected particles of powdered glass in her stomach washings.

Oleander.—(1) A healthy young woman was dead one morning. We obtained the reactions of *oleander* from the viscera and from a grinding stone and detected in the contents of the stomach and on the grinding stone, articles possessing the microscopic anatomy of red *oleander* leaf.

(2) A woman was stated to have vomited and died after eating some leaves. We obtained the reactions of *oleander* from the viscera and detected by microscopic examination particles of red *oleander* leaf in the stomach and contents.

Oduvan.—There were three cases of poisoning by *oduvan* leaf, all of them suicidal. We obtained the reactions of *oduvan* from the viscera of each (*vide* Analytical notes, below) and we also isolated from the stomach contents in each of the cases particles of lead with the microscopic anatomy of *oduvan* leaf.

Analytical Notes.

Research work was carried out on the following plants:

1. Acid ether extract more or less resembling picrotoxin was isolated from *Malai vamba* (*Melia composita* Willd.).

2. The jungle potato (*Mainhot utilissima*) was found to contain a cyanogenetic glucoside. HCN corresponding to about 14 parts per 100,000 parts of the root was detected in the specimens of the root.

3. Bamboo shoots are frequently used as abortifacents. In these, poisonous crystalline principle was extracted from the roots—formula $C_6H_{12}O_5$.

4. *Oduvan* leaf which is a common poison in this country was investigated and the crystalline poisonous principle was isolated with a molecular formula $C_{12}H_{34}O_{12}$. The name '*Oduvan*' is suggested for this principle.

5. *Oleanders* which are amongst the commonest poisons here were studied with the following results:

- (1) *Nerium odotum* was found to yield a crystalline principle—*Nerin* $C_{25}H_{50}O_{10}$ which is six times as poisonous as *Strychnine*.
- (2) *Cerbera odallum* was found to yield a poisonous principle "*Cerberin*" $C_{29}H_{38}O_{14}$ which is as poisonous as *Nerin*.

- (3) Yellow oleander (*Corbora Thevetia*) was found to yield two poisonous principles: (a) Thevetin $C_{21}H_{25}O_6$ as poisonous as Nerin. (b) A substance identical with cerberin found in *cerbera odellum*.

Miscellaneous Medico-Legal Cases.

1. A round cloth ball looking like a formidable country bomb was seized by the police and sent to us carefully immersed in water. We found the suspected bomb to be merely a round stone tightly wrapped in cloth and we did not detect any explosive substance either inside or outside it.

2. An empty wooden box stated to have been used for the stealthy carriage of gold jewels from a bank, was sent to us to find out whether there were any traces of gold on its inner surface. The shavings from the whole of the inner surface of the box were taken by us using a plane for the purpose. The shavings were ashed and the ash dissolved in aqua regia. The aqua regia solution on evaporation nearly to dryness and taking up with a small quantity of hydrochloric acid gave on treatment with stannous chloride a deep purple colour indicating the presence of gold in the ash. Gold being a soft metal appears to have been transferred to the wood in minute quantities by friction due to loose packing.

3. The minutes book of a Panchayat Board was sent to us to determine whether the sheet of paper bearing pages eleven and twelve in the book was different from the other sheets. On examination under ultra-violet light, pages eleven and twelve were found to be in fact pages one hundred and eleven and one hundred and twelve, in which the extreme left figure had been erased. Though the

carbon had been removed by the eraser the paraffin of the printing ink had soaked through the paper and showed under ultra-violet light and unmistakable fluorescence corresponding to the erased figure. There was also evidence of the original paper corresponding to pages eleven and twelve having been torn out and replaced by the present paper, which was similar in other respects, by pasting at the extreme left edge.

Stain Cases.

Nine hundred and seventy-nine cases were examined under this heading in 1938 as against 960 cases in 1937. Eight hundred and ninety-eight cases were examined for blood and eighty-one cases for semen either with or without blood. The total number of articles examined under these headings was 5,432.

Examination of Hair.

In the examination of dark specimens of hair, we have found a ten per cent aqueous solution of potassium cyanide, a good clearing medium for mounting them. We have found that immersion for about an hour in a solution of one drop of twenty per cent hydrogen peroxide and three drops of dilute ammonia solution in three millilitres of distilled water is also useful in clearing the hair without affecting its structure. For obtaining cross-sections of hair we have found that embedding the hair in a mixture of equal parts of rosin and hard paraffin melted together, gives good results on free-hand sectioning with a sharp razor. The paraffin-rosin sections may be mounted without further treatment in canada balsam, as the paraffin-rosin mixture, being transparent, does not interfere with the microscopic study of hair specimens.

Case of Tuberculous Disease of the Kidney

By S. V. RAJA RAO.

Name.—Mrs. V.

Age.—39.

Occupation.—Nil.

Admitted on.—16th June 1939.

Admitted for.—Frequency of micturition. Passage of turbid urine. Pain in the Hypogastric region. Occasional attacks of fever.

Duration.—Six months.

Family History.—Married. Has four children. All perfectly healthy. None in the family having gland, bone or lung tuberculosis.

Previous History.—Two years back, patient got mild fever with cough and chilliness, lasting for $1\frac{1}{2}$ months. When the fever subsided she developed an abscess on the dorsum of the right foot, which was incised and scraped in a hospital. The wound showed no signs of healing even after two months. So the bone underneath was removed and the patient got better.

Present History.—The present complaint started six months back with attacks of mild fever, attended with cough and chilliness, appearing at about 3 p.m. and lasting for a few hours. At the same time she had frequency of micturition, being more marked at nights. The urine was turbid and scanty in amount. Later she felt a dull aching pain in the Hypogastrium which was more marked during her periods. A month later she noticed blood clots in her urine

and this lasted for two days. For these complaints she got herself admitted into Ramesh Hospital, four months back. Patient got much better after being in the Hospital, but she was transferred to this Hospital, as they suspected tuberculous disease of the kidney. Ten days before coming to this Hospital (General Hospital, Madras) she again passed blood in the urine, but this time the blood was intimately mixed with urine.

Condition on Admission.—Patient is a poorly nourished woman of 39 years. Anæmic. Face slightly puffy. Teeth dirty; Pyorrhœa Alveolaris present. Has a temperature of 100° . Pulse rapid. Heart boundaries normal. Heart sounds normal. Lungs: movement of the right apex impaired; air entry over this area poor; a few moist sounds heard.

Local Condition.—Abdomen soft and moves with respiration. No tenderness anywhere. On bimanual palpation a mass is felt three fingers below the costal margin on the right side, firm in consistence, not movable, not tender. In the knee-elbow position it does not drop on to the anterior abdominal wall. It is dull on percussion and a band of resonance is present between it and the liver. Liver and spleen not palpable.

Investigations.

Urine Examination.—Turbid. Specific gravity 1016. Acid. No sugar. Albumin +. Pus cells + + + +. Deposit stained for acid fast organisms; no tubercle bacilli seen.

Urea Clearance Test.—18.5 per cent of the average normal.

Blood Urea:

19th June 1939—28 mgms. per cent.

28th June 1939—135 mgms. per cent.

30th June 1939—98 mgms. per cent.

3rd July 1939—41 mgms. per cent.

15th July 1939—24 mgms. per cent.

Urine Culture.—*Bacillus Coli* grown.

Plain X-ray.—Slight enlargement of the left kidney shadow.

Secretion Pyelogram.—In seven minutes the uroselection is partly visualised in the left kidney. In the two hours' picture the enlarged left pelvis and the ureter are well visualised. The considerably enlarged superior calyx does not show a definite connection with the lower calyces. The right kidney is not visualised at all. Bladder is not clearly visualised. (Figs. 1 and 2.)

X-ray of Lungs.—Infiltration of right upper lobe. Hilar shadows enlarged.

Cystoscopic Examination.—By Dr. C. P. V. Menon, on 21st June 1939. Bladder capacity of the bladder is very small. Mucosa ulcerated and tags prevent clear view. Left ureteric orifice is seen discharging pus at intervals. Indigo carmine solution is not excreted even after 30 minutes through the right ureteric orifice.

11th September 1939.—Irritability of the bladder is considerably less. Ureteric orifices are normal. Bladder shows cystitis of the membranous type. There is good amount of influx from the left ureter, but cloudy. No

influx from the right side. There is ulceration seen in the retro trigonal area.

9. *Per Vaginum Examination.*—By Dr. C. P. V. Menon. Ureter could not be felt.

10. *Guinea-pig Inoculation.*—Guinea-pig alive even after six weeks. Post mortem of guinea-pig showed no evidence of tubercle.

Diagnosis.—Tuberculous disease of the right kidney with Hydronephrosis of the left kidney and secondary infection of the bladder. Frequency of micturition; passage of turbid, acid urine; occasional haematuria; prolonged low fever and a tuberculous lesion in the lungs are all for tuberculous disease of the kidney.

Treatment—Nephrectomy.—By Dr. C. P. V. Menon, on 27th June 1939. Under C.E. General. An oblique kidney incision was made in the right flank and the perirenal area approached. The perinephric fat was rather tough and adherent to the kidney. This as well as the suprarenal glands were separated from the kidney and the renal vessels and ureter were clamped. The kidney with its capsule and only one inch of the ureter could be removed. The wound was closed in layers and a drainage tube put in.

Pathological Report.—The kidney was removed. Kidney shows scattered, miliary and conglomerate tuberculous foci and focal fibrosis with ulceration into the pelvis in places. (Fig. 3.)

