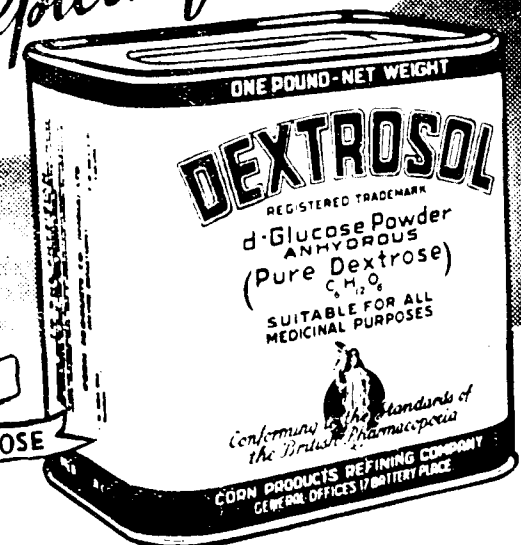


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APRIL 1941.

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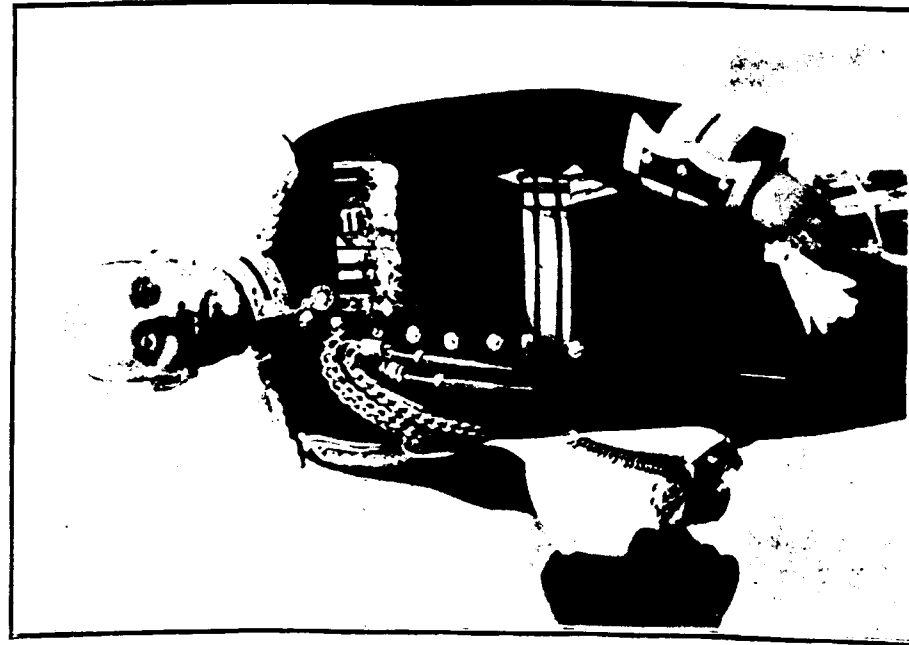
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Major-General N. M. WILSON, C.I.E., O.B.E., K.H.S., I.M.S.,
The Retiring Surgeon-General.
Who retired after a Meritorious Service.

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Col. H. STOTT, O.B.E., K.H.S., I.M.S.,
The Incoming Surgeon-General.

Col. H. Stott, M.D., F.R.C.P., O.B.E., K.H.S., I.M.S.

The Incoming Surgeon-General : Col. H. Stott, M.D., F.R.C.P., O.B.E., K.H.S., I.M.S., took charge of the office of the Surgeon-General with the Government of Madras on 21-2-41. He was a Professor of Pathology, King George Medical College, Lucknow, doing the collateral duty as the Physician of the same institution which position he occupied till 1937. During this period in 1926 he was made the Principal of the King George Medical College and Dean of Faculty of Medicine. He acted also for a short period as the Superintendent of the King George College Hospital. During his service in Lucknow, he was a member of the U. P. State Medical Faculty and took keen interest in organising the gradual evolution of the Agra Medical School which has since been converted into a College. In 1937 he was appointed as the Inspector of Civil Hospitals, Bihar, in which position he served for three years and a half till he was selected to serve as the Surgeon-General with the Government of Madras.

Col. Stott's services in the army were recognised by the military department and he was the recipient of British War and Victory Stars and Medals. He was conferred the title O.B.E. in 1917. Recently he was appointed as the Honorary Surgeon to His Majesty the King.

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No. 3.

Tuberculosis of the Eye.

Rao Bahadur T. KOMAN NAYAR, L.R.C.P. & S. (Edin.) D.O.M.S. (Lond.)

Professor of Ophthalmology, Medical College, Madras and

Superintendent, Ophthalmic Hospital, Egmore.

Tubercular diseases of the eye are rare in India as compared with the European countries. The eye may become involved in a tuberculous process, but it is not so frequently a seat of the disease as other parts of the body. This tuberculous process may affect any of the tissues of the eye and undergo the same changes as elsewhere. The difficulty of diagnosing the condition as a tuberculous one is often great; hence the true etiology of some cases may be easily overlooked. Finnoff says that obscure chronic inflammations of the eye are often due to tubercle; this shows that all such cases should be thoroughly examined for the possibility of tuberculous infection. The condition is most—often secondary to a tuberculous focus elsewhere in the body, except in cases of tuberculosis of the conjunctiva and the cornea; but in most cases, the primary focus is found to be relatively inactive. The general characteristics of tuberculous affections are chronicity, freedom from pain, and a

tendency to produce yellowish avascular tubercles that may break down later.

The *primary nontraumatic* form is confined to the lids, conjunctiva, cornea, caruncle and lachrymal sac and is rare. External direct invasion of these exposed parts is what happens. So also, in perforating wounds of the eye, tubercle bacilli may gain direct entrance into the eye producing a tuberculous process.

Secondary infection is the rule in the majority of cases; but it is often found very difficult to locate the primary lesion, except in cases of tubercle of the choroid following a generalised miliary tuberculosis or a tuberculous meningitis. Usually the disease runs a chronic course.

Two *types* may be noted, acute and chronic. The *acute* type of lesion runs a rapid course and involves a rapid destruction of the affected area by

caseation and necrosis; and if the patient lives long enough, extensive destruction always occurs. The *chronic* type develops less rapidly, is more protracted and is confined only to one portion of the eye in the early stages. Tendency to heal, but to recur later is commonly seen.

We cannot always ascertain whether ocular tuberculosis, especially of the chronic type, is due to the presence of the human or the bovine strain of the bacillus. The only methods of differential determination are animal inoculation experiments and a study of their cultural characteristics. Sir Arnold Lawson says that tubercular infection in the eye is a form of surgical tuberculosis (as opposed to "Medical" tuberculosis or phthisis) and he ascribes that, as the reason why it is very difficult to find lung lesions in these cases. He considers nearly all cases of surgical tuberculosis as due to bovine infection and says that, in young patients, no reaction is noted to the human form.

Now we shall consider tubercular disease as manifested in the different parts of the eye.

Tuberculosis of the eyelids.—It is chronic in nature and may affect any part of the eyelid. It is usually secondary to lupus of the skin of the face. The skin is invaded by the tubercle bacilli, producing a chronic specific cellular infiltration with small, dark red, soft nodules beneath the surface, which increase in size and gradually coalesce. They may either get absorbed or more frequently break down, ulcerate and later get cicatrised. Reaction to tubercle tests is distinctly positive, but the bacilli are scarcely found in the lesion. Lupus of the face may invade the eyelids and later the eyes; it may also involve the tarsal

and meibomian glands. Sometimes the subsequent contraction of the skin of the lids produces ectropion.

Tuberculosis of the conjunctiva.—Is usually primary, when, it is due to direct infection. It may also be secondary to tuberculosis elsewhere in the body. It occurs ordinarily in young people, during the second and third decades of life. The tarsal conjunctiva is affected.

In the *primary* variety, which is exogenous in origin, the commonest site of the lesion is the sulcus subtar-salis, where an ulcer develops. In cases of *secondary* infection it may be either (a) *exogenous* in origin, where the infection is carried by means of the patient's own fingers, (b) *endogenous*, where the infection occurs through the blood stream by metastasis, in which miliary forms and evanescent tuberculides are seen or (c) may occur by *direct extension* from the skin, nose or orbit. Sattler and Eyre have classified the changes in the conjunctiva as belonging to one of four clinical varieties:

1. *Ulcerative* type, which is practically painless and shows no tendency to heal;

2. *Nodular* type which starts subconjunctivally and later is surrounded by follicles and granulation tissue and finally ulcerates into a cauliflower-like growth with a central necrotic point.

3. *Hypertrophic papillary* type in which florid flattened out-growths of granulation tissue are seen usually in the fornices, with œdema of the lids, and

4. *Polypoid* type, showing as a pedunculated tumour arising from the tarsal conjunctiva.

Thus the conjunctival disease may take various forms; an ulceration of the conjunctiva may be present with greyish red granulations; it may have a yellowish red, lardaceous looking base; coxcomb like excrescences are often found; sometimes it starts as a thickening of the conjunctiva with one or more yellowish nodules, which later ulcerate; it may be seen as ulcers with ragged edges, an uneven base and a worm-eaten appearance with induration all round. The lid is thickened, but is not hard; there is a scanty discharge of muco-pus; the ulcers bleed readily; there is no pain unless the cornea also is secondarily involved. The pre-auricular glands are affected very early; the submaxillary and cervical glands are involved later. Usually only one eye is affected. The disease runs a very chronic course, spreading slowly, but shows a great tendency to recur even after a temporary healing. The cornea and the iris may become involved later.

Lupus and tubercle of the conjunctiva are practically the same, there being only external differences due to aspect and course. Lundsgaard found, in 29 of his 48 cases of tubercle of the conjunctiva, lupus of the adjoining skin; most of these cases were among females, between 26-30 years and both eyes were affected. In the remaining 19 cases, mostly among females, all were under 20 years of age and only one eye was affected. The upper lid was found to be more often involved.

In all cases of ulceration of the conjunctiva with enlargement of the pre-auricular or the submaxillary gland, tubercle should be suspected and not excluded until after repeated laboratory tests, inoculation experiments etc. The condition should be diagnosed from Parinaud's conjunctivitis in

which Verhoeff's leptothrix may be seen by microscopical examination of smears; if this is seen tubercle can be excluded. Lupus ulcers are distinguished from tubercular ulcers of the conjunctiva by (1) noting direct extension from the skin and (2) by lupus cases showing advancing ulceration on one side with cicatrization on the other side. The ulcers are not painful and there are no constitutional symptoms in uncomplicated lupus.

Treatment.—Excision of the affected tissue is required; if this is not possible, scrape it with a curette or knife and then cauterize the area with the galvanocautery or with lactic acid (50% or even pure). The application of iodoform ointment (10-20%) is found beneficial. Tuberculin therapy is not so useful in these cases. If excision is not possible, local phototherapy or application of X-rays may be tried. General treatment, such as fresh air and healthy surroundings, good food and proper climatic conditions should not be omitted.

A condition known as *Tuberculides of the conjunctiva* is sometimes met with. They are attenuated tuberculous lesions having all the histological structural features of miliary tubercles; but they, rarely, if ever, contain the bacilli. They appear as multiple evanescent lesions on the skin and the mucous membranes; they disappear without leaving any trace; there is no tissue necrosis. Probably they are only evidences of allergic sensitisation.

Tubercle of the cornea.—This is very rarely *primary*; but direct inoculation can produce it. The *primary* condition may be *ulcerative* or *infiltrating* in character, the former being the commoner of the two. The ulcers are slow, torpid, and show little tendency to heal; they are highly vascularised

and show the presence of both superficial and deep vessels. Relapses occur frequently. The *infiltrative* type occurs as either nodules at the limbus or deep lesions centrally.

The *secondary* variety usually follows anuveitis or a conjunctival or scleral infection, one or both eyes may be affected. Four distinct varieties are noted:—(i) A typical *tuberculous parenchymatous keratitis* in which there is a more or less diffuse opacity, confined often to only a sector of the cornea (usually the lower part); with *small points of whitish yellow infiltration* in the middle and deeper layers of the cornea. These spots are tubercular nodules and show as dense abscess-like type of nodular exudate. Vascularisation also is similarly localized and is not so intense as in the syphilitic cases. The disease is often unilateral. The iris, the sclera and the limbus may be involved.

(ii) *Simple parenchymatous keratitis* with a diffuse opacity of part of the cornea and slight circumcorneal injection.

(iii) *Typical scrofulous or phlyctenular kerato-conjunctivitis* which is a para-tuberculous keratitis, and

(iv) a *sclerosing keratitis* in which there are superficial or deep greyish opacities of the cornea with involvement of the adjacent portion of the sclera.

Rutherford says that in interstitial keratitis, 90% are due to syphilis; that tubercle is responsible for most of the remainder; and that in sclerosing keratitis, syphilis and tubercle are the causes in young persons, while focal infection is the cause among the older patients.

Glandular enlargement is present only if ulceration has taken place; in

superficial lesions, the symptoms are more severe. The opacities are modified tubercles.

Local treatment consists of the use of mydriatics; antiseptics are used in cases of ulceration. Injections sub-conjunctivally of 1 c.c. of a 2% solution of guaiacol are useful. Tuberculin treatment is valuable.

Scrofulous or phlyctenular kerato-conjunctivitis may be considered here. Differing views are expressed by various authorities on the subject, as regards the relationship of this condition to tuberculosis.

Fuchs says that phlyctenules are due to the action of toxic substances in tuberculous or scrofulous people and that its relationship to tubercle is at most an indirect one.

Verhoeff says that it may be due to anaphylaxis. Some consider it as "a low grade tubercular inflammation"; others say that "in many cases it is caused by tubercle, but may also be caused by other constitutional factors."

Urbanek says that tuberculosis plays an important role in the production of scrofulous kerato-conjunctivitis as well as in deep scrofulous corneal infiltration, (tubercular) interstitial keratitis, fascicular keratitis etc.

Alan C. Woods says that "its relationship to tuberculosis has been long recognised; favourable clinical evidences are the occurrence of phlyctenular diseases in children with an obvious tuberculous diathesis and the excellent results obtained in such cases with tuberculin therapy." Experimental studies have shown that the instillation of tuberculin in the conjunctival sac of men and animals,

hypersensitive to tuberculin, produces phlyctenules which are typical; but they are also produced in animals hypersensitive to other foreign protein, such as horse serum, by the instillation of horse serum into the conjunctival sac. Woods comes to the conclusion that the phlyctenules should be considered as an "allergic reaction of the hypersensitive conjunctival and corneal epithelium to sensitisation and intoxication with a foreign protein (tuberculin or other foreign protein like horse serum). Clinical evidence indicates that in a large percentage of cases the antigen responsible is tuberculo-protein; it is quite possible that other substances may be responsible for the phlyctenules in certain individuals, but the weight of evidence is in favour of the former."

Phlyctenular kerato-conjunctivitis is a condition fairly commonly seen in children of the poorer classes who are dirty, ill-nourished and who live in unhealthy surroundings. Improving the general health by tonics, good food etc., local treatment with mydriatics and antiseptics, combined with careful tuberculin therapy produce very good results in such children.

Tubercle of the sclera.—Chronic episcleritis and scleritis, especially in young people, may be said to be most likely due to tubercle. There is a uniform brawny induration of the episcleral tissue with occasional definite nodules under the conjunctiva. The nodules are raised, hard, yellowish and fixed to the sclera and the injected conjunctiva moves freely over them. Later caseation and ulceration take place. The inflammation may extend to the cornea and the uveal tract; often the sclera is affected by extension from a focus of tubercular uveitis. The affected sclera becomes thin and appears bluish or slate-coloured later

on. A dull pain is complained of when the sclera is affected. The disease may be of an allergic exudative type (i.e. sclerosing keratitis) or a proliferative type with specific tubercle formation. It is usually a hæmatogenous infection from a tuberculous focus. The disease is chronic and shows a great tendency to recur. Verhoeff produced scleritis and episcleritis in rabbits' eyes by injecting dead tubercle bacilli into the anterior chamber and the vitreous. Urbanek says that 90% of cases of sclerosing keratitis and episcleritis are due to tubercular infection. He got a positive finding of tubercle bacillus in the blood stream of these patients and also got a positive tuberculin cutaneous reaction in these cases.

Excision or scraping and cauterisation of the nodules is recommended, along with tuberculin therapy and general treatment.

Tubercle of the iris and ciliary body is mostly secondary in origin. Different types of cases are met with and the two structures are often affected together.

(1) *Acute tuberculous iritis.*—A tuberculous origin should be suspected in cases of mild acute iritis with little or no pain, slight circumcorneal congestion, slight cloudiness of cornea and aqueous with a moderate hyperæmia of the iris. In such cases, a careful search should be made for other signs of tubercle in the body. The inflammation usually rapidly subsides, but is followed later by a mild relapse, showing typical tubercles in the iris, retinal periphlebitis or tubercular choroiditis, which at once reveals the true nature of the disease. Some eyes show an acute iritis with old sclerosing keratitis, often coming on as a reaction to a tuberculin injection.

tion. In most of these cases, rapid resolution follows. In other cases, an acute iritis, with small circumscribed transitory nodules in the iris or more prominent solitary tumours of longer duration, is seen. There are also cases showing a more acute massive tuberculous iritis with caseation, which are of a serious nature and generally incurable. These lead on to general tuberculosis and death.

(2) *Sub-acute and chronic tubercular iritis*.—This may take several forms:—

(a) A subacute iritis with a solitary tuberculoma of a dormant and benign character, following an acute attack, 2 or 3 weeks previously. The tumour is grayish or yellowish and is confined within the stroma of the iris, in its early stages; later, it bulges into the anterior chamber and is sometimes covered with a layer of fibrin. At a still later stage, keratic precipitates, posterior synechiæ and pigment deposits on the lens surface are seen.

(b) a chronic iritis with several glassy nodules, 2 mm. in size situated in the stroma of the iris, grayish keratic precipitates and posterior synechiæ form later.

(c) Multiple small yellowish nodules are seen in the iris.

The base of the iris is the most affected part in these cases. In later stages, newly formed blood vessels are seen in the iris or even hæmorrhage into the stroma of the iris may occur.

(d) a subacute iritis with a broad peripupillary glassy wall may be seen, with a coating on the back of the cornea and on the lower part of the anterior surface of the lens. There is severe hyperæmia of the iris; slight corneal œdema is present. Later,

posterior synechiæ, occlusion and seclusion of the pupil may form.

In all these cases syphilis as a causative factor must be excluded first, clinically, diagnostically and therapeutically.

(3) *Quiet iritis*.—In this variety, the ciliary body is also often involved; there is no circumcorneal congestion, no corneal œdema, no redness of the eye, and no œdema of the iris. But plenty of "mutton fat" keratic precipitates are seen, as also several points of posterior synechiæ and pigment spots on the lens capsule. Small grey papules are seen on the pupillary margin; their alternate appearance and disappearance suggest their tubercular nature. Dust-like opacities may be seen in the anterior part of the vitreous, as a result of involvement of the ciliary body.

(4) *Tubercular cyclitis*.—Three phases of the disease are seen *i.e.* latency, exacerbation and healing.

(a) *Acute cyclitis*.—There is redness and pain in the eye; patient complains of headache; exudates or deposits are seen in the aqueous and the vitreous; alteration in the tension of the eye and refractive changes may be noted. Mild cases show in later stages deposits on back of the cornea, gross opacities in the vitreous, optic neuritis with engorged retinal vessels; these become chronic later. Severe cases develop a caseous tuberculous iritis and cyclitis and scleral perforation may occur; others may take a course similar to septic cyclitis.

(b) *Subacute cases*.—Do not exhibit any pain or redness; there are mild attacks of increased intraocular tension. There are more of vitreous opacities, and fine milky keratic

precipitates. The iris is swollen and there are papules on the pupillary border. Optic neuritis may occur.

(c) *Quiet cyclitis*.—There is no congestion of the eye and the cornea is clear apparently; one or two points of old posterior synechiæ may be present, on examination with a scupe, few, rather *pathognomonic of tubercle*. The anterior part of the vitreous may show vitreous opacities; retinal periphlebitis or vasculitis may be present. Later œdema of the optic disc and retina may be seen, with retinal hæmorrhages. Posterior cortical cataract may form later. The inflammatory process may end in either a secondary glaucoma or a shrinking eye.

In the majority of patients with tubercular iridocyclitis, neither an extensive nor active pulmonary involvement is common; but careful examination by X-rays etc. may often reveal slight changes, and sometimes more extensive changes. Early differential diagnosis is often difficult. In one case, Prof. Meller successfully cultured the tubercle bacillus from an eye destroyed by chronic uveitis and in two patients from their peripheral blood.

Parsons divides tubercular iritis into 3 classes:—

(1) Small yellowish or grayish miliary tubercles at the pupillary or peripheral portions of the iris, which later become confluent and involve the ciliary body and the cornea and perforate at the limbus.

(2) A yellowish white tumour mass of confluent or conglomerate tubercles with small "stellate" nodules around it, and

(3) an iritis indistinguishable clinically from other varieties of iritis.

In caseating tumour masses which perforate near the limbus, enucleation of the eye may have to be done to prevent further dissemination of the organism into the general system.

Adler and Meyer.—Classify tubercular iritis into three types according to their pathology with a distinct age period during which they occur:—

(i) The nodular type, occurring between 10 and 20 (or 25) years of age in which there are plenty of nodules, not many keratic precipitates, the choroid may show miliary tubercles, sometimes definite pulmonary signs are seen and no marked sensitivity to tuberculo-protein is present.

(ii) The inflammatory type, occurring between 20 and 30 years, in which the iritis is more inflammatory. There is little tendency to form nodules, but there is considerable pain, plenty of exudate; vitreous and cornea are involved; there is a high degree of cutaneous sensitivity to tuberculo-protein; rarely show active lesions in the lungs, but there are evidences of old healed lesions in the apex of the lungs and enlarged peribronchial glands.

(iii) The exudative type, occurring between 30 and 50 years; in which the ciliary body is equally involved; the condition is highly exudative, there are "mutton fat" keratic precipitates; vitreous is full of opacities; but there is little flushing of the ciliary region or pain. The condition is usually bilateral, the eyes go blind by glaucoma or shrinking of the globe. There is marked allergy.

Tubercular choroiditis.—Jackson says that a single tubercle of the choroid is a good example of a typical lesion of a focal infection, complete in itself,

Tubercular choroiditis occurs either as miliary tubercle as a part of a general acute miliary tuberculosis or as a chronic tubercular condition.

(1) *Miliary tubercle*.—Occurs in the late stages of tubercular meningitis before death of the patient. They occur in both eyes more near the optic discs and have a caseous centre. The retina is not affected; pigment changes are wanting—the patches are ill defined and of a yellowish or pale red colour. Before pigmentation takes place, the patient usually dies. Rapidity of growth is another feature.

(2) *Solitary or conglomerate tubercle*.—Occurs as a large light-coloured mass in the choroid, sometimes surrounded by small satellites; the retina is invaded early; the growth may invade the sclera and perforate it, either at the limbus, at the exits of the menæ vorticosæ, or at the optic nerve entrance. The condition is generally monocular. It is a rare condition, and occurs in young people. The prognosis is bad. If not controlled by treatment, enucleation of the eye is advisable.

(3) *Disseminated choroiditis*.—Also may occur as a tubercular affection. In the early stages there are diffuse irregular greyish yellow patches; in the later stages, irregular white patches bordered with pigment are seen. Vitreous is slightly turbid, not so much as in the syphilitic cases.

Tubercular choroiditis usually occurs during the following age periods:—

Between 1 and 10.—Miliary tubercles, associated with tubercular meningitis, and showing very little allergy.

Between 10 and 30 years.—Inflammation of anterior part of the uvea,

with a single large exudative lesion in the choroid, little inflammatory reaction, presence of tubercular periphlebitis, healed tubercular lesions in the body and moderate or severe degree of allergy.

Between 30 to 50 years (according to German writers) Disseminated choroiditis, with evidence of healed tubercular lesions in the body and no constant degree of allergy.

Recurrent retinal and vitreous hæmorrhages.—Usually seen mostly in males between 14 and 20 years of age. Very frequently it is associated with a tuberculous infection according to the German writers. There is marked tortuosity of the retinal veins, or sometimes even a retinal periphlebitis is seen in cases of recurrent vitreous hæmorrhages. Tubercle may also be a cause in many cases of recurrent retinal hæmorrhages.

Urbanek, of the Vienna clinic says that "the tuberculous nature of the disease of the affected retinal vessels in periphlebitis retinalis and in thrombosis of central vein due to injury to the vessel walls in young individuals is not doubted to-day. But many other authors do not share the same view.

Absorption of blood is very slow in these cases. Retinitis proliferans and subsequent detachment of the retina may follow in some cases. Vision is affected according to the density of the opacities present, their position and size. Tuberculin therapy should be undertaken *with very great caution* in these cases. Rest in bed for several days, with cold applications to the eyes, a low diet and frequent purges are advised.

Retinal tuberculosis.—Which is very rare primarily, occurs most often as

Tuberculosis of the Eye

a vasculitis or perivasculitis of the retinal vessels—a collection of white infiltrates around the vessels, most frequently the veins. It starts as a perivasculitis and later the lumen of the vessels is affected (vasculitis). Varicosities and constrictions are seen in the course of the same vessel; later thinning of the vessel walls and consequent hæmorrhages occur; this leads on to retinitis proliferans. Suspect tuberculosis if there are recurrent hæmorrhages into the retina and the vitreous, with improvement in vision in between the repeated attacks, especially in young people. Tubercular tumour-like masses are sometimes seen in the retina; when, they are associated with tubercular affection of the optic nerve.

Tubercular affection of the optic nerve.—Tubercular meningitis may extend along the optic nerve and cause a descending neuritis. There may be the appearance of a hyperæmic disc, a papillitis or a choked disc; but there will be no signs of any increase in the intracranial pressure. Vision is often not impaired or is affected only in the very late stages.

Tubercular disease of the lachrymal gland.—Is rare and is generally secondary. Enlargement, caseation and necrosis occur, but the course is very slow. It may burst through the skin or conjunctiva and form a fistula.

Tubercular disease of the lachrymal sac.—Is rarely seen; when it occurs, it is due to direct infection from the nose.

Tubercular disease of the orbital walls.—Occurs usually in the temporal margin and in the zygoma. Beginning as an indurated swelling, it forms into an abscess and bursts, leaving a sinus with carious bone underneath and periostitis all round

the lesion. Syphilis is also another cause to be reckoned with in bony necrosis of the outer and lower angle of the orbital rim. But in children, it is more likely to be due to tubercle

Sympathetic ophthalmitis.—In a study of the tubercular diseases of the eye, mention has to be made of this disease, as there is a school of thought favouring its relationship to tuberculosis; Meller says it is a form of tuberculosis of endogenous origin, affecting both eyes, but this view has not been generally accepted. Professor Meller, in the Doyne Memorial lecture of 1934, discussed the relationship of tuberculosis to the ætiology of spontaneous, post-traumatic and sympathetic iridocyclitis as follows:—The therapeutic success in the specific treatment of uveitis, acute or chronic, convinced him of its tuberculous nature. Focal reaction with tuberculin injection has its special significance. In most cases the reaction passes off very rapidly and does no harm, but such reaction should, of course, be avoided—Failure of specific therapy also does not mean the disease is not tubercular in nature. Lowenstein has proved that bacillæmia is not so rare and that it need not always result in virulent acute miliary tuberculosis; that the bacilli can circulate in the blood of clinically healthy people; that about 14% of 132 blood examinations in spontaneous uveitis have been proved positive to tubercle bacillus. (Blood must be taken at the outset of the disease or at a fresh later recrudescence of the disease.) Meller draws the conclusion that spontaneous uveitis is often caused by tuberculosis, as proved by systematic cultures of blood and tissue. He has found the tubercle bacillus in the blood and in the eye of patients suffering from sympathetic ophthalmitis. He considers that sympathetic inflammation is a true tubercular uveitis, which

appears if the patient, either before, during or after the injury is a bacillus carrier in the blood or in the tissues of the eye at the time of injury.

Pathology.—Haab first demonstrated the tubercle bacillus in the eye. Tuberculosis of the eye, whether of the conjunctiva, iris, ciliary body or choroid, shows the typical giant cell system. In the centre is the giant cell—a mass of protoplasm with radiating processes and nuclei lying at the periphery of the cell—; around it is a zone of epithelioid cells—irregular ill-defined cells with granular protoplasm. This zone is produced by the cells of the tissues, the lymphatics and the blood vessels; around this, is a zone of mononuclear lymphocytes and beyond it polymorphonuclear cells. If the bacteria succeed in breaking down the primary wall of defence they get into the blood stream and are carried to other sites where fresh infection takes place.

The secondary changes produced in the affected tissues are (1) Slight enlargement due to the deposition of endotheioid cells; (2) Caseation, the result of necrosis and fatty degeneration, due to the centre of the tubercle being avascular; and (3) fibrosis around the tubercle but separate from it, due to reaction of the surrounding tissues. This tries to prevent the tubercle from enlarging. The smallest tubercle lesions consist of lymphocytes only; when they reach 0.5 mm. in size, giant cell systems are seen; larger nodules, 1 mm. in size, usually show caseation also. Tubercles usually form around vessels which show endothelial proliferation and often blocking of their lumen. Tubercle bacilli may be found in these lesions.