Progress.—After the operation the patient's condition became bad. She was got round by giving intravenous saline and glucose and coramine for three days. Her temperature came down to normal a fortnight after

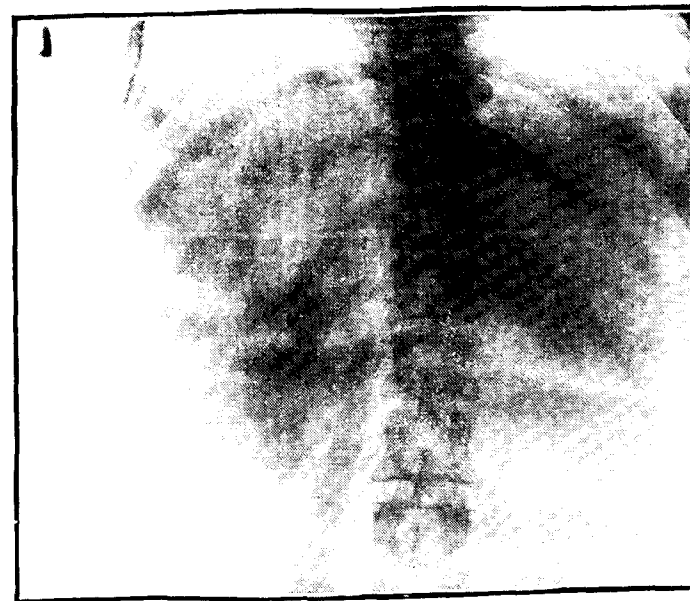


Fig. 1.



Fig. 2.

operation and her general condition gradually improved and the patient put on weight. The incision wound was discharging pus for a long time as a result of the inevitable infection from the kidney removed.

Conclusion.—The interesting points in this case are : (1) The patient had no pain in the loin, though it is a fairly advanced case. (2) No evidence of Tuberculous bacilli in any of the investigations done. It clearly shows that it is not essential to have pain in the loin in all Tuberculous diseases of the kidney and that it is not possible to demonstrate Tubercle bacilli in all cases of Renal tuberculosis.

Since the Tubercle bacilli could not be demonstrated, it indicates that the tuberculous lesion in the kidney is shut off from the rest of the urinary tract. Since the diseased kidney is not functioning as is indicated by the Uroselecton picture, Autonephrectomy has occurred in this case.

The infection of the kidney must have been from the apex of the right lung, most probably by the blood stream.

I have to thank Dr. C. P. V. Menon, for kindly going through the case sheet and for having permitted me to report the case.



Fig. III.

Extracts.

EMERGENCY MEDICAL SERVICES

(The following is an abridged version of a circular R. M. S. No. 2471, issued to medical officers of health and group officers for the Ministry of Health in connection with emergency medical services.)

Treatment at First-Aid Posts.

First-aid posts have been set up with the intention of protecting casualty hospitals from a rush of minor and ambulant cases and providing early treatment in those districts where the hospital is some distance away. The function of the first-aid post is:

(1) to treat and send to their homes the slightly injured and those suffering from nervous shock;

(2) to arrest hæmorrhage, relieve pain, and so prepare those casualties who may be found to need institutional treatment that they can be transferred to the casualty (receiving) hospital with the least possible harm—that is, by having taken steps to prevent any immediate deterioration.

Functions of First-aid Workers.

First-aid posts, whether fixed or mobile, will be staffed by both qualified and unqualified personnel. The suggestions made must be regarded as embodying the views of the consultant advisers as to the early treatment which is indicated whether this be practicable, only at a casualty (receiving) hospital or at a first-aid post. As there will be a doctor in charge of each post it will be for him during the peace-time collective training of his personnel (Circular 1831) to determine and give instructions as to the extent to which treatment will be undertaken and how far they may act independently of his assistance and advice.

The duty of the first-aid worker is not to try to accomplish too much, as this may be done at the expense of the patient. He must not assume that he has learnt in a few weeks or months what has taken the doctor and the nurse years of training and experience. Self-confidence, unless restrained by knowledge and the exercise of common sense, leads sooner or later to trouble. The first-aid worker is a very essential factor in the Emergency Medical Scheme, and without his help casualties would fare badly, but his value depends directly upon the manner in which he carries out what he has learnt. First-aid classes have given the initial grounding in the work and it is practice and application which is subsequently required, while many of the items referred to are covered by the first-aid manuals, it is the opinion of consultant advisers to the Ministry that it cannot fail to be helpful to place emphasis on certain points in view of the type of emergency work actually to be performed.

General Guidance.

Dressings. Every care should be taken to handle dressings as little as possible, and to make sure that the surface of the dressing to be applied to the wound has not been touched, since further infection may be added to a wound already infected. A dressing that has already been put on should not be removed merely to see the wound unless it is thought that with a clean dressing the patient might be sent home or unless there

is some clear indication for removing it.

Small Skin Wounds.—Small fragments that result from the explosion of bombs or modern high explosive shells may cause quite trivial wounds but inflict serious injury to underlying parts.

Severe Injuries to Soft Tissues.—These may frequently be present without fracture and should be dressed after the removal of any superficial foreign body and immobilized by splinting. Wounds of the large muscles—for example, the upper thigh—may be associated with considerable shock occasionally even to a dangerous degree in spite of the absence of damage to bone or severe hæmorrhage.

Multiple Wounds.—Many such cases must be expected and their treatment often presents very grave difficulty. Their chief importance lies in the amount of shock produced and the possibility that the chest and abdomen may have been treated by fragments that have entered through other parts of the body.

Hæmorrhage.—The application of a tourniquet is very painful. In addition it seriously endangers the vitality of a limb. It should therefore be applied only after careful consideration. In ordinary circumstances it should be relaxed after fifteen minutes to see if the bleeding has ceased. Pressure of work may render this impossible, but under no circumstances should a tourniquet be left on for more than an hour. If there is any chance of renewed hæmorrhage, a tourniquet should accompany the patient in the ambulance when evacuated. A tourniquet should be applied just tight enough to stop the hæmor-

rhage; if it is too tight it may cause serious injury to the limb. Always ensure that patient with a tourniquet on is prominently labelled and that the time of application is endorsed on the label.

Partially Detached Limbs.—Limbs hanging by shreds of soft tissue, where there can be no hope whatever of saving the limb, should be removed even at an aid post. A general anaesthetic is to be avoided and is seldom necessary; the morphine which has been administered will usually suffice. The affected limb should be splinted.

Abdominal Wounds.—Missiles may have penetrated from any aspect of the trunk or nearby parts of the neck, limbs, or through the buttocks. The entrance wound may be insignificant. Pain in such cases is usually present but rigidity of the abdominal muscles may be absent. If a blood vessel has been ruptured the pulse will increase in rate. Protruding intestines should be left *in situ* and simply covered by a moist, warm gauze dressing. Morphine should be given when there is pain or restlessness. The chance of recovery depends on early operation and so on rapid evacuation. Special note should be made at an aid post on the Casualty Card, M. P. C. 46, if it is believed penetration may have taken place as shown by the pulse rate and rigidity: this is especially valuable if morphine has been given, since the drug may subsequently mask the more urgent symptoms for a time.

Burns.—No attempt should be made at cleaning these. They should simply be covered with a suitable dressing. The burn dressing (picric acid) should be moistened before application. Picric acid does not interfere with efficiency of tannic acid dressing applied later. Morphine will probably be required.

Morphine.—This should only be given in such dosage as the medical officer indicates.

A. T. S.—Tetanus antitoxin should be given to all casualties with open wounds. The routine dose is 2 c.c.m. of the standardized serum (2,600 international units). This serum will go through an ordinary hypodermic syringe needle.

Orthopædic Injuries.

The general treatment for orthopædic cases will depend upon the presence or not of open wounds complicating fracture or injury. Those with wounds will require the preliminary treatment for shock, hæmorrhage, and an injection of tetanus antitoxin. Those without wounds may be suffering from a considerable amount of shock for which treatment is required.

Simple Fractures.—Fractures and extensive wounds are the kind of injuries of which most will be seen. Apart from stopping any hæmorrhage, the worker should do his best to immobilize the part as quickly and with as much gentleness as possible. Fractures should be splinted, but no attempt should be made to "set" a fracture at a first-aid post. It is quite easy to convert a simple fracture into a compound one unless the limb is gently handled.

Nerve Injuries.—If obvious signs of damage to a peripheral nerve are observed, apart from noting this on the Casualty Card, M.P.C. 46, and immobilizing the part, no time should be spent on neurological investigation.

Wounds of Joints.—These should always be carefully immobilized on splints after the wound has been

covered with an appropriate-sized dressing.

Compound Fractures.—As with all wounds every effort should be made to anticipate and prevent shock, or combat it if already present. Keep the patient warm by avoiding unnecessary exposure and covering him with blankets, if necessary. Cut away the clothing rather than remove it wholesale to expose a wound. Morphine grain $\frac{1}{2}$ to an adult and in smaller doses for children is definitely of value if the wound is severe or very painful. Efficient immobilization of a compound fracture at the earliest possible moment is all-important. It is wholly inadvisable to be too thorough in searching for the presence of a fracture; if in doubt treat it as if it were one, since handling may increase the shock and possibly spread contamination in a wound. Gentleness is the essence of first aid for fractures. No attempt should be made at an aid post to "set" a compound fracture: only gross deformity should be corrected. Immobilization is the object, and the more efficient this is the better. Particular care should be taken to see that the turns of bandage above the fracture are not too tight and so interfere with a probably already enfeebled circulation.

[Detailed suggestions are given in the circular as rough guides to the best methods of temporary fixation for compound fractures of various bones.]

Head Injuries

On reception of head wounds the general treatment for shock and against tetanus should be as for other wounds, but doses of morphine greater than $\frac{1}{6}$ grain should be avoided. Non-penetrating wounds would be treated in the manner of any other kind of wound. Open head wounds—that is, where the skull has been penetrated—would not ordinarily reach an aid

post, but where they do they should be treated with special antiseptics that will not cause damage to brain tissue. The ideal procedure in such cases set out below would be generally beyond the capacity of the first-aid posts, although they have been provided with the necessary material, and therefore after such treatment as is felt can usually be undertaken and the application of a non-irritant dressing, they should be evacuated as soon as possible to the casualty hospital in the vicinity that has been indicated as suitable by the group or other officer in charge of evacuation.

Penetrating Head Wounds.—The procedure which should be carried out as early as possible:—

(1) Apply artery forceps to bleeding points in scalp.

(2) Lightly pack the wound with gauze soaked in aqueous solution of azochloramid (Azochloramid should be dissolved in sterile water).

(3) Close-clip hair from the scalp over a wide area around the wound. It is of first importance to ensure that hairs and dirt do not get into the wound.