Tubercular infection of the eye is usually hæmatogenous except in the

rare cases of primary infection referred to previously and is derived usually from a mild, quiet infection of the tracheo-bronchial or abdominal lymph glands. Two distinct types of lesion may result from this hæmatogenous infection: (i) if the subject is previously uninfected a slowly developing progressive lesion forms with regional lymphatic enlargement—which is mainly proliferative in type and is characterised by formation of tubercles and known as a “non-specific defensive reaction.” In these caseation may develop and the tubercles may either get absorbed, which is rare, or fibrosis may take place around them or a progressive necrosis may occur with spread of the infections.

(ii) While, if the subject is previously infected and a second infection occurs sufficiently virulent to break down the immunity caused by the first infection, “an exudative allergic reaction takes place—an acute inflammation, the essential features of which are massive necrosis, accumulation of polymorphonuclear cells and no lymphatic enlargement. This may lead on to either (1) death of the bacilli and a return to the normal, or (2) survival of some bacilli which will help to form new tubercles, or (3) an extension of necrosis and fibrosis.

Ocular tuberculosis occurs ordinarily as a blood infection in persons who are previously infected and who are allergic to tuberculo-protein; this condition exists in patients with apparently healed tubercular adenitis or pulmonary tubercle. Bacteræmia may also sometimes be present in such persons.

In non-allergic persons, either in early life, before the development of tuberculo-allergy or when massive infection has destroyed allergy as

in miliary tuberculosis, infection with tubercle produces solitary lesions which are progressive in character. In allergic persons, the lesion is more acute, and becomes confluent and caseating. If both resistance and allergy in the affected individual are high, the lesion is sharply localised. High resistance with a low degree of allergy produces lesions, non-specific in appearance, with a definite tendency to get circumscribed and to heal, e.g., tubercle of the iris and the choroid. Low resistance with a high degree of allergy produces mostly inflammatory lesions which are of a spreading and necrosing type. If the organisms are large in number and very virulent, there is marked inflammatory reaction, a tendency to spread and eventually perforate the eyeball, as in tuberculoma of the uveal tract. Diminished tuberculin hypersensitivity, due to an extensive generalised infection produces miliary tuberculosis due to a bacillæmia e.g., iris or choroid miliary tubercles; necrotic caseating lesions do not form on account of the low degree of allergy present; if death does not follow the bacillæmia allergy increases and a massive tuberculoma may form. The greater the sensitivity of the tissue is to the toxin, the earlier will the severe reactions like the hypopyon, caseation and perforation of the eyeball occur, as seen mostly in children.

Diagnosis.—“The diagnosis of ocular tuberculosis should be based on the course and character of the lesion, on the exclusion of other ætiological factors and on a study of the general tuberculous status of the patient. The tuberculin reactions are of value only when strongly positive; weak or negative reactions are of no significance for or against the diagnosis of ocular tuberculosis.” (Woods.)

Tubercle bacillus may be active in the eye but latent in other parts of the body, without causing external signs of symptoms. A careful and thorough search for the primary focus is therefore necessary. Finding of the bacillus in the lesion makes the diagnosis certain but in chronic lesions, the organism is not always found. If possible, remove a piece of tissue for pathological examination; if not, take scrapings for microscopical examination. Do animal inoculation experiments by injecting the diseased tissue scrapings into the peritoneum or eye of guinea pigs and watch for several weeks. Poyales says that exposure of guinea pigs to X-rays increases their susceptibility to the tubercle bacillus and shortens the time required to develop the lesions; it renders the method more sensitive. Cultures may be tried but are not so reliable.

Tuberculin for diagnostic purposes should be used only after a thorough general examination of the patient, so as to prevent complications.

Calmette's.—Reaction is not safe to use in eye lesions; and must be given up.

Von Pirquet skin test.—Is of little value; in children, however, a positive reaction may be of importance. In adults, a negative reaction with other negative physical findings makes tubercle doubtful as an ætiological factor; this is especially true in the secondary type.

Moro's test.—Is neither as sensitive nor as reliable as the Von Pirquet test.

Mantoux's test.—Tuberculin injections subcutaneously or better intradermally is the most favoured test. As a severe focal reaction may serious-

ly damage the eye, be very careful as regards the dosage in cases of ocular tuberculosis. A positive focal reaction within 11 to 20 hours means a tubercular affection of the eye; while a general reaction with no focal reaction only gives a probable hint regarding the etiology of the eye lesion.

Tebeprotein is used at the Vienna Eye Clinic for intracutaneous injection by Urbanek (Meller Clinic). Tebeprotein is made by extracting cultures of human tubercle bacilli chemically, thus retaining the pure bacterial proteins and eliminating the toxic by-products. The advantage claimed for this is that only very slight focal reactions are produced and that the reaction is of short duration. Four injections are given at different sites as follows:—

- (1) Control 0.2 c.c. of 0.25% phenol solution.
- (2) Tebeprotein 0.2 c.c. of a 1 in 1,000,000 solution.
- (3) do. 0.2 c.c. of a 1 in 100,000 solution.
- (4) do. 0.2 c.c. of a 1 in 10,000 solution.

The reaction is noted; and 1/10 of the amount of the weakest dose that gave a positive reaction of more than 3 mm. size is chosen as the therapeutic dose.

Treatment.

(i) *Local*.—E. V. L. Brown says that modern treatment is not on a satisfactorily sound basis, either in theory or practice. The most effective local treatments for tubercle of the iris or ciliary body (X-rays or injection of patients' blood into the anterior chamber of the eye) do not prevent recurrences nor attacks in the other

eye and do not influence the primary lesion.

In affections of the iris, ciliary body, choroid, cornea etc., mydriatics should be used to give the parts rest. In external affections, the involved tissue may be excised if possible or scraped and cauterised. Iodoform is a beneficial drug for use as a dusting powder or as an ointment. Guaiacol cacodylate (2% solution) may be given as a subconjunctival injection (1 c.c.) and may be repeated once in 3—5 or 7 days according to the reaction produced; the injection is painful and so the solution may be combined with novocaine solution before use. The effect is "quick and surprising" according to Pines. Subconjunctival injection of sterilized air has been tried by some with good results. The eye should be shaded with dark glasses or goggles. In intraocular affections, any surgical interference is dangerous and should be avoided. Enucleation of the eye may have to be done if the acute tuberculous process extends and caseation and necrosis have occurred.

(ii) *General*.—Burch advised, in the early stages of retinal and choroidal tuberculous disease, the use of calcium gluconate internally and says that a dose of 1 grain per lb. of body weight of the individual daily is definitely helpful; it is also useful in uveitis and acute iridocyclitis.

If there are active lesions elsewhere in the body, general treatment by a physician is required. Rest in favourable surroundings and under proper climatic conditions with good and nourishing food is necessary. Well regulated sanatorium treatment, with moderate exercise, is beneficial. The patient's powers of resistance should be increased by phototherapy, heliotherapy and careful tuberculin ther-

apy. In all acute cases, absolute rest and antipyretics are essential.

Light therapy-General.—This has been found to be very beneficial in cases of ocular tuberculosis. Duke-Elder sums up his results as follows:—

In tubercular iridocyclitis, the results are more satisfactory than in the infective cases; in early cases, the response is surprisingly rapid; in very advanced cases, it is slow. If there is a tendency in these cases to relapse, the treatment should be continued for some time (a month) longer after the apparent cure. "Ultra-violet light is the treatment of choice for this condition."

In tubercular keratitis, the best treatment is local light therapy, combined with general light therapy.

In phlyctenular keratitis, the results are good. Excellent response is obtained in the average acute cases; in more chronic cases, the response is slower. If the cornea is involved local light treatment is also required. Prophylactic courses after an apparent cure are required. Light treatment is considered a specific for this disease.

Duke Elder says that "this method is an adjunct of considerable value to the ordinary routine therapeutic measures; particularly is this so in tuberculous diseases of all kinds." "There is much to be said for the old Italian proverb." To bathe in water is good, in air better, but in sunlight best of all."

Goulden says, "All those cases of tuberculous iridocyclitis and phlyctenular diseases that have given such striking results occur in children and adolescents; those in which no beneficial result has been seen, have all been patients over 50 years of age."

The optimum effect is obtained with radiation of such intensity as will produce a mild erythema, followed by a fine desquamation over an area, one-fourth of the body surface. An excessive dose induces a negative phase and the hæmobactericidal power diminishes. In acute stages it does more harm than good. Excessive dosage is harmful; do not increase the dosage because improvement is slow.

The dosage is regulated as follows:—Expose four small areas on the body for 2, 4, 6 and 8 minutes respectively, note the result and determine the dose required. The average initial dose with a mercury vapour lamp (K.B.B. atmospheric) running on 220 volts, 2 to 3 amperes, patient sitting at 3 feet distance, is 3 minutes. Divide the body surface into 3 areas, (1) the chest and front of the abdomen; (2) front and back of legs; and (3) the back. Irradiate each one of these three areas in turn during the week (3 exposures a week). Begin with the mercury vapour lamp and gradually raise the dose from 3 to 9 or 12 minutes, according to the tolerance of the patient. After the first few weeks, use the carbon arc lamp. The Royal London Ophthalmic Hospital, uses an arc lamp with one pole of carbon and the other cored with iron and cerium. After three weeks' use of the mercury lamp, the carbon arc lamp is used, the initial dose averaging 15 minutes at a distance of four feet. This is used until 20 treatments in all are given, the duration of exposure increasing from 20 to 25 or 30 minutes. The treatment is then stopped if the condition of the eye permits it—then 2 or 3 weeks of rest is given. A second course is then given if necessary—similar to the first except that the carbon arc is introduced a week or so earlier and the dosage is increased more rapidly. Repeat again

Heart the Innocent.

BY DR. P. S. VARADARAJAN, M. D. (Mad.). M. R. C. P. (Lond.).
Formerly Honorary Physician, Govt. General Hospital, Madras.

This somewhat unusual heading had to be chosen as this alone designates accurately the subject matter of this short paper. At any rate, through this title, no sensation is aimed at, since the very spirit of this paper is to counteract "Sensations" in the field of cardiology. One notices with sincere regret that in recent years there is a morbid interest in the minds of the laity in matters connected with disabled or diseased heart. Further, the unwitting publicity given by the lay press to "deaths due to sudden heart failure" or "acute heart attacks", has acted very adversely on the minds of the introspecting readers inducing obsession neurosis with all its "aches" and "phobias" of the cardiac type. Unless, these people are handled kindly and sympathetically by us, they are bound to be victimised by quacks and other unscrupulous persons.

This preamble has had to be so lengthy, if only to clarify the objective of this paper, *viz.*, place correct facts before the public, if at least to allay the doubts and despairs with reference to the heart—whether healthy or diseased.

If claim for hard and sustained work of all the organs in human physiology, is considered, the heart pre-eminently takes the first place. It begins its work at birth and stops at death. Though the work period and the rest interval are equal, yet the organ has no option to accumulate its rest period.

In an average healthy heart, beating at 75 per minute, each cardiac cycle takes 8/10 of a second; thus the

auricular systole take up 1/10 of a second; the ventricular systole 3/10 of a second and diastole (or rest) takes up 4/10 of a second.

Nature is willing to appreciate the extremely severe test set for the heart and thus allows the heart as much rest as the work it has got to do. But the heart can never accumulate its rest period. The clinical condition known as Strokes-Adams Syndrome clearly indicates the impossibility of the heart being able to rest for even a few seconds. Thus if the cardiac cycle takes up 3 seconds or more, unconsciousness supervenes, if more than 6 seconds twitchings, cyanosis and distended viens point but grimly to the inevitable end. A few seconds of rest—would the heart get it? no, not unless syncope and later death is to be anticipated.

It is worth one's while to consider some cardiac morbidities acquires through compensating for disease elsewhere in the body. The renal heart and the hypertensive heart are two outstanding examples meriting special mentions.

In the first of these conditions, there is a progressive difficulty in the filtration of blood through the kidneys. Most often, the glomerular tuft which has been strangled out of use through fibrosis, permits of no entry of blood (if the process of strangulation is complete). Since in a chronic disease, it is but fair to hope that a few of those filtering units are only partly mutilated still permitting filtration to a varying degree, provided blood can be forced through them. This force can only be achieved through increase in

force of the pump (meaning the heart of course). It is a laudable effort—Heart keeps on hypertrophying, till the unfiltered poisons in the blood cheat the heart muscle out of its well-earned nutrition. The high pressure of blood was needed for forcing the blood through available filters and once the heart muscle begins to decay—the pressure drops. Further filtration is not possible—uræmia sets in prior to final dissolution. Yet one hears of efforts treat a renal heart by therapeutic reduction of pressure!

The other condition, *viz.*, (the heart in essential hypertension) is similar to the renal heart, except that we do not know the identity of the offending source for whose resistance, the heart compensates by hypertrophy and thus helps to increase the pressures which is so essential. The effect of sudden reduction of pressure in this case is even more manifestly harmful than in the renal heart. These examples of help that heart renders to the body when disease exists elsewhere can be multiplied "ad lib—ad naus." Any thoughtless interference with the work of the heart in these conditions is bound to be a misadventure.

Another lot of conditions in which heart is victimised as being responsible for divest groups of pains which have nothing to do with heart are of much practical importance in medical practice. The subject of pseudo-angina merits a very definite chapter in any work of "cardiology". Thanks to ill-assimilated, knowledge on this subject, the sufferers are many. In one large heart clinic, 70 per cent. of patients securing treatment were sufferers from pseudo-angina. This diagnosis was fixed after complete clinical, radiological, electrographical and serological examinations. Unlike Angina-pectoris, vasodilator drugs afford no reliefs, to the sufferer, furnishing thus a therapeutic

test. Two-thirds amongst these were convinced of the non-cardial nature of these pains, and one-third possible needed expert psycho-analytical treatment which was not available. At any rate, this group of cases seemed to have gathered through ill-advised advertisements and alliance with sensation mongers.

Equally unfortunate one among the heart-disease sufferers are those with palpitation. Though palpitation does occur in some diseases of the heart, it can occur equally well in diseases elsewhere as in dyspepsias, diseases of the thyroid gland, and of gall-bladder, septic foci all over the body, etc., etc. The saying, that when a patient complains of palpitation, examine the stomach and when he complains of breathlessness examine the heart—is well worth remembering.

Now we shall pass on to a third group of cases wherein sudden death overtakes an apparently normal person and the heart is incriminated as being diseased without any subjective symptoms or objective evidences. Such a state is almost impossible. Sudden death of cardiac origin can only occur in an individual, who must have had either subjective or objective symptoms (the former alone is possible—but the latter without the former is rare) or both. In a substantial percentage of cases, even clinical evidence is obvious to the discovering age. Often the history of the case furnishes the missing link in the diagnosis of cardiac morbidity. The radiological evidence may be much less helpful than those furnished by the electrocardiogram.

Under the above circumstances it is unfair to call them "Sudden deaths" and to accuse the heart as failing without any warning. So the heart is as innocent as the skull is in a railway accident.

A Case of Scirrhus Carcinoma of Male Breast.

(From Canning Ward under Dr. B. M. Sundaravadanam, F.R.C.S. (Lond.),
Honorary Surgeon, General Hospital, Madras.

BY T. DURAIRAJ, (Final Year).

A patient by name, Muniswamy, male, aged 55 years was admitted into this ward on 1st February 1941.

Complaint and duration.—He complained of a painful lump in his left breast, the duration being three years.

Family History and previous illness.—Nil particular.

History of present illness.—Three years back, the patient first noticed a small nodule round and hard about an inch in diameter just below his left nipple. It was freely movable and it gradually increased in size and became painful. A year and a half back, he was operated in Conjeevaram Hospital and the lump was removed. The pain persisted after the operation in the same region. After four months he again developed a visible nodule, which was hard, behind and below his left nipple. The size of the lump and the pain were increasing slowly.

Condition on admission.—Patient was a fairly well nourished man of 55 years of age. His teeth were dirty and the tongue was clean and moist. He was not anæmic.

Local condition.—On inspection, the lump was situated behind and below the left nipple and axilla. It was globular and its surface was irregular, about four separate nodules were visible. The size was about 3" by 3" by 2". The nipple was stretched and was pushed forward along with the

areola. A scar was seen to the medial aspect of the lump. The skin over the lump was stretched out and thin.

On palpation.—The skin as well as the nipple and areola were adherent to the swelling, which was uniformly hard throughout and nodular with a certain amount of induration all round. The lower border of the pectoralis major muscle was felt to be definitely thickened, as compared to the other side. The swelling appeared to be freely mobile over the chest wall, but on making the patient fix the left pectoral muscle by putting it into strong contraction, the definite limitation of mobility was revealed.

The axillary lymphatic glands were not palpable on either side.

Other systems.—There was no evidence of secondaries in the liver, bones or lungs. His alimentary, circulatory, and respiratory systems were normal.

Diagnosis.—The case was diagnosed as one of scirrhus carcinoma of the left breast based on the following facts.

Signs of malignancy

- (1) History of recurrence.
- (2) Evidence of infiltration as shown by
 - (a) retraction of nipple.
 - (b) Fixity to the skin and pectoral fascia.

Signs of its being of the scirrhus type

(1) Hard and nodular nature of the tumour.

(2) Slow rate of growth and the non-involvement of the regional glands.

Treatment.—6th February 1941. A radical operation for carcinoma of the breast was done on the left side by Dr. B. M. Sundaravadanam under C₂ E₃.

Operation.—An oblique incision was made in the skin starting from the epigastrium and passing towards the tumour, then encircling the tumour about 1½" from its margin all round and finally continued well above the anterior axillary fold.

The skin was reflected on either side leaving the portion covering the tumour.

The fat and fascia were then reflected as a whole from the clavicle and manubrium towards the axilla.

The sterno-coastal portion of the pectoralis major muscle was separated from its clavicular head and its insertion to the bicipital groove of the humerus was then excised.

By careful dissection in the axilla, the fat and fascia were reflected together with the lymphatic glands.

The nerve of Bell and the subscapular nerve were identified and preserved.

After these preliminary steps, all the structures were dissected *en-bloc* including the origins of the pectoralis major and minor with their fascial sheaths, the breast, the tumour with the overlying skin, fat and fascia up to the upper quarter of the sheath of the left rectus abdominis, and excised.

The bleeding that occurred from the perforating branches of the intercostal vessels was controlled by carefully ligaturing them before the cut ends retracted.

Finally the skin edges were approximated and the wound closed with interrupted linen stitches with drainage.

A few nicks were made in the skin to relieve the tension on the suture lines. Patient had a normal convalescence. He was discharged on 26-2-1941 to be treated as an out-patient with a course of deep X-rays. The movements of his left arm were practically normal on the day of discharge.

Pathological report.—Spheroidal cell carcinoma with infiltration of lymph node.

(My thanks are due to Dr. B. M. Sundaravadanam for his help and permission to report this case.)

A Case of Sub Acute Bacterial Endocarditis.

(From DR. V. C. G. MENON'S WARD.)

Balakrishnan, H. M. Age 20 was admitted on 29-12-1940.

Complaint.—Fever with pain and swelling of right wrist and elbow joints. Duration:—10 days.

Previous illness.—had frequent attacks of fever with slight pain in joints; three months ago.

(2) History of burns of both legs about one month ago which mostly healed.

Habits.—Vegetarian, not addicted to drink, but smokes.

Family history.—Nil relevant.

History of present illness.—Fever started ten days ago. The previous day patient had felt out of sorts. The fever was accompanied by swelling of the right ankles with severe pain and tenderness. Two days later as the swelling and pain in the ankle were subsiding, the right knee joint was involved. Since then the pain and swelling have been fleeting from joint to joint, at present the right wrist and elbow are affected.

Condition on admission.—Patient looks very ill, moderate wasting temperature 102° F,—looks anæmic,—no jaundice or cyanosis—no clubbing of fingers—no dyspnoea—no oedema, lymph nodes not enlarged—Right wrist and elbow joints are swollen, painful and acutely tender—no pigmentation seen anywhere except over the healed areas of burns of the two

legs. There was one small area on the right leg healing under scab, apparently not septic.

Patient was very toxic with low muttering delirium.

Cardio-vascular System.—Pulse 125 per minute, volume and tension moderate. Apex beat visible and palpable in the left 5th intercostal space first external to the cardiovascular line and slightly heaving on character. A systolic thrill was felt over the mitral area and a stronger systolic thrill over the Aortic area.

Border.—Left—just external to the mid-clavicular line; right—right lateral sternal line.

Upper.—3rd intercostal space in left parasternal line.

Sounds.—1st sound strong in mitral area and 2nd sound accenuated in pulmonary area and faintly heard in Aortic area.

A systolic murmur heard in all the areas, but rough over the aortic area and conducted upwards to the neck—The systolic murmur was moderately conducted to the axilla.

B. P.—88/68 mm. Hg.

Respiratory system—did not reveal any abnormality.

Alimentary system—Lips were dry and cracked—Teeth dirty, tongue dry and furred.

A Case of Sub Acute Bacterial Endocarditis

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Abdomen was scaphoid, liver and spleen not palpable.

Investigations done: Blood:—Moderate Leucocytosis, total W.B.C. 10,000 per c.m.m.

Urine:—No abnormality except triple phosphates.

Progress and treatment

29-12-1940.—Provisional diagnosis of Rheumatic fever with endo-carditis was made—and he was prescribed soda salicyles 3 $\bar{\bar{u}}$ for the day in mixture and paradehyde 3 $\bar{\bar{u}}$ twice, to control delirium.

30-12-1940.—Delirium better; Splinter hæmorrhages were noted on right index finger. Pt. was put on M. & B. 693; 10 tablets for the day. Blood sent for culture before M. & B. 693 was given.

31-12-1940.—Fresh splinter hæmorrhages were seen on left index and little finger; delirium was less.

1-1-1941.—There was violent vomiting—M. and B. 693 was stopped.

2-1-1941.—Temperature 99°. Liver and spleen were not palpable—fresh petæchial hæmorrhages were seen in the left little and right index fingers—Fresh splinter hæmorrhage in left ring finger nail was also seen. A fresh systolic harsh murmur was heard for the first time in the pulmonary area—aortic systolic murmur was louder. Heart rate was less than better

3-1-1941.—Temperature 101.6° F. Fresh splinter hæmorrhages were noted under both the thumb nails. Pulse: volume and tension poor. Rate 120 p.m. The pulmonary and aortic systolic murmurs were rougher than

before but pulmonary 2nd sound was softer. Spleen was not palpable—pt. looked delirious.

4-1-1941.—General condition was poor. Temperature 99. Pulse 100. Volume and tension poor. Left middle and ring fingers and right index finger showed fresh splinter hæmorrhages. A big hæmorrhagic bleb on the left little finger as well as hæmorrhagic on the back of left forearm were noted. Heart showed no alterations in sounds; Patient was not so delirious. Patient passed malena twice by night.

5 & 6th.—Condition was same but weaker—temperature was kept almost normal.

7-1-41.—Temperature shot up—patient was sinking and died at 9 A.M. on the same day.

Investigations done

30-12-1940.—Blood culture non-hemolytic streptococci grown in culture.

2-12-1940.—Urine culture negative for organisms.

Urine on 29-12-1940.—No abnormalities.

On **4-1-1941.**—alb +; R. B. C. + + granular cast + + acetone + Triple phosphates + + +: sugar absent and urine continued to be frankly hæmorrhagic till almost the end.

Ophthalmoscopic.—Examination was not done as the patient was not co-operating due to delirium.

M and B. 693 soluble 3cc, Intramuscularly was given every 6 hours from the 3rd till the end, accompanied by glucose intravenously once daily.

Diagnosis.—A provisional diagnosis of rheumatic fever with carditis and fleeting arthritis was made. But a keen look out was kept for embolic phenomenon and the first splinter hæmorrhages was noticed the very next day. The bacteriological report of isolation of non-hæmolytic streptococci from his blood, confirmed the diagnosis although by that time evidences of fresh embolic phenomena in other situation crowded in upon us—under the skin as petechiæ as well as nodes—in the kidneys, frank hæmaturia and malena from the gastro-intestinal tract.

The appearance of a new pulmonary systolic murmur with changes in the character and intensity of the already existing murmurs, still further confirmed the diagnosis of Subacute Bacterial Endocarditis. From the rapidly fatal termination, one could well label

it as malignant endocarditis but for the non-hæmolytic type of organism grown in the case. Sulphapyridine drug administered in this case brought down the temperature, but the case did not live long enough to judge the effects of continued administration.

It is said that a primary focus of infection is usually lacking in subacute bacterial endocarditis, but that some such focus is normally apparent in the malignant variety. In this case, the presence of the wide scared area after burns on the legs with the still healing small area in one of them, make one feel that probably the activating infection may have started from this area.

I thank Dr. V. C. Govinda Menon for permitting me to report this case and Dr. Vaidyanatha Iyer for his invaluable guidance and help in the writing of this article.

The Madras Medical College Magazine.



WHILE apologising for the delay in the publication of the journal, we request the readers to take into consideration the fact that the preoccupation of the 'Varsity Examinations has in no uncertain measure damped the ardour of many of our contributors. Nevertheless a few that have sent us matter for publication shall have the satisfaction of seeing the contributions being printed *in toto* without any censor or 'cut'.

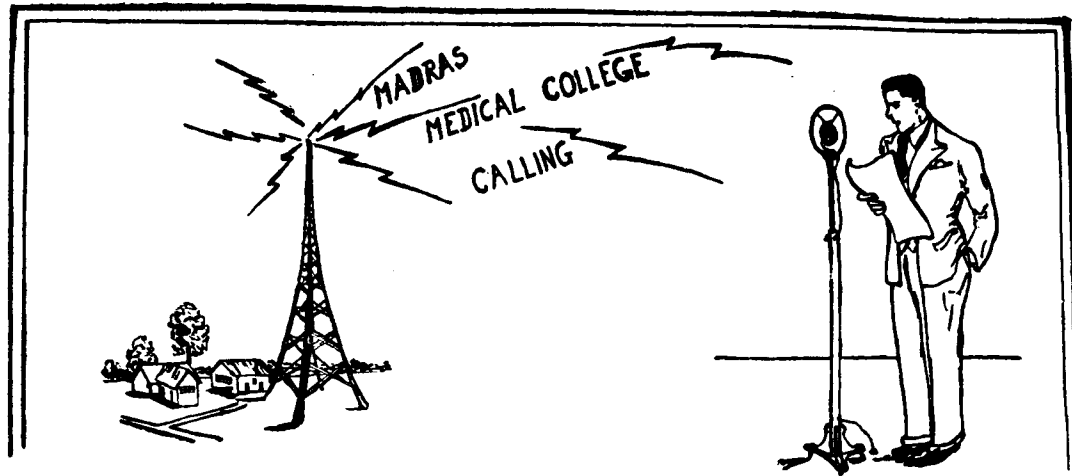
Incidentally, a few readers of this journal picked out at random were asked to express their views regarding the types of matter they like to read in the journal without fear or favour. Their views merit a reference here if only as a guide to editors in future. They are: (1) they wish to see short clinical notes by

students entirely made up by their observation on cases without any padding or dressing which may be inspired by books or the members of the staff. (2) Short stories with little or no relation to medico in general are not wanted. Indeed, a few desire the total omission of these type of matter. (3) One act plays with some medical interest are better tolerated especially when there is one in each issue.

(4) They are not in favour of the staff making large inroads into the limited space of the journal; while they do appreciate a brief article or two of the staff lending tone and character.

We hope to be able to publish more views on this subject in our next issue.

EDITOR.



Dique

THE MADRAS MEDICAL COLLEGE FINE ARTS SOCIETY.

Time and again we have been urging for the maintenance of a Dramatic Club in these columns and indeed it was very gratifying to see the birth of such on 1st March 1941. It was rather a red-letter day of our college. After the annual sports were over, we had a "Costume" dinner which was well attended. Shortly after dinner the General Secretary in his speech mentioned the necessity of starting A Fine Arts Club. He stated that under the Fine Arts Club, such of those who possess real talents would be encouraged in all possible ways. Further the trouble of hunting down the actors and actresses for the variety entertainment, would be much mitigated. Apart from these, the Fine Arts Club could put on board a variety entertainment and collect funds for improving the amenities of our Association. After concluding his speech for the necessity of a Fine Arts Club, he requested Dr. A. L. Mudaliar to inaugurate the Club.

Dr. A. L. Mudaliar in declaring it open stressed the importance of such

a Club and hoped that this Fine Arts Club would survive infantile mortality and grow up into a graceful girl and in course of time would woo ardent enthusiasts and real workers for the successful careering.

To obviate the necessity of holding election, due to lack of time in this examination period, the following persons were nominated to hold office for a period of one year.

President

Ex-Officio President of M. M. C. Association.

Vice-Presidents :

Dr. D. Govinda Reddy, M.D. and Dr. T. Janardhanam, M.B., B.S.

Hony. Treasurer :

Dr. K. N. Krishnan, B.A., M.B., B.S.

Joint Secretaries :

Miss Ruby Verghese and Mr. U. Ananda Rao.

Ex-Officio Secretary.

The General Secretary, M. M. C. Association.

Committee Members :

Miss K. C. Thangamma.
 „ P. V. Janaki.
 „ Indrani Chandran.
 Mr. Amareswara Rao.
 „ Satyanarayana.
 „ Venkatappa.