(4) Remove the azochloramid pack and examine the wound, removing dirt and loose chips of bone from beneath the scalp, but do not touch the brain.

(5) Pack the wound *lightly* with gauze soaked in the aqueous solution of azochloramid.

(6) Remove any artery forceps from scalp, and if bleeding has ceased, apply an external dressing without stitching the wound. If there is bleeding stitch the scalp loosely together over the

gauze, leaving the gauze protruding between stitches.

(7) An external dressing of gauze soaked in euflavine should be applied to the wound, followed by a firm bandage.

(8) If available give two $\frac{1}{2}$ -gramme tablets of sulphapyridine as a prophylactic against meningitis (note this on the Casualty Card, M.P.C. 46, if given at the aid post).

Chest Injuries

The general preliminary treatment for shock, hæmorrhage and prevention of tetanus should be carried out as for other wounds. In addition two $\frac{1}{2}$ -gramme tablets of sulphapyridine when available can be given for such benefit as it may offer as a prophylactic. When such of these measures as it has been found possible to carry out in the first-aid post have been taken, the case should be sent to the nearest casualty (receiving) hospital as soon as any condition of shock will allow.

Non-penetrating Injuries.—Patients with injuries due to crushing, which are generally associated with fractures should, if dyspnœa is considerable and other circumstances permit, be placed in a slightly raised position. The chest should be strapped from below upwards with adhesive strapping extending over the middle line in front and behind, care being taken to ensure that this will not produce perforation of a rib fragment through the skin or into the lung.

Tension Pneumothorax.—If dyspnœa is urgent and increasing, a "tension pneumothorax" may be present. This can be determined by evidence of gross displacement of the apex beat to the opposite side, a high

percussion note, and absence of breath sounds. In such cases a short sterile serum syringe needle should be inserted into the pleura under local anaesthesia (1 per cent novocain or 1 per cent procaine) through the skin over the second intercostal space in front, just internal to the mid-clavicular line, and the excessive air in the pleura allowed to escape. This operation may require repetition or, if the escape of air from the lung into the pleura is continuous and rapid, the needle should be left *in situ* fixed by adhesive strapping and surrounded by sterile gauze.

Penetrating Injuries.—Small penetrating wounds of the chest should be dealt with as circumstances indicate. Either a small aseptic dressing should be applied after cleansing around the wound, or the case should be dealt with as for the non-penetrating injury if symptoms of a similar nature are present.

Open Pneumothorax.—As these wounds give rise to considerable dyspnoea and shock they should be closed as soon as possible.

1. Obvious superficial foreign bodies—fragments of missiles and portions of clothing—should be removed from the wound.

2. Visible bleeding points should be secured with forceps and ligatured. Bleeding from an intercostal vessel can be controlled by passing a suture around the corresponding rib and tying firmly. In some cases two such sutures—one each on the proximal and distal sides of the bleeding point—will be required.

3. The wound should be packed with gauze wrung out 1/1,000 euflavine solution, and the surrounding skin cleaned up.

4. If the nature of the wound permits, the edges should be drawn together by silkworm-gut sutures, sufficiently closely inserted to close the communication between the air and the pleura. If the wound is too large to permit such approximation, the deeper layers are lightly packed with euflavine gauze (see above) and the superficial part with dry gauze. Overlapping layers of adhesive strapping should be applied extending widely—at least six inches—from the wound edges in all directions.

Maxillo-facial Injuries

The early treatment chiefly entails the prevention of suffocation and the arrest of haemorrhage in those with extensive injuries. The general treatment for shock against tetanus should be carried out as for other wounds. As soon as regarded safe by the medical officer, cases requiring further treatment should be sent to the nearest casualty hospital that has previously been indicated as suitable by the group officer. A nurse or orderly must remain with the patient during transit by ambulance to the casualty hospital.

Prevention of Suffocation.—The danger of suffocation is most commonly due to loss of control of the tongue. As a result of the injury, displacement of the tongue may occur to such a degree that the air passages may be obstructed. To avoid this happening it is of vital importance that the wounded person should be placed face downwards with his head hanging over the end of the stretcher, and any foreign material removed from the throat. If the wounded person can walk, he must be made to stoop well forward. The object should always be to keep the tongue well forward. If, in spite of positioning, the patient shows signs of suffocation, the tongue

should be seized with a pair of forceps or a suture put through and the tongue pulled forward. No case of this kind should be left unattended until it has passed into medical care.

Control of Haemorrhage.—Correct posture will also tend to lessen haemorrhage by keeping the tongue in the forward position, although it may in addition be necessary to plug external wounds and to apply digital pressure.

Relief of Pain.—The ordinary triangular bandage should *not* be used for a lower jaw fracture, as it is likely to increase the displacement of the fragments by its backward pull. The "barrel" type of bandage is suitable and easily applied, and gives an upward and forward pressure well back from the chin, and relieves pain.

Feeding.—Patients despite extensive injuries can swallow fairly well if fed from a feeding cup with about 3 inches of free rubber tubing.

Neuroses

The first essential in the handling of these patients when they arrive at an aid post is to convince them that their symptoms indicate no serious injury, and that they will soon disappear. This necessitates reassurance and the re-establishment of self-confidence combined with such methods as may lead to even temporary disappearance or abatement of the symptoms. This requires a firm and authoritative but sympathetic attitude on the part of the medical officers and their assistants.

In simply frightened and emotional cases reassurance combined with an appeal to personal and patriotic pride and a large dose of bromide will be usually sufficient. The patients should then be sent to their homes.

When confusion, excitement, loss of memory, or disorientation is the chief symptom, rest, warmth, hot drinks with plenty of sugar, or a large dose of bromide (grains 20—30) or phenobarbitone (grain 1) will be necessary. When patients are restless or excited, a hypodermic injection of morphine (grain $\frac{1}{4}$) or preferably an intramuscular injection of sodium phenobarbitone (grain $1\frac{1}{2}$) combined with hyoscine hydrobromide (grain 1/100) may be required. The latter is provided in tablets which are easily soluble. It may not be possible to retain these patients for long in aid posts and smaller medical establishments, but every effort should be made to return them to their homes if they improve sufficiently to do so with safety.

When hysterical symptoms predominate, an attempt should be made at once to influence or remove them by suggestion, for instance, by showing the patient that a powerless limb is not paralysed or anaesthetic, or by making a speechless patient phonate by coughing and then utter a simple sound as "Ah". Hysterical tremor can be usually arrested by making the patient relax his muscles.

It is of fundamental importance for medical officers to understand that as the incidence of neurosis is determined by psychological factors, the severity and duration of the disorder and its extension to other individuals depends in many cases on the treatment it receives at the onset. If patients in whom the step is not absolutely necessary are transferred to hospital, the conditions from which they are suffering may be accentuated or prolonged, and the extent of neurotic disorder in the population may be greatly increased. Every effort must therefore be made to send, after the preliminary treatment

and whenever it is possible to do so, such patients back to their own homes, under escort, if necessary. It will, however, be necessary in many cases to provide for sending these cases home, and consequently the question of transport and escorts will have to be considered by those responsible for organising the aid posts.

As it will rarely if ever be possible for a specialist to visit an aid post, it will be necessary for the medical officer to evacuate those whom it has not been found practicable to send home to a "casualty" hospital. Again, it cannot be hoped that there will even be a specialist on the staff of every casualty hospital, and therefore the medical officer of the aid post should ascertain which of the "casualty" hospitals nearest to his aid post is so provided. This will avoid unnecessary delay in getting the needs of the case decided. The desirability cannot be over-stressed, however, that in circumstances that may be expected every patient suffering from neurotic conditions, unless the symptoms are so severe or prolonged as to make this course impossible, should be sent home. General practitioners should not send

cases arising out of their private work to first-aid posts, but direct to the special clinics which will be set up in connexion with casualty and intermediate hospitals.

Warning Labels

First aid parties have been instructed to put a plain label on casualties, with a symbol marked on it, in the following circumstances:

'T' for tourniquet.

'H' for severe haemorrhage.

'X' for penetrating wounds of chest or abdomen.

'C' for gas-contaminated.

It is not an unusual practice alternatively or also to mark the forehead, by means of an indelible pencil, with these code letters. The first-aid worker in charge of reception at a first-aid post should keep a constant look-out for these labels in order to expedite the attention to be paid to these patients.

[The circular ends with instructions concerning the records to be kept at aid posts.]

—*British Medical Journal*.

SIR NILRATAN SIRCAR IN HIS ANDHRA CONVOCATION ADDRESS

Teaching of Medicine in India

Let us turn our attention for a few minutes to medicine and public health on the teaching of which your University has devoted considerable attention. With the passing of the Indian Medical Council Act in 1933, attempts have been made to raise under-graduate medical teaching to a higher and more uniform standard. The medical curricula have undergone many changes since 1892 when direct connection was established between

the Indian Medical College and the General Medical Council of the United Kingdom. Although the Indian Medical Council has done good work within the short period of its existence, handicap to co-ordinated progress in the teaching of medicine and surgery in India has arisen as a result of the control of this body by the General Medical Council of the United Kingdom. The special needs of India and of Indian students must be kept in view in framing a medical curriculum and in introducing appropriate courses of training. Indian

students and Indian conditions should receive special emphasis from the teachers. A fair amount of research work has been carried out by Indian workers on diseases prevalent in this country within the last fore or five decades; hence an Indian orientation to medical teaching can very well be given now by those who are responsible for the same. Researches into the aetiology and pathology of unexplained diseases and on therapy, particularly in the domain of indigenous drugs, should receive special attention. With the excellent advantages which India possesses as regards her soil, climate and plant flora, and with proper and adequate training of young students in chemistry and allied subjects for handling these and other relevant matters, it should not be necessary for her to depend wholly on imports. Each time a war blockades the communications between the West and the East, we realise our helplessness in the matter of the supply of medicinal preparations and chemicals. I hope the young generation which I see before me here will try to remove these wants in a large measure.