The following are the bye-laws of the Society.

1. The Society shall be called "Madras Medical College Fine Arts Society." It shall be an affiliated body of the M. M. C. Association.

2. *Aims and Ideals.*—To promote the histrionic talents of its members.

3. Membership :—

(a) Membership of the Society shall be opened to the students of the Madras Medical College, members of the Staff of the College and all members of the staff (including House-Surgeons) of all affiliated hospitals.

(b) There shall be three classes of membership.

(1) Patrons—who are life members.

(2) Staff:—Consisting of all the members of staff.

(3) Ordinary:—All students of the Madras Medical College.

(c) The subscription shall be :—

Rupees Twenty five (Rs. 25) for life members.

Rupees Five (Rs. 5) per annum for a staff member.

Rupees two (Rs. 2) per annum for demonstrator and House-Surgeons.

Rupee one (Rs. 1) per annum for an ordinary member.

4. The affairs of the Society shall be managed by a committee elected

by the members of the Society at the end of each academic year.

5. The managing committee with power to co-opt shall consist of.

(a) A President—Ex-officio President of the M. M. C. Association.

(b) Two Vice-Presidents—Elected from among the staff members.

(c) General Secretary—Ex-officio General Secretary of the M. M. C. Association.

(d) Two Joint Secretaries who shall be elected from among the ordinary members of the Society, of whom one shall be a lady student.

(e) The Treasurer—The Treasurer of the M. M. C. Association to be the treasurer of the Society.

(f) Six committee members who shall be elected from among the ordinary members of whom three shall be lady students.

6. The activities of the society shall consist of :—

(a) Staging at least two variety entertainments every year, one in connection with the Graduates' Reception and another at any convenient time for the purpose of collecting funds for the Society or for any other purpose connected with the improvement of the Social amenities of the students.

(b) To acquire the necessary theatrical equipment like curtains, musical instruments, dresses, etc.

(c) To maintain a regular orchestra of the College.

(d) Such other activities connected with the society as may be found necessary from time to time and approved by the Executive Committee.

7. Participation in the activities of the society shall be open only to the

members of the Society, but non-members may be allowed on the approval of the Joint Secretaries.

8. Finance :

- (1) The funds of the society shall rest with the managing committee who shall spend it as it deems fit.
- (2) All the property of the society shall be in the immediate charge of the Joint Secretaries.
- (3) The accounts shall be audited at the end of each year by an auditor approved by the Managing Committee.
9. The quorum for a general body meeting shall be at least twenty.
10. These rules shall not be altered unless at least 75 per cent. of the members present at a general body meeting vote in favour.

THE ANNUAL SPORTS.

The College Annual Sports were held on 1st March 1941 under the distinguished Presidency of the Hon'ble Justice Sir Abdur Rahman, Kt., Judge of the High Court.

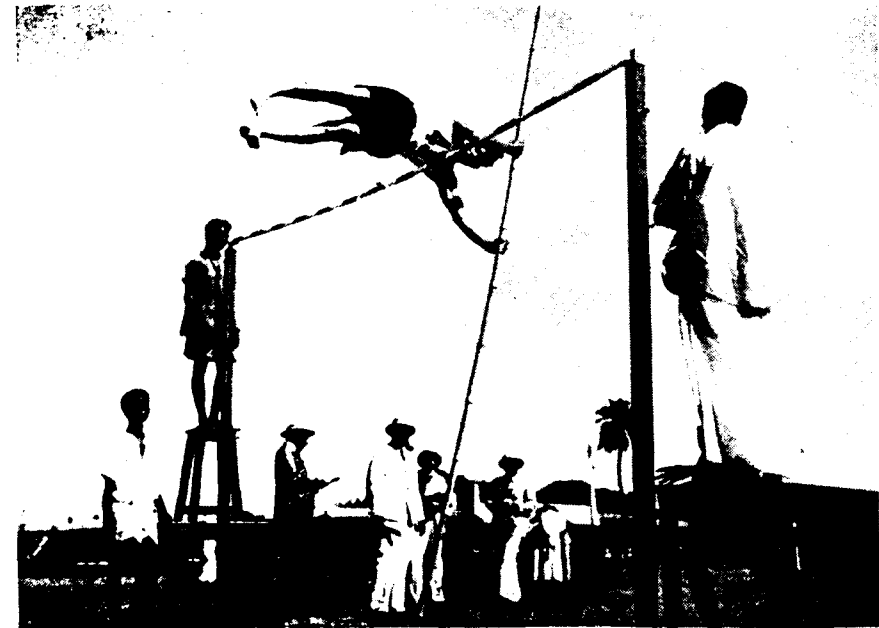
Dr. S. Ramakrishnan, President of the Athletic Association stated ;

" This has been a rather lean year for us as an institution, but we have no cause to be unduly depressed seeing that many of our students distinguished themselves individually in representative games and athletic meets.

" In hockey, the medical college won the Stokes Shield for the second year in succession in the Inter-Collegiate knockout tournament and finished as runners-up in the Panagal Cup and the Mysore Cup league tournaments. In the Chettinad tournament, our "A" team has reached the final and

the "B" team has come up to the semi-final and we are hoping for an all medical final. Many of our players distinguished themselves in representative hockey. B. J. Pereira, P. V. Krishnamurthi, D. Harirajan and E. F. Harben were selected to take part in the Pentangular Tournament in aid of H. E. the Governor's War Fund. Our supremacy in hockey found fitting recognition when as many as seven of our players viz., B. Carvalho, B. Ince, P. V. Krishnamurthi, D. Nugent, B. J. Pereira, E. Harben and E. S. Linton were selected to represent the Madras University in the South Zone Final of the Inter-Varsity Tournament at Bangalore and the first four mentioned above were again chosen to play for Madras in the Inter-Varsity Semi-final played recently at Lucknow.

" Many of the members of the College Cricket team being in the final year, we were unable to turn out our regular side for the Inter-Collegiate Tournament. Despite this we did well enough to be runners-up in the Pennyquick Trophy League Tournament. A. K. Haridas and A. V. Rajagopalan were chosen to play for the Madras Junior XI against the Mysore Junior XI, Haridas captaining the Madras side. Again A. V. Rajagopalan and M. Muthukumaraswami were selected to play for Madras University in the South Zone Final of the Inter-Varsity Tournament at Bangalore. Some of our players have been doing remarkably well in the First Division League in Madras and special mention must be made of the splendid batting by A. K. Haridas who, playing for T. C. C. against the M. & S. M. Railway, hit up a century before lunch. Our best bowler V. Padmanabhan who contributed to many of our successes deserves special mention.



Pole-Vault: Punja Clearing in Fine Style.



Staff: Tug-of-War.



High-jump: V. P. Naidu.



Staff Mixed Race.



Ladies 80 Yards Race: Start.

Our Foot-ball team, though yet young, has been improving with every match and did extremely well to reach the final of the Wilson Cup knock-out Tournament.

The Athletic team took part in the Inter-Collegiate Athletic Meet at Annamalainagar. B. J. Pereira, distinguished himself by winning the individual championship and our team finished as runners-up. A. J. Nicholas, N. J. Punja and B. Carvalho were selected to represent the M. M. C. A., in the Madras Olympics.

"For the first time, most of our boxers entered for the Inter-Collegiate Boxing Tournament and were runners-up, losing by a very narrow margin of 2 points. L. G. Bartley and G. W. D'Sena were winners in their respective weights.

"The ladies have fared even better this year. In fact they have done remarkably well. Our College represented by Misses. Thankam, Devi, Durgambal, Lakshmibhanamma and Leelavathi Bal, won the Inter-Collegiate Badminton final. Miss Hughes and Miss. Leelavathi Bal, representing the College, won the Inter-Collegiate Tennis Doubles for the fifth year in successions. Miss. N. Hughes won the Junior Championship and was runner-up in the Cubbon Park Tennis Tourney at Bangalore.

"Though our record for the year may not reveal glittering triumphs yet we put up a good show in all the events in which we participated. We have always endeavoured to live up to the best sporting traditions knowing that the game is even greater than the Prize.

"Ladies and Gentlemen: I am certain you will join me in heartily

congratulating the medical college athletes and wishing them continued success in future."

After the report was read over, Dr. A. L. Mudaliar, Principal of Madras Medical College welcomed the distinguished guest and requested him to address the students assembled on the lawns. Later Mrs. McRoberts distributed the prizes to the winners and runners-up.

ASSOCIATION NEWS.

The last general body meeting was held on 4th March 1941 by the outgoing General Secretary in the Common Hall with Dr. A. S. Mannadi Nayar, M.B., B.S., Ph.D. as the President.

Due to unforeseen circumstances, the annual report could not be read. Later a resolution that "this general body of the M. M. C. Association recognises the Madras Medical College Fine Arts Society as an affiliated body of the M. M. C. Association and approves the nominations of the Managing Committee" proposed by Mr. P. C. Reddy and seconded by Mr. P. R. Balakrishnan was passed unanimously.

The nomination for the Sports Secretary and Captains for the various games were called for and the following were elected unanimously.

Sports Secretary—Mr. V. P. Nayudu.

Captains:—

(a) Hockey—Mr. B. D. L. Carvalho.

(b) Cricket—Mr. Herbert Gnana Olivu.

(c) Tennis—Mr. George Thomas.

(d) Boxing—Mr. L. G. St. Clair Bartley.

(Continued on page 191).

THE MADRAS MEDICAL COLLEGE

EVENTS	FIRST	SECOND
1 400 Metres Hurdles	A. J. Nicholas	B. E. G. Garson
2 16 LBS Shot Put	J. C. A. Dique	J. A. Muthiah
3 16 LBS Hammer Throw	J. A. Muthiah	J. C. A. Dique
4 800 Metres Race	K. R. Ganesh	N. Kappini
5 Discus Throw	T. L. W. McCullagh	G. W. D'Sena
6 Hop Step and Jump	L. M. Hogg	K. N. Kothnath
7 200 Metres Hurdles	C. B. Alexander	A. J. Nicholas
8 Tug-of-War (<i>Inter-Class</i>)	Fourth year	First year
9 110 Metres Hurdles	B. D. L. Carvalho	E. F. G. Harben
10 Javelin Throw	J. A. Muthiah	J. T. Marshall
11 Pole-Vault	N. J. Punja	G. Herbert
12 100 Metres Race	A. J. Nicholas	C. B. Alexander
13 Servants Race Club Boys Race	John Samuel M. Angamuthu	Marimuthu A. Doss
14 Long Jump	C. B. Alexander	D. A. W. Nugent
15 Ladies 100 Metres Race (<i>College and Hospital</i>)	Miss. U. Hargreaves	Miss. T. Jayalakshmi
16 U. T. C. Alarm Race	Cpl. Velu	Cpl. Arunagiri
17 200 Metres Race	A. J. Nicholas	C. B. Alexander
18 Ladies Three-Legged Race	Miss. H. Welsh and Miss. C. N. McRobert	Miss. T. Jayalakshmi and Miss. B. Mukambu
19 1,500 Metres Race	K. R. Ganesh	Kappini
20 High Jump	V. P. Naidu	L. M. Hogg
21 Old Students Race (<i>Handicap</i>)	M. M. Hussein	Dr. C. Raghavachari
22 400 Metres Race	B. E. G. Garson	A. J. Nicholas
23 Students Mixed Race	Hogg and Miss. N. Hughes	MacCullagh & Miss Hargreaves
24 4 × 200 Metres Relay Race (<i>Inter-Class</i>)	Second year	First year
25 Staff Mixed Race	Dr. Roy and Miss. Achiah	Dr. Basir and Miss. K. Westwood
26 4 × 200 Metres Relay Race (<i>Open</i>)	Christian	Stanley Medical
27 Tug-of-War (<i>Profs. vs Assts.</i>)	Dr. Mannadi Nayar's Team	
28 Sack-Fight	T. J. Cherian	Sebastian
29 Disguise Competition	(Pregnant Woman) C. R. Suryanarayan	(Cripple) S. Suryanarayanan

Champion Athlete :—Rolling Cup presented by Lt.-Col. K. G. Pandalai, I.M.S.

Individual Athlete :—Cup presented by Rao Bahadur Dr. S. Ramakrishnan,

ANNUAL SPORTS 1st MARCH 1941.

THIRD	FOURTH	TIME, HEIGHT OR DISTANCE	RECORD HOLDER
N. J. Punja	E. F. Harben	66 Sec.	59'8 Sec. B. J. Pereira
D. A. W. Nugent	E. M. Wilson	33 Ft. 8 In. (New Record) J. C. A. Dique	33 Ft. 2½ In. E. P. O'Neill
G. W. D'Sena	D. A. W. Nugent	87 Ft. 3 In. (New Record) J. A. Muthiah	82 Ft. 2 In. G. W. Bird
B. E. G. Garson	D. Lakshmanan	2 Min. 21 Sec.	2 Min. 13 Sec. B. J. Pereira
J. A. Muthiah	A. J. Brafield	86 Ft.	102 Ft. 11 In. D. J. Toomey
E. F. Harben	C. B. Alexander	38 Ft. 1½ In.	43 Ft. 11 In. S. F. D'Costa
C. R. Suryanarayana	E. F. Harben	29 Sec.	27'6 Sec. B. J. Pereira
C. R. Suryanarayana	G. Crosse	18'8 Sec.	16'6 Sec. B. J. Pereira
L. G. Bartley	W. S. Hart	132 Ft. (New Record) J. A. Muthiah	127 Ft. 8 In. L. M. Hogg
T. J. Cherian		9 Ft. 10½ In.	9 Ft. 10½ In. N. J. Punja
L. M. Hogg	D. A. W. Nugent	12 Sec.	11'2 Sec. A. J. Ralston
Kothandapani V. N. Muthu			
E. R. Hensman		19 Ft. 10 In.	22 Ft. 2½ In. S. E. D'Costa
Miss H. Welsh		14 Sec. (New Record)	
D. A. W. Nugent	G. Herbert	24'4 Sec. (Equalled Record)	24'4 Sec. F. J. Satur & B. J. Pereira
		11 Sec.	
B. E. Garson		5 Min. ½ Sec.	4 Min. 50'4 Sec. R. A. Jansen
T. J. Cherian & N. J. Punja	(Tie.)	5 Ft. 1½ In.	5 Ft. 7 In. S. F. D'Costa
Dr. V. Bayliss			
G. Herbert	G. F. Perry	57'6 Sec.	54'8 Sec. A. J. Nicholas
		1 Min. 42 Sec.	
Pachiyappas			1 Min. 35'8 Sec. M. M. C.
P. T. Balarama Varma			
Pakistan Krishna Reddy			
Holder :—B. J. Pereira.			
A. J. Nicholas, IV year			

INTRA-MURAL COMPETITIONS.