Rural Medical Relief

A time has come when we should give a public health orientation to medical teaching, and this should be in consonance with the needs and the environment which a student or a medical practitioner or a public health worker will have to deal with. If we have to supply one qualified doctor and qualified public health man to a group of three villages, we shall require 200,000 workers of each category to put a well-considered scheme into operation for India's 600,000 villages. As a result of scientific medical teaching for the last 100 years, we can now supply 35,000 qualified doctors and only a few hundred public health workers for the above purposes. If

we go on at this rate, it will take for us another 200 years to raise India to an up-to-date world level. The need for rapid progress in these directions is, therefore, obvious.

Need for Single Medical Register

With the establishment of provincial autonomy in the provinces, efforts are being made to give official recognition to the Ayurvedic, Unani and Homœopathic systems of medicine. The basic sciences of chemistry, physics, biology, physiology, pharmacology, pathology and bacteriology are the same all over the world. The present tendency to register practitioners of various so-called systems of medicine, lacking systematic scientific training of any sort, is a move in the wrong direction. The question of prevention of epidemic diseases cannot be successfully solved, unless scientific methods of proved efficiency are adopted. How can we apply all the different systems of medicine towards this end? The proper move should be to have only one medical science which has been worked out by the scientists all over the world, incorporating into it whatever good there may be in the indigenous medical sciences of the country. If this is done there will be only one medical register in the country which should facilitate the control of medical relief and sanitation for the entire population. It is for this reason that I am compelled to discourage the teaching of the so-called medical systems, without the help of the basic sciences. If India is to achieve her place among the first rank nations of the world, she must advance with the help of modern sciences and she must discourage retrograde measures of the sort that are being encouraged in some of the provinces, without fore-thought and imagination.

—*The Hindu*, October 7, 1939.

Collateral Venous Channels on the Anterior Abdominal Wall.

BY T. BALAKRISHNAN,

Final Year, Medical College, Madras.

In considering the aetiology of ascites, the differential diagnosis between cirrhosis of the liver and tuberculous peritonitis is often a matter of great difficulty. The general appearance of the patient in both cases is almost identical. A laboratory examination of the fluid will settle the diagnosis in most cases, but we will not go into that for the present.

The presence of enlarged collateral venous channels on the abdominal wall is a point of diagnostic importance in this matter. If we consider for a moment the pathogenesis of the ascites in these two diseases, we realise at once that in the peritonitic form a collateral circulation is not called for. But the matter is not quite so simple as it sounds. Enlarged tuberculous glands pressing upon the portal vein at the porta hepatis is one of the recognised causes of ascites. In such a case, naturally, collateral venous channels must develop. This

no doubt masks the picture, and makes diagnosis difficult.

It is well known that a majority of patients with cirrhosis develop tuberculous peritonitis in the later stages of the disease. But here, as the cirrhosis precedes and does not follow the peritonitis, the collateral veins are still of some use in diagnosis. It is possible that we may miss the peritonitis altogether, but in the present state of our therapeutic knowledge, it is not a matter of very vital importance.

It is not proposed to consider the other points of distinction available in the diagnosis of these two conditions.

A word of warning is perhaps necessary. The enlarged veins must be really collateral in character, as can be demonstrated by the fact that, after obliteration of one of them above the umbilicus, it fills from below upwards.

Our Personalities—No. 6.

PERUMAL.

Who, the dickens, is Perumal? I dare say, no one would venture to ask that impertinent question. His name is a byword in the Biology Department. There would be no Perumal without the Biology Department, and, of course, no Biology Department without Perumal!

Imagine the number of rabbits that have stared at him, the number of frogs that have slipped through his hands, or the countless worms that have wriggled through his fingers, not to speak of all the cockroaches and leeches that he has encountered! Add to this that rare species with two legs—called man, and that makes a complete list of Perumal's visitors.

A person sees Perumal for the first time when he attends his first Biology lecture. The lecturer discourses on "Heredity" and important subjects of the like, and mutters between his teeth that something is missing. He would try his best to manage as he is, but, at last when he is about to break down, he calls out—nay shrieks out—"Perumal"!

There would be no response, but a solemn silence prevails. After some moments, there appears from nowhere the figure of this august personage whose striking features and immaculate dress lend a touch of suave severity against the black back-ground of the board. A few long hairs escaping from under a cap, and a long-bearded face terminating in a much longer chin, would lead one to doubt whether he is after all a personality or a poster.

The lecturer voices his need and Perumal retreats with a bow. He

vanishes as mysteriously as he appears and is seen no more. A few minutes later, it is his assistant who walks in with a load of specimens and apparatus.

It is a common sight for those going up to the Office to see Perumal engaged in his multifarious activities. Sometimes, he may be asphyxiating a few frogs or murdering some cockroaches. At other important occasions, it may be couple of innocent rabbits that put their silly noses under a pad of chloroform held by this not-too-well-known anaesthetist. It is not uncommon, too, for an intruder into his realms, to see Perumal indulging in one of those pleasant occupations—a nap.

Perumal has his friends, too. His assistant is always at his beck and call, and who, though deaf as a door post, would never miss the sound of Perumal's calling him "Venu". But there is something that sticks to him more than anyone else, and that is his faithful cap. They never part company, and, it is a rare sight if one could see Perumal *minus* his cap.

Perumal is a veteran, and, like all veterans, he too has his tales. He would tell us how this illustrious doctor once dissected a frog under his very nose, or how that great public person had to leave the College because he could not learn his Biology well. And tales of the like. Perumal's may not be an arresting personality, but it certainly is an assertive one. The oldest bug in the College, he is still going strong.*

"ZAC."

* The College bid Good Bye to this worthy personality who after forty years of service has retired in the beginning of the year. (Editors)

Proceedings of the Women Medicoes Club for the Year ending April 1939.

The first meeting of the Women Medicoes Club for the year under review was held on the 21st July 1938 to welcome the new lady students of the College. The gathering held in the College Common Hall was well attended, all the members being present. Mrs. K. Nimbkar presided. After tea, the usual formalities of reading the last year's report and electing a new Committee were gone through. The freshers were then introduced to their seniors. They were so favourably impressed by the good fellowship extended to them, and—shall I add—the well-laden tea tables, that the majority wished to join the Club immediately. Rather than damp their ardent enthusiasm, undue ceremony was dispensed with, and they were enrolled as members forthwith. The function then came to a close.

7th August 1938.—The Club can indulge to-day in excusable self-congratulation. Due to the untiring efforts of its members, the lady-students have at last been provided with a bus. No longer need they join the weary throng at the bus-stand but like birds of passage can fly merrily home as soon as classes are over. We congratulate the Committee on its perseverance, and we are very grateful to the Principal of the College for acceding to their insistent demands. Jubilant Women Medicoes are now anxious to find a suitable pet name for their latest acquisition. Since it is never to deviate from the stony path of duty, that leads from Hostel to Hospital, perhaps "The Valiant Woman" might not be inappropriate!

On the 15th August 1938, the members of the Club were at home to the Graduates of the year. A dinner and an entertainment were held in the College Park Hostel, and Miss Shanta Sundari addressed the Graduates. The enjoyable function came to close with three hearty cheers for the Graduates.

On the 10th September, the members of the Club went for a moonlight picnic to Elliot's Beach, and the bus, for the first time in its history, deviated from its customary route. The picnic was thoroughly enjoyed, as all tastes and temperaments were catered for—sea bathing for the adventurous, boating for those lazily inclined, while livelier spirits enjoyed the games organised by the Sports Secretary. Of course, the excellent catering was appreciated by all, for though Women Medicoes believe in high thinking they do not always couple it with plain living. The bus finally took home a crowd of weary revelers who still made night hideous with their vociferous rendering of "Old Medicoes Never Die".

The members of the Women Medicoes gathered in the College Common Hall on the 3rd November to bid Farewell to the Final Year students and to wish them luck in their ensuing examination. Mrs. H. S. Hensman who had just returned from Europe kindly consented to preside, and gave us a very interesting account of her experiences abroad. Her encouraging words should have infused hope into the most despondent candidate, nevertheless the guests of the evening

Proceedings of the Women Medicoes Club

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suddenly realised that the ordeal which so far had seemed dim and distant, now loomed dangerously near. Such is the result of wishing people good luck. They immediately discover how unlucky they are! This brought the meeting to an untimely end.

The 8th January 1939 was another proud day for Women Medicoes. From the Club funds was paid the advance for the installation of the Telephone in the College Park Hostel (Women's Section). Now that this convenience has been supplied, I am sure there will be a large increase in the number of Hostel residents.

The fifth anniversary of the Club was celebrated on the 15th February 1939, and Mrs. Lakshmipathy presided

at the function. Tea was served on the Hostel grounds which were delightfully decorated for the occasion. The open air entertainment that followed gave evidence of the latent histrionic talent of several of our members. I hope that under the auspices of the Club some of this talent will be developed. This, the last meeting for the year 1938-39, ended with many cheers for the Club.

The Women Medicoes Club has been growing from strength to strength. Its members now number 65. I hope that soon these shall include all Women Medicoes qualified practitioners as well as students.

J. MATHIAS,
Honorary Secretary.

College Comments

The College Magazine.—‘How is it’, I am asked, ‘that there are no contributions to the Magazine from the students!’ If one is to answer this truthfully one might say it is just because students do not contribute. A new edition is a thing which is anxiously awaited, for it really offers an hour’s diversion from all serious studies and we really cannot afford to be too serious at all times, for, as some one said somewhere, ‘Seriousness is a disease; and the most serious of all animals is the donkey.’ But it may truthfully be said that the student is most sadly disappointed when the new issue is distributed, which disappointment is manifest by strange and threatening looks at the poor student-editors who think that the world has really gone mad. The student is much surprised that there are no ‘good articles’ at all in the Magazine. As it stands to-day I must confess the Magazine cannot really interest half the students of the College and perhaps it is not far from right to say it is too serious for the rest to take any notice. The contributions are mostly case reports from the wards in the Hospitals, extracts from other Medical Journals, and such like, and these are things which cannot amuse or command the attention of the students of Anatomy and Physiology, and much less, the boys and girls of the Pre-Registration Class. The Magazine must suit the taste of many types of students who are in the various classes, and the only way this may be achieved is by students contributing to it. One need not, during one’s academic course, necessarily always trace the course of the radial artery or optic impulses, or for that matter study the usefulness of digitalis in

heart diseases, or know the different diagnosis of Anasarca. We shall declare a literary, and intellectual democracy. Let us for once be delightfully and happily ignorant of the acid base reaction of blood, the classification of tumors, or the cause of tachycardia, or even the life history of the malarial parasite; we shall go on *a spree*. Let us for once in a while relax and learn the truth about life. Let us discuss our loves and our hates, our likes and our dislikes, our comedies and our tragedies and, if possible, others as well.