CRICKET

(Rolling Cup presented by Dr. N. Mangesh Rao)	Winners: (V years) Runners: (III years)
Best Batsman of the year (Cup presented by Gordon & Co., Ltd., Printers)	A. V. Rajagopalan
Best Bowler of the year (Cup presented by Dr. A. S. Mannadi Nayar)	V. Padmanabhan

FOOTBALL

(Rolling Cup presented by Dr. S. Ramakrishnan)	Winners: (II years) Runners-up: (V years)
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HOCKEY

(Rolling Cup presented by Dr. R. K. Chettur)	Winners: (II years) Runners-up: (V years)
Tennis Singles (Open) (Gents) (Cup presented by Kota Alwar Chetty)	Winner: P. P. Paulose Runner-up: A. Poornan
Tennis Singles (Club)	Winner: K. Bhaskar Runner-up: B. Krishnamoorthy
Tennis Doubles (Open) (Gents) (Cups presented by Dr. P. V. Cherian and Dr. C. P. V. Menon)	Winners: P. P. Paulose and A. K. Haridas (V years) Runners-up: Dr. C. Raghava Acharya and Mr. B. L. Ranganathan (Staff)
Tennis Doubles (Club) (Cups presented by Dr. B. M. Sundara Vadanam)	Winners: P. S. Babu Naidu and K. Bhaskar Runners-up: N. J. Punja and S. Venkataraman
Tennis Singles (Ladies) (Cup presented by Dr. S. K. Menon)	Winner: Miss Noreen Hughes Runner-up: Miss. Nora Catherine McRobert
Tennis Doubles (Ladies) (Cups presented by Dr. A. L. Mudaliar)	Winners: Miss. L. Ball and Miss. N. C. McRobert Runners-up: Miss. S. Sarada and Miss. L. Bhanamma
Tennis Mixed Doubles (Cups presented by Dr. N. M. Rao and Dr. J. C. David)	Winners: Miss. N. Hughes and Mr. G. Thomas Runners-up: Miss. N. C. McRobert and Mr. S. Zacharias
Tennikoit (Inter-Class—Ladies)	Winners: Fourth years Runners-up: First year
Badminton (Inter-Class—Ladies)	Winners: Final years Runners-up: First years

Varsity Blues, Cricket:—A. V. Rajagopalan (1940), M. Muthukumaraswami (1940), A. K. Haridas (1939) and L. M. Hogg (1938).

Hockey:—B. J. Pereira, P. V. Krishnamoorthy, B. W. J. Ince, D. A. W. Nugent, B. D. L. Carvalho, E. F. Harben and E. S. Linton.

(e) Field and track Events—Mr. C. B. Alexander.

Two candidates contested for the General Secretaryship for the year 1941-42.

(a) Mr. A. G. Leelakrishnan was proposed by Mr. C. Balakrishnan and seconded by Mr. H. S. Nayak.

(b) Mr. T. Nandagopal was proposed by Mr. Augustus Appadurai and seconded by Mr. Cooper. The election by secret ballot was held on 6th March 1941 and Mr. T. Nandagopal was declared elected by a majority of 287 votes.

A general body meeting was held on 21st March 1941 in the Anatomy Lecture Hall with Dr. A. S. Mannadi Nayar on the Chair to condole the untimely death of Dr. P. K. Koshy, Professor of Anatomy, Madras Medical College.

Messrs. K. N. Alva, C. Balakrishnan and Kappini referred to the life of late Prof. Koshy and spoke in terms of praise the valuable services rendered to the Anatomy department by him. Mr. K. N. Alva in his speech desired that a "Koshy Memorial Fund" should be started and urged the students and members of the staff to contribute liberally for the same; he hoped that in near future, the M. M. C. Association would do the actual

spade work and raise up a suitable memorial.

A resolution of condolence "The General Body Meeting places on record its deep sense of sorrow and regret at the untimely death of Dr. P. K. Koshy, B.A., M.B.B.S., F. R. C. P. (Edin.), Prof. of Anatomy, Madras Medical College and authorises the General Secretary to convey the message to the members of the bereaved family" was proposed from the chair and passed unanimously—all the members standing in mute silence to the memory of the dead.

PERSONAL.

Major-General N. M. Wilson, C.I.E., O.B.E., K.H.S., I.M.S., Surgeon-General with the Government of Madras has retired after a long and meritorious service.

Col. H. Stott, O.B.E., K.H.S., I.M.S., has been appointed as Surgeon-General with the Government of Madras vice Major-General N. M. Wilson retired.

Lt.-Col. V. Mahadevan, F.R.C.P. (Edin.), F.R.C.S. (Edin.), I. M. S., Prof. of Operative Surgery has been called for active Military Service.

Dr. C. Raghavachari, F.R.C.S. (Edin.), has been appointed as First Surgeon and Prof. of Surgery, Stanley Medical College.

Student Editors.

Late Prof. P. K. Koshy, B.A., M.B.B.S., F.R.C.P. (Edin.)

Alas! What a tragedy it is that has befallen to this institution by the death of Prof. Koshy. Few of us could dream that he would be so early snatched away from our midst. True, he was ailing for a few months before his death, and everybody thought, he would pull thro' safely, but the inevitable had happened.

Born of respectable parents in the year 1885, late Prof. Koshy had an uniformly successful College Career, and after taking his degree both in Arts and Medicine of this University he served in the Madras Medical Department since 1917. Immediately after joining the department, he volunteered for Military Service and held a temporary commission for a period of three years. In 1923, he joined the teaching staff of the Medical College. In 1927, he proceeded to England for special study in Anatomy and obtained there the Membership of Royal College of Physicians of Edinburgh by Examination with Advanced Anatomy as his special subject. On his return, he joined the Anatomy Department. In 1931, he was appointed as the Professor of Anatomy, which post he held till almost the time of his death. At the time of retirement he was of indifferent health. In spite of the best medical help rendered, Prof. Koshy breathed his last on 19th March 1941.

His Contributions to the Museum.

By his death, we have lost one of the ablest Professors of this College and a real guide of the Anatomy Department. His valuable contributions to the Department of Anatomy and to the Museum in particular, none

could deny. If to-day the Museum stands at the present exalted position as the best in the East, it really owes a deep depth of gratitude to late Prof. Koshy for his able reorganizing capacity and for his untiring zeal and energy. Doctors from various parts of India and World and students from other universities looked with wonder and appreciation at the numerous specimens contained in the Museum. There were not a few who envied at the rare opportunity of the students of this College, who could command the usefulness of the Museum.

It was all due to Prof. Koshy's able guidance and his sincerity for his work. His sincerity was such, that he denied himself the comforts and happiness which others in his position would have had. Even after retiring, one could see him daily pacing up and down the theatre slowly or smuggled up on a stool dissecting over a basing brains. Indeed he defied the disease, he defied the doctors and he defied death for the sake of the department. Perhaps he could have survived the disease and lived for a few more years, if he had cared to. It looked as though his sincerity was the very cause of his death.

In realms of research, he was not lagging behind. Nothing abnormal would pass unnoticed from under his eagle's eyes. His eminence as a researcher was recognized by his election to the fellowship of the Royal College of Physicians of Edinburgh.

In Memoriam



PROF. P. K. KOSHY, B.A., M.B.B.S., F.R.C.P. (Edin.)

A PAINSTAKING TEACHER.

As a painstaking teacher, who could surpass him. Those of us who had the fortune of attending his classes could never forget the way, he taught us. He was almost practical in his teachings and simple in his expressions. His searching looks were ever on the watch and not a few felt the smarting glance of his when unwary or unattentive. To the intelligent, he was encouraging, to the chronic he was sympathetic, to the naughty he was stern and to the novice he was helping.

Alas! in his death, this Anatomy Department has lost its guiding spirit, this College one of its ablest and admirable professors and this profession one of its ardent votaries.

May his soul rest in peace at the feet of the Almighty.

General Secretary,
M. M. C. Association.

'AN APPRECIATION'.

By R. Ganesan, III Year.

"The Professor", what an electrical effect these words used to have on the tumultuous groups of students! No sooner these words were passed on than the whole theatre used to become quiet and you could see the students get very enthusiastic about their work. No one used to escape his scrutinizing eyes. From behind the gold-rimmed spectacle he used to study each student. If there was anyone who could refute the statement that Professors of to-day do not take any personal interest in their students it was the late Dr. Koshy. He had a remarkable memory for names and faces. He was a walking dictionary both of Anatomy and students. His whole life was dedicated to Anatomy Department and to its teaching and hence he can never be forgotten. "He lives, he wakes, it is death that is dead not he."

In his death we lose one of the greatest of Professors of all times. His greatness was mainly due to his proficiency in the practical aspect of science, purity of heart, simplicity and devotion to truth. He had a determined conviction that Anatomy should be studied in the dissection theatre and not in one's room. He was unquestionably responsible for the development of the rational study of Anatomy. He was a man of immense vitality and his enthusiasm was contagious and every student was stimulated to work when they saw him spend hour after hour with a brain before him tracing every fibre to its final destination. His joy knew no bounds when he discovered an abnormal tract. He would call in all his assistants and show them the deviation from the course allotted to them in the text-books. His aim was to make Anatomy a practical subject and not an "Ethereal one." His indefatigable energy and interest were responsible for the daily changes in the museum which has given rise to the best museum in the East. Every specimen there was to him a precious jewel and to use his own words "Every specimen is worth its weight in gold." The whole of Gray's Anatomy was explained by means of actual specimens and for this great deed posterity would ever be grateful to that good old Professor who sacrificed his life for the sake of Anatomy. And in Koshy's death it appears as if the last and lingering genius—the genius of the 'Dead house' has expired for ever.

' Now the labourer's task is over
Now the battle day is past
Now upon the farther shore
Lands the voyager at last.

There the tears of earth are dried
There its hidden things are clear
There the work of life is tried
By a Juster Judge than here.

Father, in Thy gracious keeping
Leave we now, Thy servant sleeping."

A Rare Complication in Labour Case Report.

MRS. KAMALAM M. MENON, M.B.B.S.,

Lady Elgin Hospital, Gaya.

Recto Vaginal fistula as a result of bad obstetrics is a rather common occurrence. But complication in labour due to R. V. F. either before or after operation is rare and the following case is of interest in that respect.

A woman aged 25 years 2nd. para full term pregnant was admitted on 4th January at 8 p. m. with the following history. Labour began at 6 p. m. 3rd January. Patient said that she started from home 6 hours after pain started. The membranes ruptured on the way and the head started coming through the anus. She had to travel 50 miles by bus from her village to this place.

Previous history.—Previous labours. Full term natural-delivery 2 years ago. The patient was in labour for four days and delivered a still born child 2 days after rupture of the membranes. History of R. V. F. since then and for which the patient was operated at Patna one year ago. The operation was successful and she had no trouble after that.

Condition on admission.—Having strong uterine pains and rather restless. Pulse feeble and thready 130 per min.

Abdominal palpation.—Uterus tense and not relaxing foetal parts could not be palpated. F. H. absent. P. V. foetal head showing at vulva and protruding through the anus which was dilated to diameter of 2".

There was only a layer of skin separating the orifices of the vagina and anus. Cord nipped in between the pubis and the foetal head. No pulsation of the cord.

Measurements. I. S. $8\frac{1}{2}$ " I. C. $9\frac{1}{4}$ " E. C. $6\frac{1}{2}$ ".

Treatment.—Under chloroform anaesthesia a small lateral episiotomy was done and the head pushed up and from the anus. Low forceps was applied and a dead female child extracted easily. On a second examination it was seen that the whole of the posterior wall of the vagina, perineum and the anterior wall of the rectum were torn completely right up to fornix with the result that the vagina and rectum was converted into one single cavity. The episiotomy wound was sutured with silk-worm gut. Repairs of the torn vagina and rectum could not be done as the tissues were lacerated very badly and could not be brought together.

Progress.—Pulse and general condition improved by the 2nd day. She had septic temperature for a week for which she was put on Sulphonilamide therapy. Lochia was very much offensive due to the sloughing of the lacerated tissues and the faeces which was leaking through the vagina. She was discharged from the hospital on the 34th day. Her general condition was fairly good and she had some amount of control of faeces when it was of solid consistency. Examination

A Rare Complication in Labour Case Report

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tion per vagina showed a large recto vaginal fistula extending right up to a level slightly higher than the posterior fornix. The skin in the perineal region was intact separating the vaginal and anal orifices.

Remarks.—The weak recto vaginal septum (after operation) must have given way due to the presence of the foetal head. The sitting posture during the long journey by bus must have been an additional factor.

The patient was advised to go to Patna Hospital after 3 months and most probably her condition may need a permanent Colostomy.

My thanks are due to Superintendent for allowing me to report this case.

Nocturnal Counterpart of "Building Castles in the Air."

BY MR. B. KRISHNAMURTHY

I Year, Medico.

Most of our people are quite accustomed to think that dreams have got a prophetic value and that more often than not they are harbingers of future application and impending disaster, yet others think that they are physical processes, always useless and in many cases actually morbid. To this latter class belong our brethren the members of the honourable profession of Medicine. In the one case the misconception is due to ignorance and superstition whereas in the other it is due to blindness of certain established facts and lack of perceptibility. If then, both these conceptions are wrong, what is the real nature of a dream? What is its cause? and what is its purpose? The answers to these apparently puzzling questions have been investigated in a brilliant and more or less exhaustive manner by one of the greatest scientists of the late 19th and early 20th centuries, Sigmund Freud. After a long life devoted to the unravelling of mysteries associated with the workings of the mind, this great German genius discovered that after all there is nothing very mysterious about dreams in general. In this article I would endeavour to answer the above three questions in a very brief manner.

The first common characteristic of all dreams is that we are asleep at the time. What is sleep? Sleep is a

condition in which we refuse to have anything to do with the outer world and have withdrawn our interest from it. The biological object of sleep seems to be recuperation, its psychological characteristic the suspension of interest in the outer world. We believe that dreamless sleep is the best, the only proper sleep. There should be no mental activity during sleep, if any such actually bestirs itself, then we have failed to realise the ideal state of sleep. Why does not mental life go to sleep? It is because there is something that will not leave the mind in peace; stimuli are acting upon it and to them it is bound to react. Dreams are therefore the mode of reaction of the mind to stimuli acting upon it during sleep. Where do these stimuli proceed from? They may be (1) of a physical external character, or (2) of internal or somatic nature or (3) they may proceed from the Unconscious. At this stage we must concede the existence of the Unconscious. This is not a far reaching hypothesis to make at this stage, since proofs positive of the existence of the Unconscious have been discovered in other fields of science, especially in the hypnotic field. For the sake of convenience we may take that there are two parts of the mind, the conscious part and the unconscious part. We know much about the former and but little about the latter.

Nocturnal Counterpart of "Building Castles in the Air"

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Now let us consider in detail the part played by each of these different kinds of stimuli in causing dreams.