There is perhaps a belief amongst the students that they are not good enough and their articles may not be of standard. Time and often have I discovered latent talent in many, and the Magazine is the place for them which offers scope for development and expansion of their capacities which, if not utilised, will only “waste its sweetness on the desert air”.

The Graduates’ Reception.—The new Graduates’ Reception came off very well as many opined but for the poor tea and bad service. There was nothing to say in favour of the tea except perhaps that like all things in the world it too had to come to an end. One is at a loss to know why those who are at the top favoured an outsider on a big and important occasion like this when one could have the whole thing done by the College Canteen to the satisfaction of all. Last year the College Canteen catered and in one’s opinion, and the opinion of many too, the tea was up to expectation; though of course there were a few to find fault with it,

and it may be said these mighty critics never could pass a thing of God’s creation without finding fault with it. Considering this the Secretary did a wise thing indeed and with great foresight engaged an outsider to cater, and the result as all experienced was that the dishes were days old, and very bad, and service was worse. In future it is to be hoped that the Secretaries will ignore foolish and useless criticism and get the College Cafe to cater which to say the least is doing excellent work.

The success of the function after tea depends entirely on the mike which ought to magnify sound well and, more important still, reproduce it faithfully. The majority of mikes magnify the sound in a fashion but, as experienced by us (especially those at the farthest end of the hall), they never seem to be very particular about faithfully reproducing what they magnify with the result that all one hears is a series of grunts and groans—a lack of honesty on the part of the mike. This is really the cause for the mad rush for the front seats in the hall immediately after tea. Many a Professor has strongly spoken on this point and expressed the view that the students should behave themselves and observe the queue system. But imagine for a moment the plight of the poor student who, after going through the farce of tea of questionable quality, has to spend three hours in the hot and stuffy hall miserably watching the show without hearing a single word of what is being said and, added to his misfortunes, the mike barking away for what it is worth as though mocking at the poor chap and the very enviable sight of the fortunate few who in a grim struggle have successfully pushed themselves to the front enjoying all the fun. Under these conditions it is

asking too much of any student to be a good boy, and behave himself, and calmly without making any noise walk into the hall and seat himself. We have just now quotations from various firms and we may say that a good mike with loud speakers and all will cost about Rs. 1,000.

This year’s entertainment was said to be the best in many years. For once the members of the staff have forgotten all their professional dignity and roared themselves hoarse, the nurses screamed their lungs out, the boys burst their sides with laughter, and, the girls—well they blushed and blushed. The ladies gave two items this year and as usual were very good indeed and, if I may say, were better than in the previous years. The ‘Usha’s dance,’ for simplicity and sheer beauty and rhythm, cannot be beaten, and Miss Premela Lakshmipathi must be congratulated on her brilliant efforts to bring out an all-classical Indian Dance.

When every medical man and woman is talking about the honorary system and male nurses it was very apt that the students should have given the ‘night rounds’ which was best received by the audience. The only thing one has against it is perhaps that it has been a little exaggerated. The ‘College Rhapsody’ by the hostellers called for many a cheer (and many a tear, too). For sober humour, the dumb show carries all laurels to which we are to be thankful again to Miss P. Lakshmipathi. The ‘tableaux’ which was the last item, I must say, helped to sober up the audience to realities of the present day situations and to the only solution, if any.

The songs by the various students, the Indian orchestra, were all well received.

With such brilliant talent one wonders why there is no encouragement given to the students. Almost every college has a dramatic club where scope is offered for the development and expression of one's histrionic talent. Further looking at the more practical side of things the College Association is badly in need of funds; the Secretary can do all but manage to balance the budget.

A few improvements and a permanent stage which at the most may cost Rs. 1,500 with mike fittings and all, will be an asset to the College Association. In this connection we may mention that both the Vice-Presidents have expressed their willingness to help the students in their enterprise. And we all know very well indeed from our experience that they are to be depended upon. With them to back us up, it but requires an initiative to start a dramatic society which will enact a short play or a variety entertainment once a year and the proceeds of which can go to the Association.

The Cycle Stand.—The College authorities have fixed up a cycle stand between the Pathology Block and the compound wall which though very good is not big enough. We hope that in the near future it will be extended. It has also been arranged with an outsider to look after the safety of cycles for the consideration of three annas per month. There, however, seems to be a small batch of students (I do not mean the lady students) who are throwing their cycles all over the place rather than

keeping them in the provided stand. It is to be hoped that the College authorities will see to it that this breach in rules will not occur in future.

College Day. It is a pity we are the only College who do not have a College Day. Social gathering in our College, strangely enough, are very rare indeed. Either, there seems to be no response from the students, or more still, there does not seem to be any initiative from the office-bearers. The College Day is something which cannot be dispensed with. Will we start it off from this year or are we just too busy (or just too lazy)? In this connection it would not be out of place to suggest that we have an annual picnic, or, at least an annual dinner, though, if one is to voice one's opinion, it should be that we have both. The nearest to an annual dinner we have had was during the centenary when about four hundred of us rallied round and made it a semi-official thing with our (present) Principal as the President. This was a special occasion. There should really be nothing special about it but a normal annual event. Will we have it in future, I wonder!

The Magazine Committee instituted (in 1936) three prizes, viz., (1) for the best case report; (2) the best general article, and (3) the most humorous article especially caricature. The value of each prize was Rs. 20 and the contributor must be a student. Will the students note that this is being revived?

The Student Editor.



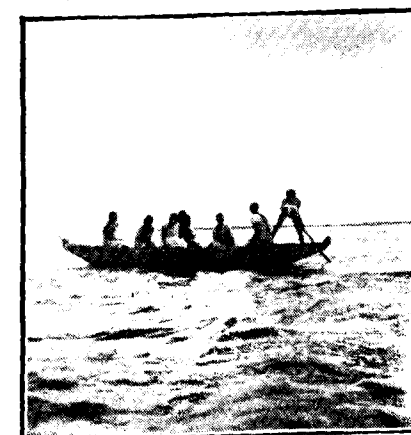
"The happy family."



Usha—"The earth awakens—the trees sway in the gentle breeze—the lotus buds unfold to the howering bees—"



—the peacock woos his mate—the maidens dance in ecstasy to welcome the dawn."



"Away we go."

“Scheming” Class.

BY K. SHAKUNTALA,

First Year, M.B.

One of the diseases of modernity is a craze to generate new fashions. We find style is thrust upon us by magazines which tastefully devote a personal page to physical perfection, and the immaculately dressed man is a universal hero amongst the gentler sex. The cigarette has come to stay, not because of its tobacco but because the modern gentleman has learned to poise and whiff it in the accepted manner. The tendency now is to adopt the languid eye and restless gait and prowl about for adventure.

Another affliction is *knowledge phobia*. Lectures are boring and class-hours monotonous nowadays. The most ingenious lecturer awakens no sympathetic resonance in our intellectual centres. With our hearts at the Marina in vain we smother yawns and headaches over hours that really matter and blink when the unexpected question is fired at us. No wonder then that some inspired person introduced the infection of ‘scheming’ into the student population. At the expense of a guilty conscience we spend dissection hours at the Matinee show of a theatre miles off while our brothers and sisters are silvering their hair over Cunningham or Gray. But these are but pinpricks compared to the stabs of remorse when the results of your public examination place you leagues away from the dais you expected to occupy at the top of the lists.

You can recognise the criminal in the pupil with the furtive eye and

the sidelong glance awaiting the earliest opportunity to escape the hawk-eyed staff members. No one could be more unpopular than the wide-awake demonstrator who instinctively keeps his eyes hovering around the table where the guilty one dwandles away time with scalpel and forceps while invoking the clock to indicate an early 4-30 p.m. A sleepy superintendent is the greatest asset of the ‘schemer’. He is practically a non-entity like any of the skeletons swaying in the hall. It is as easy to slip away under his nose as to gulp down a cup of coffee at the Modern Cafe. And the spectacled ones are handicapped by their short range of vision which they dutifully confine to the profunda artery or genicular nerve before them. These are the blessed ones to whose prosperity and short-sightedness the ‘schemer’ dedicates his prayers every night showering blessings on their path to paradise.

There is excitement as well as suspense in all their criminal proceedings. Midway down the staircase you might be confronted by somebody with a sarcastic smile whose sight freezes the blood in your circulatory system. There is the thrill of gaining the gateway successfully and chasing the Mylapore tram while the afternoon sun beats down on you relentlessly. You may puff and steam afterwards but there is the exhilaration of having achieved a great victory. You have the pleasure of smiling at the thought of

your friends who are conscientiously cutting flesh or sawing bone while you are already scenting on early ice-cream with the spark of liberty in your arteries.

The problem of procuring soap before the gong heralds freedom is another handicap. Of course the attender could supply you with tons of soap if a few annas exchanged hands but that might place his job in a precarious position especially in these days of acute competition. Besides, the tell-tale sounds of bubbling water may elevate the superciliary arches of some inquisitive gentleman of authority and he might register your act of simple hygiene as one of marked rebellion against the rules of the Central Institute. Speech is an atrophied form of expression in the dissection hall. Much more telegraphic communication is flashed by the eyes than the postal authorities could undertake in two million years perhaps. You know exactly when the demonstrator's eyes are focussed on you by a sort of telepathy. You can interpret his suspicious glance and smile disarmingly when his attitude really becomes dangerous as when he actually gets hold of a femur and wants you to mark out the attachments of some obscure muscle.