External physical stimuli.—We are quite familiar with the type of dreams we get when somebody raps at the door loudly when we are fast asleep. The noise disturbing our sleep causes some dream in which the actual noise plays a minor part. We dream as though we are taking luncheon in a hotel when all of a sudden the servant breaks a lot of plates by dropping them down or something of that sort. Sometimes we may awake from such a dream if the external noise is sufficiently loud.

In a certain experiment a sleeping person was made to smell Eau de cologne. He dreamt as though he was in an Oriental City whose streets were full of shops from which extravagant odours emanated.

From the above two examples we see that external physical stimuli can produce dreams.

Internal or somatic stimuli.—Dreams may also be caused by stimuli proceeding from within our body. Dreams which people get due to distension of bladder or excited condition of sex organs are too obviously familiar to need any explanation.

Stimuli proceeding from the Unconscious.—The major number of dreams we get is due to this class of stimuli. Civilization has demanded that certain natural tendencies of human nature should be curbed. These repressed tendencies recede into the Unconscious and try to assert themselves during sleep. The greater the degree with which a person has succeeded in curbing these primitive

impulses during his or her waking life, the greater will be the obstacles which these tendencies encounter while trying to assert themselves. Suppose for instance an egotistical craving tries to assert itself when a person is asleep. It is bound to disturb the peace of mind. To this stimulus the mind is bound to react with the result a dream is produced. Thus we have understood all the causes which produce dreams.

Now let us consider the purpose of dreams. At the very outset I can say that dreams are the guardians of sleep. This may sound strange to you. You may shoot out the question that but for dreams you would have slept better. But this is far from truth. In reality you would not have slept as well as you did but for those dreams. When a stimulus acts on your mind when you are asleep, it is bound to disturb the peace of your mind and make you wake up. It is the disturbing tendency. But the tendency to sleep is the disturbed tendency. A compromise is effected between these two contradicting and opposed tendencies and a dream is the result. The disturbing tendency is given vent to in a dream and at the same time your sleep is not disturbed. Let me be more explicit by quoting an example. Suppose a person who is accustomed to drink is made to abstain from it for a day or two, if necessary by using force. At night when he sleeps the desire to drink tries to assert itself. It tends to disturb his sleep. It acts on the mind and the mind reacts producing a dream in which the person dreams as though he is having his full share in a 'drinking' party and thus the disturbing tendency is given vent to while at the same time the person is still sleeping. Thus dreams try to guard sleep. If in spite of it we wake up from a dream, the blame is to

be attributed not to the dream itself but to the weakness of the mental-make-up of the person in question which enables the disturbing tendency to overwhelm it. Invariably the disturbing tendencies will be either egotistical cravings or erotic desires. Hence the dreams which are produced must be wish-fulfillments. The man who wishes to be the Emperor of China ardently, realises it in a dream. The child who is denied sweets in waking life has its full quota in its dreams.

Thus far we have seen in a brief manner the nature, the cause and the

purpose of dreams in general. Certain dreams may not seem to have any meaning at all, so that we cannot ascribe the function of wish-fulfilment to them all at once. But this is due to the highly distorted nature of those dreams. If we succeed in doing away with the distortions and come to the underlying meaning of the dreams, we will see that the same old purpose of wish-fulfilment is there. The technique of doing away with these distortions or rather demolishing the dream work belongs to the field of interpretation of dreams which subject shall be treated in a subsequent essay.

His Day's Duty

"SPOT ME."

With a fresh look and a suit tip top
To the O. P. at seven I hop.
Face fresh by using (snow) Hazaline
And hair shining by the use of vaseline.

I examine cases like tabes
Or straight I go to the Antirabies
With a 5 cc. syring in my hand
I imagine to be a doctor-grand.

Sometimes I avoid the O. P.
And go to the canteen to have some coffee.
I leave the O. P. at nine
For I keep a punctual time.

Spending my time between nine and ten
Is but very easily done
At ten I enter the wards
With my hazaline melting into my heart.

I loaf here and there
Admiring the girls fair.
The clinics I hate and curse
And spend my time looking at the nurse.

At twelve out of the ward I come
And eat my food wholesome.
The Hazeline Snow has melted down
And now I look with an oily frown.

The next class I attend alright
For I have got enough to sight
In the last class of the day I sit in the front row
(Though dozing occasionally) just to crow.

The end of the day finds me haggard
And I curse the snow dealer the Blackgard.

Lead 5Z.

BY S. K. CHAND.

Carpelli sat huddled, a picture of misery and poverty opposite Dr. Jade who looked a strange contrast to the man who had come to consult him.

"Yes Carpelli." started Dr. Jade "You sent me a note earlier, making this appointment."

The other man nodded and his eyes lit up momentarily.

"Doctor, you know what I am" he said. "You know I am to be trusted. You know I am quite sane. Yet why is it you will not believe what I have said often before?"

Jade looked at the ceiling. There was a faint crack running diagonally across the roof. It reminded him of mankind and the flaws associated with that term. He had been straight right from the beginning. His friends even had remarked that he was too straight for the erring world in which he had to spend his time.

Two yards from him was a man. His clear sharp intelligent eyes proclaimed him to be more than an ordinary person. On his face was the clean cut stamp of the scientist—that species of mankind who spends their time most usefully. The scientist finds a happiness in his work which is unexcelled. Yet here was a man who did not look happy. He looked sorrowful, his face was full of resentment.

Jade brought his glance to his friend and focussed his attention on

the scientist. The scientist looked anything but mad and yet.....

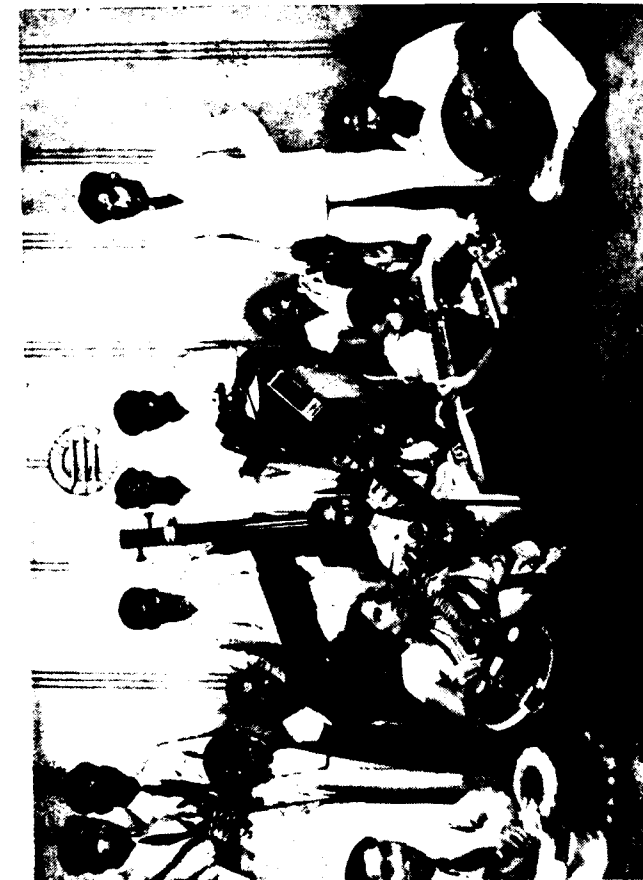
Jade had to face reality.

"It's a difficult question to answer" he parried, and surely you don't want me to go into details and kick them off one after the other." The other man was adamant. "I should like to hear the reasons" he said. "I am not afraid to face facts. In my work, what do I work for? Facts. What do I work with? Facts."

The cell I have made has everything I claim for it. Yet when I ask you to use it and test it, you refuse."

"I can't play with my patients. They trust me and I cannot try a thing which suddenly appears at such a risk."

"I don't ask you to play with your patients doctor, my invention has been tested. Only he lowered his voice, "only on lower animals. I have however been able to try it on some of the tailless apes. Now the final test is on the human subject. It is painless, ha—" He paused, he was going to say harmless when he remembered that only a week back the dog on which he had been working with the new apparatus had suddenly died and turned cold in less than one minute. He had searched for the mistake but could find nothing. He couldn't tell the doctor this, it would certainly bias his mind. He turned the topic, twisted, squirmed and came back to it. He set there speaking, driving conviction into the



M. M. C. A. Orchestra on A. I. R.

doctor till the latter couldn't help acceding to his request.

"Carpelli", he tuned. "You have, shall I say forced me to listen and it doesn't look so fantastic now. However I still say I am not doing this full of conviction, but for the furtherance of human knowledge. If your carpellometer is really what you think it to be, and if it turns out to be successful on the human system, I must say it will cause a sensation. But carpelli why not be satisfied with what it can do on animal systems?"

"Why not extend it to mankind?" Carpelli's face was slightly illuminated with hope. "No one thought of a new lead, they were satisfied with their electrocardiogram. I arranged the lead, 5Z I call it, in memory of my professor Zatio of Padua. I have carefully drawn planes showing the exact marking—they have to be applied and the result obtained."

"I'll do it Carpelli but I'll hold you responsible for anything that happens."

Before Carpelli's eyes rose the image of the dog, dead. An idea entered Carpelli's brain then he thrust it aside. Could the death of the dog have been due to inhibition? Inhibition—it persisted in his imagination. No he said to himself it couldn't be inhibition, the dog must have been old and the heart must have been rather erratic. Lead 5Z certainly didn't inhibit the heart by sending stimulus. It was a great discovery, this lead 5Z, for humanity. He turned to Dr. Jade.

"Jade," he said. It was the first time he had dropped the "doctor". "I'll always be grateful to you. Nothing can happen, you have my word for that."

He rose, stretched himself, shuffled to the door and lifted his hat from a stand near by.

"I'll let you know," said Jade "when the experiment can be tried. Good morning."

"Thank you again doctor," said Carpelli "Good morning." 5 L

Forty eight hours passed before Carpelli heard from Dr. Jade. It was a note asking him to meet the latter on the morrow at 11-30 a.m. at his surgery. Carpelli smiled and the frown on his forehead disappeared for a few seconds. Lm 21, 7A 221

Fifteen minutes before the appointed time he ambled into the office of Dr. Jade and seated himself on a hard bottomed chair. N 41-20-3

Jade smiled at him. "You are 15 minutes early," he said "however to-day the usefulness of your instrument and lead 5Z shall be either proved or ..."

Carpelli frowned at this,

"Lead 5Z" he said shortly "is infalliable."

"Amen" mouthed the doctor.

At 11 30 a.m. they entered the operation theatre. Jade performed his part of the business namely of operating on the patient and thereby attempting to check an internal malignant growth. The patient was still under the anæsthetic when Carpelli eagerly starting fixing the apparatus with the aid of Dr. Jade. Jade lifted the three dials of the apparatus and placed them on a table near by. In doing so by accident he knocked the table, on which the patient was, stretched. Carpelli switched on the apparatus. 9 35 17

"Look at the dials" he said pointing to the oscillating hands. Jade watched fascinated. Barely 5 seconds had elapsed when the hands suddenly dropped to the zero position.

"The patient" yelled CarPELLi as he switched off the apparatus. Jade hurried round and felt the pulse. Even before he felt it he knew. That patient was dead.

"He's dead CarPELLi-5Z I suspect," he said. CarPELLi stood petrified.

"Dead" he repeated. "And I thought I had succeeded."

It was apparent to them that the man could not have died of any other cause. Everything could be explained but not lead 5Z and the CarPELLoment.

"CarPELLi" said Jade "You made me do it when every instinct of mine warned me. Now the sin of murder is on your head".

"CarPELLi looked white and drawn, his breath came in great gasps. Suddenly he turned to Jade.

"Something was wrong" he said "I'll find it even if I have to die experimenting." He dashed from the room, while Jade called in some attenders. The dead man had been poor

and so an easy explanation covered his death. Dr. Jade couldn't forget 5Z.

Months went by, often Jade would imagine he saw hands moving on dials only to recall the tragedy.

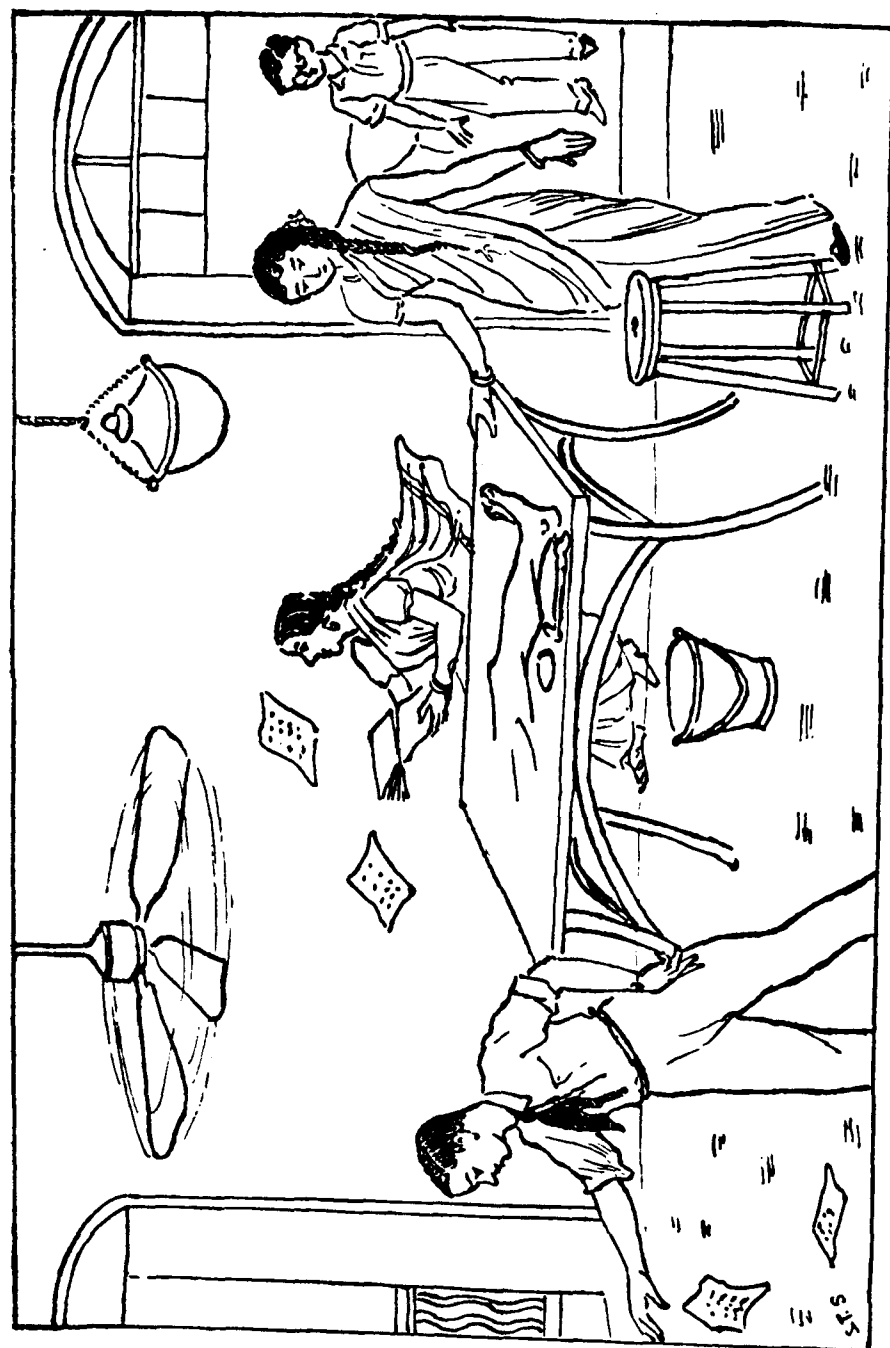
Then one evening he received a note from CarPELLi and hurried to see him.