In a lecture class, 'scheming' is a matter of tactics. A minute after the rolls are called you might be able to sink on the floor beneath your desk and crawl to the doorway or make a bold dash for liberty through the 'French' window while your frenzied classmates caterwaul their throats hoarse. However indignified the *modus operandi*, the 'Schemer' has the satisfaction of breathing the pure oxygenated outer atmosphere and experiencing the pleasure of a 'lark on the wing' with an early cigarette

and a light-hearted whistle. In some seventy per cent of cases he strolls along to the Cafe and sets his gastric juice in action over *dosais*. Life is but a means unto an end and the student, who feels life is too transient, may naturally rebel at having to fill his skull with muscles and vessels when he might instead fix a microscope to his eye and pilfer glances at the contents of Sedan cars as they pass by diffusing powder and scent. Sometimes his proxy gives him a brief hour of unauthorised freedom; but proxies do not possess sufficient acting ability and the demonstrator may find a Lakshmanan mimicking a Ranganathan's quiet, brief 'Here, Sir'.

In a way these students are definitely favoured by the Professor who finds them a source of distraction in his lectures. For, the 'schemer' occupies classhours sketching Leila Desai or circulating comments on the style of dress of the figure on the platform. The lecturer finds a subdued conversation is briskly going on somewhere in the region of the back-benches where the 'schemer' is carrying on a secondary lecture on the demerits of the Indian Stage. Naturally, the lecturer is inclined to precipitate him somewhere in the vicinity of Mount Road.

'Scheming' is not a profitable venture. Those who have once been guilty of evading classes will recognise their folly over the question papers. Here the regular 'schemer' finds that no amount of scratching his head will lead him out of the maze or haze of memory in which he is inveigled. To penetrate the dark recesses of what is to them ancient history and associate the origin of the deltoid with the clavicle, scapula, and acromion requires great intellectual strain. 'Cardiac output' is Greek and 'aldehyde' Latin

to this variety of candidate. But if the effect of last night's late show persists you write 'Bibbo' for 'bursa' and place her below the insertion of a muscle, your Cunningham had not dreamt of in his wildest dreams.

A 'schemer' would not recognise a skeleton but for his hair-raising dreams where he is chased round the dissection hall by a Frankenstein or confronted by a mummy, who wakes up, rubs his eyes and asks "where is

my circumflex nerve?" (after it had been successfully split by the dissector). He wakes up in a cold sweat, grateful to God for being in bed instead of the graveyard. Perhaps he might supplement his gratitude by a good resolution or two. One to be highly recommended is: never to act the guilty 'schemer', but to be up and doing and to patiently await that wonderful day when after a labour of six years (or more!) his present rainbow-hued castles in the air might hope to be founded on reality!

Reply by Dr. P. Ramachandran, M.B.B.S., on behalf of the New Graduates

MR. PRESIDENT SIR, LADIES and GENTLEMEN, Allow me to thank the Secretary and members of the Madras Medical College Association for the delightful tea and the very hearty welcome they have given us, the new graduates of the year. Six years have rolled by since our inception into this College, and what glorious years have they been! We began by probing into the mysteries of the primitive amoeba, meandered through the fascinating forests of anatomy and physiology to find ourselves lost in the bottomless oceans of medicine, surgery and midwifery. It is a matter of great pride to us to have been the students of the Madras Medical College, one of the foremost—if not *the* foremost—institutions in the East. Here indeed we have been helped to develop a spirit of broad-mindedness and tolerance towards our fellowmen and, more still, to realize that most essential feature of a University that we call 'culture'.

Before we are carried away, let me, however, mention some disabilities that we, as students, have laboured under.

With due respect to our teachers, I must say, we have always felt a very big gap like a fathomless crevice in the mutual co-operation and understanding between the teachers and the taught, a sense of aloofness is present at all times. At the commencement of each academic year, long tutorial lists are put up on the notice boards assigning various groups of students to the various members of

the staff. There the matter ends—I for one have never even seen the shape of my so-called tutor.

It is a fact, too well known, that the Medical student at the end of his studies is unhappily deficient in the most essential, clinical and practical side of things and often cannot be induced even to write a prescription with confidence. Too little attention is paid to ingrain the fundamental and practical principles and far too much time is fizzled away in long academic lectures. No amount of didactic teaching can ever help a student to recognize a pre-systolic murmur or appreciate the stony dullness of empyema. It is not at all an unfamiliar sight to see a third year student just escaped from the dissecting room listening with rapt attention to a very learned discourse on Amaurotic familiar idiocy, or perhaps the minute differences between progressive bulbar palsy and paramyoclonus multiplex. Nor could one have failed to hear a heated discussion on the most modern and up-to-date classification of the tumors of the pituitary at the bedside of a patient whose complaint happens to be hydrocele!

Lectures on Ophthalmology and Midwifery are delivered in the respective hospitals instead of at the Medical College persumably with the intention of demonstrating cases of clinical interest side by side. But one has not had occasion to see even a single case during the entire course of one's lectures. Usually a few antiquated

illustrations and diagrams adorn the walls of the lecture-rooms which phenomenally enough have never any connection to the subject under consideration. It would be a great boon to the students of the fourth year class if the respective lectures be delivered in the Medical College.

Now, coming to our immediate prospects, we are faced almost at once with the honorary system. Our parents have spent a small fortune in seeing us successfully through this College. I grant our country is apallingly poor and reeking with starvation. But, is it asking too much in the very uncertain early years of one's practice that we be given at least a living wage to keep up body and soul together instead of that

miserable pittance which is euphemistically called an "HONORORIUM"? Honorary Service to be worth its name must be spontaneous. It must come from those who have long established themselves at the top far beyond all wants and necessities and place their valuable time and experience within the reach of the general public but surely not from the newly hatched chick. That, in a nutshell, is our very rosy future.

Ladies and Gentlemen, we are living through a period of great upheavals and uncertainties. Nothing is certain, no, not even the honorary system. We have youth, grit and—above all—a sense of humour, and we *will* face it.

The Memory Lingers.

By M. S. KRISHNAMURTHY, B.A.,

Fourth Year, Medical College, Madras.

The Graduates' Reception held on the 7th August in honour of the New Medical Graduates of the year was the high light of the month in our College. The new graduates of the year foregathered in their favorite College precincts by 5 p.m. The guests of the evening, mostly members of the Medical profession of Madras, drove in by the main gate in their sleek and dinky limousines. By a quarter to 5, the College lawn was packed with smiling and enthusiastic students and guests. A stranger at our College gate would have witnessed a rather unusual scene for this part of the world—a mixed party of ladies and gentlemen—and would have been agreeably surprised, too, at the healthy co-operation that prevailed between the volunteers of either sex.

Black and white was a favorite choice in dress among ladies. Miss...s dress of black crepe had a wide border of pink and the same colour appeared on the blouse. Fair and timid Miss... looked very well in lime-green. Stately and stern Miss... had flame-coloured embroideries in her saree and carried a handkerchief to match. The tall and proud Miss... looked as if she was before a mirror leisurely beautifying her face with mystic potions and colours and mounting mascara with incredible skill. How they brightened up every place they came into! They looked like a bed of tulip flowers in motion. It was as if a wandering rainbow had dropped in to pay us a visit.

Beautiful thin printed woollen tweeds, white pants, and college blazers were the favorite choice among the boys. Bow legged... was seen in a tweed coat and a pair of white trousers with a fold down the front (carefully preserved by keeping them under the pillow the previous night). But what are bow legs to the cleverness of a good tailor? Aristocratic Mr... dressed in tweed looked as though he had just stepped out of a fashion plate. But alas! Perspiration had taken all the cream and hazeline out of his cheeks to the angles of his mouth. 'The beautifully arranged curl over his forehead was now a limp wisp resembling a lump of sea-weed.' See unshod R. He has taken pains to convert his ogre face into something that would swiftly shatter the hearts of women.

The proceedings began with light refreshments served on the College green. Persons, whose happiness in this world centres round their stomach and for whom the kitchen is a temple and the chef its high priest, found our College tea very disappointing. Persons with a good appetite and a good digestion and known for their jovial and chatty temperaments were transformed into sour and starchy individuals after our College tea. Most of them looked as if they were fed on vinegar and Epsom salts.

After refreshments, the hosts and guests—the strong jostling the weak, the cunning creeping past the foolish, those behind elbowing those before,

The Memory Lingers

those in front kicking as they ran at those behind—adjourned to the Examination Hall.

The drab, mosaic paved, sombre looking Examination Hall was transformed as though by an Aladdin's lamp into a luxurious stage, with scintillating chandeliers, brilliant light, gay floral designs and coloured dresses. Hangings with light blue-black clothes of artistic paintings formed the scenery for a star-spangled variety entertainment.

It was a scene of great animation. Every one was gay and happy and ready for a spot of fun.

The Principal, the President of the gathering, welcomed the graduates in a short but impressive speech. He then requested the Vice-Chancellor to address the new graduates of the year. The Vice-Chancellor then rose amidst loud cheers and in a short but felicitous speech gave some words of wholesome advice to the new graduates. An interesting reply was given by Dr. P. Ramachandran, the Johnstone Medalist of the year, on behalf of the graduates.

The variety entertainment began with a prayer by Miss Savitri. The 'Night Rounds' was a pungent bit of satire, highly exaggerated and overdone. Perhaps it was nothing but some wicked fun at the expense of our modern reformers.

The 'College Rhapsody' of the hostelites was a bit of clever personation and must have caused a disturbance in the minds of those who were the subjects of personation. In fact, it is embarrassing to know that one has got a double, who at inopportune moments may pop up from nowhere like a Jack-in-the-box, and impose

on the world by passing off as the real "goods". Gestures, mannerisms, peculiarities of speech may be imitated, but the professional skill of Dr. Lakshmanaswamy Mudaliar or Lieut.-Col. Mahadevan are inimitable indeed!

The 'Shadowgraphy' was funny indeed but there is fun and—fun.

Now, the dance by the Lady students. It was a fragment of mediæval romantic India, recreated as though by the wand of a magician. 'The setting was simple and under the subdued lights, danced boys and girls, some girls masquerading as boys. Gay and colourful to soft melodies, even as Krishna and the Gopis must have danced by the blue waters of the Jamuna, in moon-lit nights, under the Kadamba trees to the sweet-throated birds.' The dancers' bodies swayed in perfect rhythm and there was grace and charm in every curve of their limb and in every step of their feet. Certainly it was an achievement of which the lady students could be proud.

Koshy's melodious 'Chronic Medicine' was more true to real life than many of the professedly biographical novels. The audience expressed their criticism in thunderous peals of laughter.

Dr. Natarajan showed us that he could not only sing with ease and grace but that he was a master of its scientific knowledge and technical skill.

The Indian Orchestra and the Hindustani Chorus were very much appreciated by the audience in perfect silence.

The 'Interlockers' gave a deliberate piece of finely controlled acting which was most effective.

A vote of thanks was then proposed by the Principal to the chief guest of the evening. The President, while thanking the audience, congratulated 'the magnificent' Secretary for his able get-up of the function.

'This World of Ours' was a tableaux which skillfully portrayed the contrasting forces operating in the world to-day—those of destruction ranged against those of preservation and regeneration. But nothing went home to the hearts of the audience as the melancholy pathos that hangs over the portrayal of the Indian peasant of to-day, crushed down to poverty by irresistible circumstances, and putting up a struggle, pathetic in its futility. Is it significant that

the function should close on this melancholy note?

Every one is jostling and scrambling, looking for his automobile..... noise...noise...bits of gossip floating in air...brightness, gaiety and zest... discussion of what they have just seen..., etc.

A word of thanks is due to the General Secretary, Mr. Pillai. It is certainly a name full of delicate reminiscence like the smell of lavender in a drawer. It suggests not a personality but an influence—not a presence but a pervasive spirit.

Memory counts the sunny hours, when the long day is over, its beauty remains.

The Internment.

BY R. ANANTHANARAYANA IYER,

Final Year, Medical College, Madras.

It was the month of June. The very fag end of it. The few of the most enthusiastic met and discussed the exciting month to be born. The month of births. Having come to the conclusion that July first starts by zero hour on 30th June, I packed my trunk, took a couple of books and by 9 p.m. of the 30th reached the sombre portals of Giffard School. The rickshaw man demurred at the fare. The poor devil forgot that he was tackling would-be honoraries and not the old Medicoes born with silver spoons in their mouths. I rushed up the wooden stairs, with all the excitement of an adventure to find the fans working in full swing, a light burning, a couple of students sleeping and two inviting beds without occupants. In a few minutes, I saw two more of the old gang and found out that I was ten hours earlier. With suppressed disappointment I peered into the distance to see vague figures flit by, and hear occasional shouts, from suffering "frailty".

It was 7 a.m. and still in bed. The owner of the bed was pleasantly surprised at the person dressed in 'Sambamurthy Suits' sleeping. He woke me up, and after a cursory bath and, pulling over "the maternity hospital dress"—a cream-coloured banyan-white pants and sandals—and with the log book, pen and pocket watch, hurried down. Where is Prabhu? The question was on everybody's lips. To the stroke of 8-30, in came Dr. Tampan, active and smiling

to a chorus of 'good morning's from eager and enthusiastic faces. He sat at his table, took out the brass key and the ominous Register—I mean the attendance register—was taken out. He gave us a small sermon as to what we were expected to do and where we were. We were directed to the Labour ward and the sister-in-charge in the twinkling of an eye, something like the Punjab Mail, told us the rules, regulations, duties, etc., and sent us away.

We quickly fell in with our surroundings and took to work. I took up night duty, as somebody had told me that by some mysterious ordinance deliveries occur more in the night than during the day. I have always been lucky, and luck didn't fail me then too. To three cases in the night twelve came for the day. When my turn for the day came, the reversal took place. Yes, this is a world of surprises. By the 20th we finished our scheduled cases.

Our life was extremely pleasant. The weather was fine. The work was interesting and instructive and we met with uniform kindness and courtesy everywhere. Though we were only 17 posted, we felt that we were 18, the 18th being Dr. Tampan. He was one of us, and ever ready to help us, guide us and philosophise with us. His mine of knowledge was always at our disposal.

The general calls, punctuated by the three consecutive bells—the mystic

three, who pitched upon that number and why?—was the bright spot of our life there. We liked them so much, they were so instructive, that, ultimately, I felt flat if I was not rung up in the middle of slumber (sweet) by them. All obstetric abnormalities and emergencies we had the good fortune to witness and learn within the short space of three weeks. Triplets, caesarians, secondary abdominal pregnancy, hydramnions, compound presentations, placenta praevia, etc., in fact, every thing we saw, every thing we were taught. It was a unique experience, a unique opportunity, a vitally necessary one, too, which many of our brethren in the same field do not have the same facilities to enjoy.

Dr. Prabhu's unique discussions on antinatal care and children's diseases dealt with a rare charm and ease will always be remembered by every one of us. His angle of view, novel and necessitous, has opened up vistas in our mind, which, I am sure, will stand us in good stead in the large practice which we are bound to enjoy.

Dr. Mudaliar's bedside clinics were always a source of instruction and inspiration, punctuated as they were by pungent wit and satire,—that hits but not hurts, wounds but not pains,—a necessary thing for people picking up their work—personal reminiscences, and experiences, spread over thirty years, almost a life-time. We used to look forward to his arrival in pin-drop silence and watch for his solemn mien and sedate steps, when called upon in the middle of the night, to witness a forceps or a caesarian. We are very grateful to him for the great care and pains he took, in explaining and demonstrating to us, as to how to apply the forceps or to extract a breech or to do a version, the things which any practitioner may be called up to do.

Lt. Col. Paton, smiling and kind, calm and collected, had a charm and attraction of his own. His snappy clinics were instructive. His surgery was an art in itself. It is a pity that Madras loses such a good surgeon. Wish him more glory in fresh fields and pastures anew!

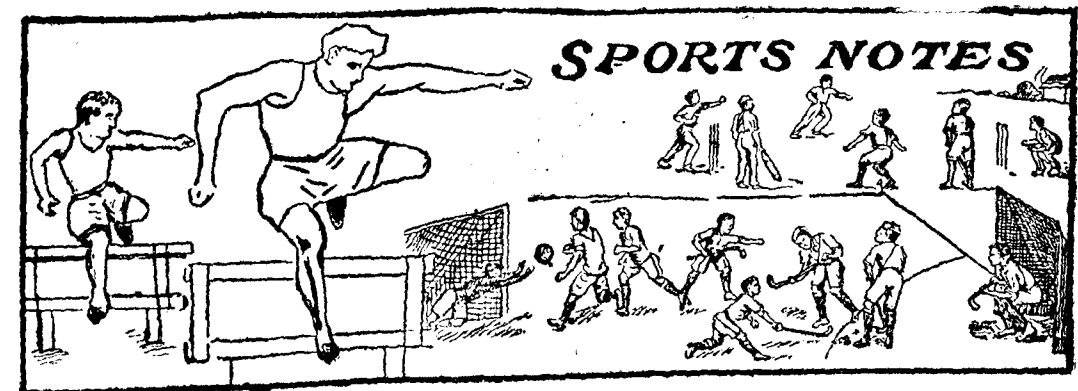
Dr. R. G. Krishnan's palpation classes and tips for the examination were refreshing and interesting, though the classes were held at a time when all of us were tired.

We missed Dr. Kuriappan very much but everything was masked by Dr. Thampan, here, there, everywhere, wandering like a cherub but occasionally peering into the skies in sudden serious silence for a couple of minutes.

This one month—we can, without exaggeration and fear of contradiction, say has been the most practical and realistic period in the theory-ridden course. However much a student may mug and however clever he may be at intellectual gymnastics, he cannot beat an average student in the description of a thing which the latter has *seen*. When both try to practise what has been taught, the latter always scores as one having seen and felt the little, little difficulties that one is bound to encounter when descending to realities from the realm of theory.

May I suggest, with all the humility at my command, that one month each of internment in medicine and surgery will equip the student better and lighten his burden in the matter of 'cramming'.

"Deny not Light to the Faithful," sayeth the Lord, and so AMEN.



The Sports Casuarie

BY "SENNEX."

Cricket.

The 'music of the willow' was heard early this year. Our team lost three good players in Doctors K. R. Rama Rao and G. Atma Rama Rao and Mr. A. Rangarajan. The first two were good all-rounders, who served the College with distinction and the last a sound bat and a good field, who rose to heights as occasion demanded. The Captain, Mr. Muthukumara swamy—a cumbersome name and so I shall call him Muthu for brevity—deserves praise for the great interest he has infused into the game by giving opportunities for all to play.

Madras Medical College—

1. Vs. Government Muhammadan College:

G. M. C. 63 (A. V. Rajagopal, 6 for 7); M. M. C. 76 for 2 wickets declared (Haridoss 30; A. V. 21*).

[This was our first match, and our opponents were new entrants to

the league. We had things our own way and the match was won comfortably. Haridoss, as usual, helped himself to a good score and A. V., with clever variation, ran through the side.]

2. Vs. Nehru Cricket Club:

N. C. C. 141 for 8 declared (Suri 4 for 55; Muthu 3 for 45); M. M. C. (B) 94 for 6 (Muthu 32; Suri 17*).

3. Vs. Stanley Medical College:

M. M. C. 150 (L. M. Hogg 47; A. V. 33.) S. M. C. 95 (A. V. 1 for 20; Pattu 4 for 27).

[We won the toss, and took batting so as to have a try-out. After being 141 for 6, we were all out for 150, revealing—shall I say—'a rats-tail'. Hogg and A. V. played well. The former was well set but was unfortunately run out. The latter missed three sixes (!) due to obstruction by trees.]

* Not out.

4. Vs. Triplicane United XI:

M. M. C. (B) 148 (Guruswamy 52); T. U. C. 60 for 7.

5. Vs. Madras Christian College:

M. M. C. 206 for 6 declared (Marshall 43; A. V. 38; B. Mahadevan 38; Haridoss 37); M. C. C. 5 (Pattu 5 for 20; Garson 3 for 37).

[The match though marked by good batting was marred by missed catches.]

6. Vs. Loyola College:

Loyola 99 (Garson 3 for 12); M. M. C. 109 for 8 declared (Haridoss 29).

[This was a match of matches. In the sweltering sun and with war in the air, it was played in alien grounds. Loyola won the toss and put us in the field. We dismissed them cheaply enough. Things went the wrong way when we went to bat. A. V., Hogg and Madhava Rao were out with but 30 on board. Bhaskar Mahadevan, who kept wicket in fine style earlier in the day went in and brightened up things. Haridoss, who had played himself in nicely, suddenly attempted a big hit and was out: 62 for 4. Muthu went in and was run out while inside the crease (!) 86 for 5. Bhaskar was out next, to a weak shot, after a timely and well play of 24. It was then an affair of the tail. Garson and Cherian, in subdued excitement and with all eyes on them, pulled us out of the mess. They deserve all our praise and congratulation, for having stood the test at the hour of need.]

7. Vs. Saraswathi Recreation Club.

M. M. C. (B) 119 for 9 declared. (Muthu 53*). S. R. C. 110 for 6.

8. Vs. Presidency College:

Presidency College 119 (Pattu 6 for 26); M. M. C. 126 for 6 (A. V. 40*; Muthu 21; Hari 21).

From the inception of the league, our encounter with Presidency College has been a grim fight, with all the gravity and importance of a test match. It rouses the greatest of interest and the greatest of attention and the winners are invariably the champions. They won the toss and elected to bat. Great determination and doggedness characterised their innings and they 'played to the book.' Two catches (or three?) and two possible stumping chances were missed. Padmanabhan, our mainstay in bowling, worked like a Trojan. He has always been a 'bowler of count' to opposing batsman, liberty with him spelling disaster. With a sprained leg, he bowled almost unchanged 28.4 overs, 18 of which were maidens and took 6 wickets for 26 runs. We entered at seven minutes to three. Haridoss was out early and with the next ball Hogg too was out. A. V. had split his nail, in making a catch in the slips and was 'under the trees' with a paining thumb. Muthu entered at 26 for 2. Playing cautious and correct cricket and with Madhava Rao playing a polished game, he built up the score to 60. Muthu, who had got over his 'Captaincy complex' in a way, was out, followed closely by Madhava Rao. The score board indicated 60 for 4 and the clock 4-16. A. V. Rajagopalan was in next, but by

* Not out.

the time he opened his innings with a three, he lost Bhaskar 60 for 5. All responsibility rested on him, with a long but a weak (?) tail and an injured thumb to boot. With Mathias at the other end, A. V. played aggressive cricket, taking the bowling to himself as far as possible and won the match by 5 p.m. 'Pat,' as Mathias is popularly known, showed himself to be a man for the occasion and produced his previous years' form. The team got a well-earned victory after a hard day's labour.

Our College was well represented in the M.C.A.A.'s XI. Hogg, Marshall, Muthu and Haridoss played in the first match against M. R. C. Hogg captained the side. Hari played a scintillating innings, characterised by fine cuts and forceful drives and earned for himself a name, as one made for 'big cricket'. The second match was played at Tambaram, in picturesque surroundings, marred occasionally by blinding dust storms, against T. C. C. Hari captained the side. Marshall, A. V., and Bhaskar were invited. Marshall on account of war and the latter two due to injuries couldn't participate in the match. Hari impressed as a good captain but was baulked of victory by Muthu (who played for T.C.C.) and time. Muthu entering 3 down played patient innings and was out to the last ball of the day.

Haridoss has been selected to represent Madras in the M.C.A.'s Second XI to meet Mysore. We are sure he will add another feather to his cap and keep up the great traditions of the College.

When all is said and done, one cannot but observe that the team sadly lacks a slow bowler of merit. No

team can be considered complete, without such a one.

Hockey.

In the M. U. C. Gold Cup, we had an easy victory over the Chinglepet Reserve Police. The new entrant, Nugent, impressed very much as a player of merit. The next match with the Hockets was a ding-dong affair, very flat and very unimpressive. Was it Hockey? Somehow we won. We met the M. & S. M. Railway next. The team played an inspired game and drew with them. In the replay, we couldn't do anything right and we collapsed like a pack of cards.

In the Inter-Collegiate League, we lost the match against Y. M. C. A. due to over-confidence. All others we have won comfortably.

Results:

Madras Medical College—

Vs. Presidency College	6—0
Vs. Loyola College	4—2
Vs. Veterinary College	6—0
Vs. Y.M.C.A. College	0—1
Vs. Government School of Technology	4—0
Vs. Pachaiappas College	6—1

Tennis.

A. V. Rajagopal represented us in singles and he partnered A. K. Haridoss in doubles. We lost the singles even in the first round to Loyola but in the doubles we won a round, to lose to the year's champions, in the semi-finals.

Football.

Our Football Eleven has been gradually becoming weaker since 1935. With practice, the team is bound to improve. We are improving with each match and our defence is good with Sridharan and Visvanathan outstanding but in the forward line except Haridoss, there is none else of marked ability. Shambu Shetty, our captain, deserves our congratulation, for so ably leading the eleven in such difficult and lean times. We are bound to do well in the knock-out tournament, when some players will be released from the Hockey Eleven for streng-

thening the team. Wish the team better luck.

Results :

Madras Medical College—

Vs. Presidency College	0—2
Vs. Loyola College	2—0
Vs. Veterinary College	3—1
Vs. Y.M.C.A. 'A'	0—2
Vs. School of Technology	3—3
Vs. Pachaiappas College	2—0

"The Chronic Medico."

I am a grey-old Medico
They call me a chronic Medico.
But once I was young
And I didn't care a thing,
I wanted to be a Physico. 1.

I started with Pre-registration,
Failing in regular succession.
But ev'ry thing changed
At last when I passed,
I started at eight my dissection. 2.

I had to work from the morning
Sometimes till five in the ev'ning.
In my twenty-ninth year
When I got out of there,
There was O. P. at seven in the morning. 3.

The stethoscope gave me the feeling,
That I was the Goddess of healing.
When questions were put,
I often stood mute,
I used to look up at the ceiling. 4.

Once I saw the back of a "sister,"
The front view, I thought, must be better,
So, I quickened my pace
To look at that face,
O! it was a glum nursing BROTHER! 5.

When will I pass M.B.B.S.
After my going through all this?
But though it is true,
I hate to tell you,
I haven't yet passed even Juris. 6.

The Principal sent me a Memo.:
"If you fail this time, out you go"
May be he's right,
But look at my plight!
I might become an ex-Medico. 7.

If some day I'm made a Physico,
From Madras will flee this Medico.
To earn a pie here
I must wait for a year,
I'd rather go off to Jericho. 8.

JOHN E. KOSHI.

"Give us the Good Old Days."

Oh! when that bell starts ringing.
At eight, ten, one, and four.
Up my spine goes creeping
A feeling dull and sore.
Back to me it 's bringing
Old memories once more.
Of all those days at school
When we were young and gay,
Oh! how we used to fool
Our teachers, old and grey.
Please give us back those good old days—
The happy days we knew.
When we could have our ways
And the restrictions were few
Troubles we didn't face
Though we cut a class or two.
But now those days are gone,
we cannot get them back.
They 're sure to pull us down
If in attendance we lack.
Now we have got a Principal
With moustache—black and long,
In speeches he can excel
Mark Antony the Strong.
Your fate you can't foretell
If he finds you in the wrong.

"Give us the Good Old Days"

69

At you he may not swear
But can you face his stare?
For if you were to dare
You 'll get a jolly good scare.

Our joy we cannot tell
After waiting for so long;
They 've built for us a hostel
A building mighty strong.
If you don't have a cycle
You join the bus-stand-throng,
And wait, my boys, and wait,
For the bus to come along.
By one sec. if you 're late,
You 'll be marked absent, that 's all.

And here 's a bit of news,
To the Chronic Medico:
"This time if you don't pass,
The next time out you go"
For orders are but orders,
No concession he 'll show.

So, let us do some work:
We 'll sit and mug till morn;
If duty we should shirk
They will catch us by the horn.

JOHN E. KOSHI.

Exchanges.

We acknowledge with thanks the following exchanges :—

1. King George's Medical Clinical Society, Lucknow.
2. Grant Medical College Magazine, Bombay.
3. Vizagapatam Medical College Magazine, Vizagapatam.
4. Indian Journal of Venereal Diseases, Bombay.
5. The Kemcol Journal of King Edward Medical College, Lahore.
6. Burma Medical Times, Rangoon.
7. Journal of Andhra Medical Association, Bezwada.
8. Indian Medical Association, Calcutta.
9. Ceylon Medical College Magazine, Colombo.
10. The Prince of Wales Medical College Magazine, Patna.
11. St. Joseph's College Magazine, Trichinopoly.
12. Patna Medical College Magazine, Patna.
13. Osmania Medical College Magazine, Hyderabad.
14. St. Aloysias College Magazine, Mangalore.
15. Loyolla College Magazine, Madras.
16. Sind Medical Union, Karachi.
17. Medico Surgical Suggestions, Madras.
18. Rangoon Medical College Magazine, Rangoon.
19. National Medical College Magazine, Bombay.
20. Medical Digest, Bombay.
21. Journal of South Indian Medicine, Madras.
22. Indian Medical Journal, Madras.
23. Lahore Medical College Magazine.
24. Indian World, Bombay.
25. Stanley Medical College Magazine, Royapuram, Madras.
26. Journal of Indian Medical School, Kilpauk, Madras.

NOTICE.

The Second Annual General Conference of the Association of Surgeons of India will be held in Madras on 28th, 29th and 30th December 1939. Details as to conditions of membership of the Association and other particulars can be obtained from the Honorary Secretary, 'Binfield,' Poonamallee High Road, Kilpauk, Madras.

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THE QUALITY SHOP - END 1945

புவனைத்தாள்.

சே எண் : 129249 ப. எண் :

[illegible]

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