CarPELLi was lying on a bed looking very ill. He was haggard and one could see he was on his death bed.

"Dr" he croaked. "It was the wrong lead. Some how the lead was displaced and it inhibited the heart. I am going I know but I request you to try it on me now, remember lead 5Z.

Jade looked at him, "from the data you supplied me" he said "I investigated your lead. It is sound. You are right. By accident I displaced the lead that day." He smiled you musn't except me to try it on you.

CarPELLi raised himself on a wasted arm "Dr. Jade" he murmured. "I can't live to see my lead 5Z carpello-meter helping humanity. I am going first. Anyhow I am happy I have spent my life usefully."



Fate of Moore Market Book & Modern Chivalry.

Leaves from the Diary of a Bright Young Medico

BY "THE CHOSEN FEW."

Monday.—Rose at 5 minutes to 8. After usual matutinal ablutions (limited to a cat's lick, and a dab of lipstick, due to lack of time)—dived after a tram. Landed in the conductor's arms—Thought regretfully of opportunity rose. Decided in future to cannon into a more eligible male, such as "Rhett Butler."

Seemed to be my lucky day. Was racing up the Anatomy stairs, when I glimpsed the rear view of Dr. X. Decided that discretion was the better part of valour, and slipped thro' the swing doors of the Museum like a shadow—and then—be still my heart! was it the profile of the current heart throb, or was it? Stood staring like a stuck pig for half a second. Remembered that the foetal skull needed looking into, and so lingered round in the rear vicinity, until rewarded by a long look. Treaded air for the rest of the day.

Tuesday.—Dear Diary, this was a black Tuesday—very BLACK.

Remembered too late that Dr. X was going to spring one of his pet tortures on us. Resolved that since knowledge was of the P type, I'd have to turn on the charm, and use that never failing formula—a dash of coty's and an odol smile. It was evident from the start, however, that Dr. X was quite immune to such feminine wiles. Left the Hall very crest fallen.

The afternoon proved no better. Provided amusement to the class, by

acquiring a distinct shade on my upper lip during the Recording process in the Physiology lab.

Wednesday.—Bounced out of bed full of "Joie de-vivre," and narrowly escaped bumping my head against the bed post. While waiting in queue for bath, looked over latest "Home chat." Answered the Personality Questionnaire, and found that I had developed quite a magnetic charm. Resolved to try it on young S who lived next door. Exceeded far beyond expectations by receiving a shy invitation to "Bandhan."

Altogether a busy day. Evidently looked far too healthy for safety's sake, for was button holed on the way through the G. H. Corridor, by an anxious H. S. who appealed to me for a blood transfusion; was terrified to learn that his patient required 300 ccs. So politely refused. Thought if the subject had my blood running thro' her veins, she'd be inheriting my frivolous tendencies. However, boasted of the young H. S's appeal to my classmates till they nearly gaged me.

As usual, a monotonous day. Could n't help wondering why God had created men like Starling and Gray.

Thursday.—A gloomy day—why?—A week. 6 days, 55 minutes and 47 seconds before that "Massacre of the innocents." Thought too late that the place of a woman was the HOME and not—abso-blinking—lutely not—the M. M. C. Feverishly felt my pulse

to see if I had developed "Rhettica—Buttlerrhoea Katonia." Found that the proper symptoms were not forthcoming. So decided to have an honest-to-goodness fainting fit in the Exam. Hall.

Was quite pleased to find that chivalry was not yet dead. Discovered potential qualities in shy, retiring "Tyron Power" who gallantly came to my rescue by delving for the otic ganglion.

The afternoon was an exceptionally uneventful one.

Friday.—My long-longed—for Birth Day. Remembered that the cupboard was bare, and decided to invest in a Birthday cake. How many candles? Dear Diary, that would be telling!!

Arrived in college to be greeted by an embarrassing crowd who garlanded me, and squeezed my phalanges. Promised in an impulsive moment—(regretted soon after)—to treat them to

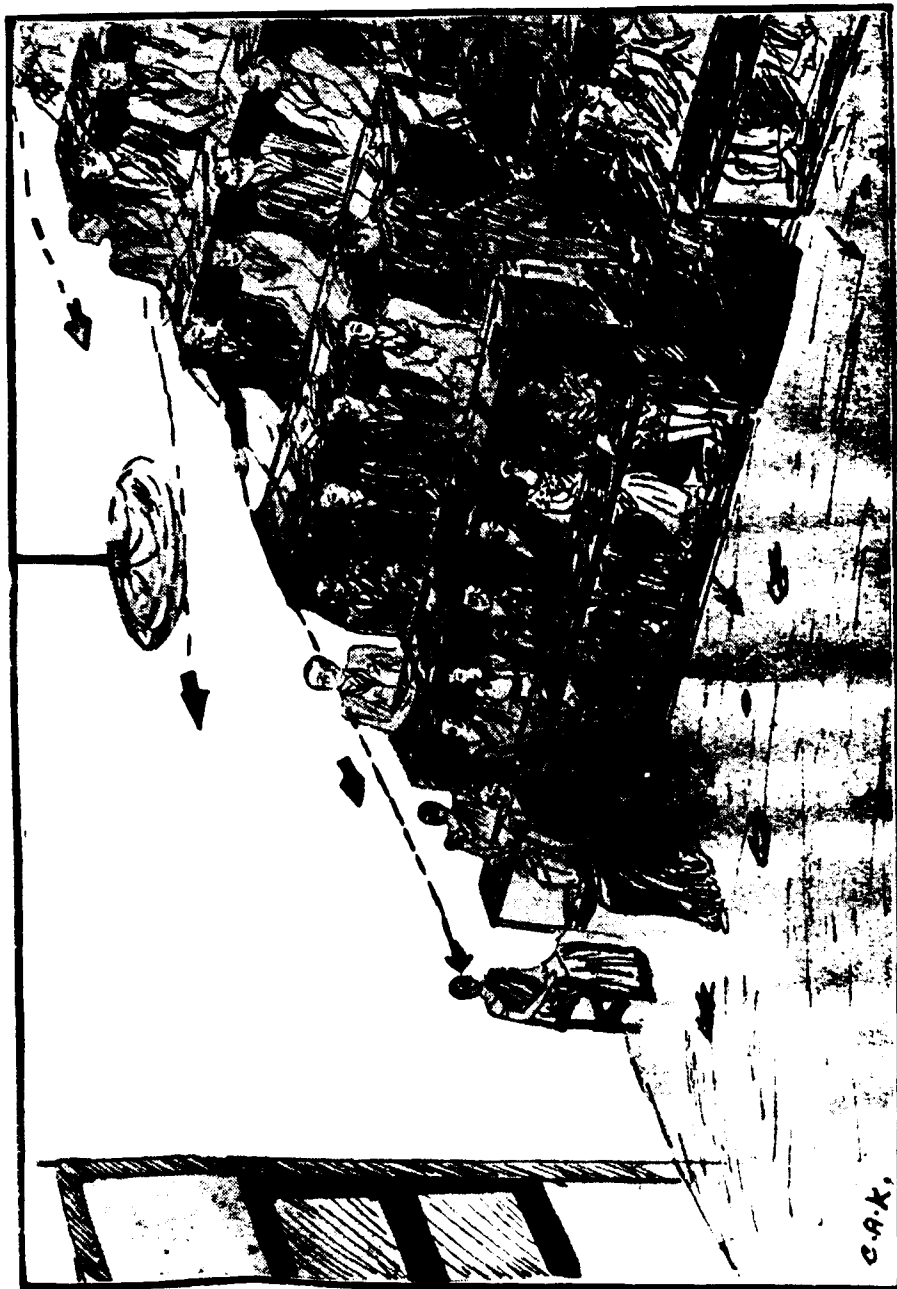
a Matinee show. Spent Birthday check thus. What a waste!!!

Saturday.—Still recovering from after effects of the Birthday. Resolved never to see, smell, or trust in chocolate cakes again.

Spent the morning in bed, and strolled into the "shed" at 10. Did absolutely nothing worth mentioning, till suddenly found the eagle eye of Dr. X fixed on me. Hastily opened a cunningham at random and gave the sub-Mandibular Region my full attention. Heard the bell ring, but refrained from uttering an exclamation of relief because, found Dr. X breathing down the back of my neck. Looked demure and barned, and so the incident was closed.

Had an early lunch and tripped home gaily to get ready for the "New Moon Bathing Party" at Elliot's Beach.

Sunday.—Rested in peace perfect peace.



M. M. C. Air Force in Action.

"Finding a Friend?"

BY "PAYNE".

Kamala was a student of one of the Women's College in the City. She was a fair, slim tall and attractive girl. She possessed all the charms to captivate any youth. And no wonder, Ram, an arts student lost his head over her. Ram was a handsome lad of about twenty and he had an admirable personality.

It was in a picture house that Ram made the friendship of Kamala. What all he did was, just to give place to Kamala when she came in. They just talked and talked and when the picture ended they did not know what the story was. They fixed up another day to meet and they went pretty fast. They had at least one "date" in a week.

Kamala had a chum. She used to tell everything to Leela. Kamala was really sorry that her chum had no boy friend. She could only take Leela with her on certain days when she met Ram but Leela was a sport and did not want to spoil Kamala's day. So she used to give lame excuses and keep away.

Kamala, told Ram about this and told him that Leela should also find a nice boy friend. They planned how four people could be going about having endless fun. "Two is company" alright, but "four is company with mirth and joy ;"

Ram's best friend was his room mate Srinivas. Naturally Srinivas's name was the first to strike him. So he told his sweetheart that he would get Leela a boy friend the next week. They promised to meet at a private hotel.

At the appointed hour Ram and Srinivas walked into a separate apartment. Kamala was there with Leela but to give her more pleasure she never told anything about Ram's and her plan for getting Leela a boy friend; and Srinivas was also unaware of the plot. He knew only that there was a party of four consisting of Kamala and her friend and Ram and himself.

Ram and Srinivas entered and were greeted cordially. Leela:—"Hullo! Seenu! you never told me you are coming here."

Sreenivas:—Leela! I never knew that you are Kamala's friend; it is a surprise to see you here.

Kamala:—So this is your brother Sreenivas about whom you were talking to me so often, Leela?

Leela answered in the affirmative and Ram and Kamala looked at each other and could not speak further.

* Ode On The Lamentations of an Unhappy Lover

BY V. V. PARAMESVARAN, B. A., *II year.*

'Long and lonesome is the weary way,'
So I have heard this often say,
'To that place of eternal bliss
Where lovers often meet and kiss.'

Where is she, she who is mine,
That sweet darling who is mine,
She who bestowed on me her love,
And flew to me as a dove?

Where is she whom I love?
She who has charmed her dear love
With ravishing notes once so dear,
That now seem not so near.

With her mellowing voice can she draw
Iron tears from the eyes of Pluto,
As did the melody of Orpheus old
At the swarthy infernal threshold.

Gone, gone are those days of bliss,
When we together did dally and kiss
On that nuptial couch of charm.
For kissing then was without a harm.

Well do I remember that happy night,
The same as of Dido's night
When she with Aeneas did play
Many a game of mirth and joy.

Gone art thou, leaving me alone;
Thy loss I have to bemoan;
Gone art thou without again charming me,
You who art only dear to me.

Now do I stand like a blighted oak
By the side of a murmuring brook;
Thus stands many a hapless boy
Leading a life devoid of joy.

There you lie under cover of stone
O'er hung by a growth of myrtle brown;
Never again with thou rise from that place
To bring to thy lover some solace.

So will I resign myself to despair;
For a gloomy life will I prepare,
For a life devoid of love,
With a calm prayer to almighty Jove.

But then yonder do I see a silver streak
Through the dark clouds break,—
That streak which soothes my malady
Which to me was without a remedy.

Though now gone from this earthly pleasure,
Thou wilt have divine leisure,
There where the souls of the blessed go
To wander without the least woe.

So with calm resignation have I to rest,
With calm and peace in my sorrowing breast
Till at last some kind cherubin come
To take me into the same blissful home.

Thus with rebelling thoughts do I live,
Waiting for that cherubin to arrive
To lead me there with a heart so kind
Where alone soars my distressed mind.

There will I mingle with that dear soul,
In ecstasy emptying many a vintage bowl;
Then will I caress that darling sweet,
And attain oneness without a meet.

* This ode is written and dedicated to the memory of a late friend of mine on whom the calamity of losing one's sweetheart befell early in life, and from whose dear face I derived much inspiration.

"Gleanings from the Great."

"Have you ever thought that life can be a cruel thing to women? A man is detached, independent, a separate thing in himself-but a woman really finds herself through man and look how men serve them. Women wrap us round with tenderness from the time we are born, and we take it just as a matter of course. We take-and take, and take again and they go on giving. We talk a great deal about fair play and honour, but by God, there are few of us who play the game by women! We take advantage all along the line. We talk a great deal about self-control; but when do most of us show it where women are concerned? We give away to every mood, every impulse of the moment, it is what we want-for the moment-that counts-not honourable dealing. We let them down all along the line. We destroy their beliefs, their hopes, their joys in life, and their every illusion, and when we have done it successfully, and they've turned against us in the bitterness of spirit, and use against us the methods that we have thought them, we're the first to cry out and condemn them unsparingly.

'Rotters', we call them-we that have too often made them so. When I think of the treacheries, the cowardices, the contemptible betrayals shown to women by men-all my life I've seen it happen-the sordid lying and cheating of them that goes on every day, I am ashamed of my manhood. Savage brutality is nothing to it; that may be nature-I don't know-but the things that are done every day by men who call themselves gentleman make me sick to my soul.

Gentleman! They don't know the meaning of the word! A gentleman, if he is anything is a man of honour, who keeps his word, a man with a code who doesn't take advantage, or let a woman down. How many of us can they say that of? How many?"

*From the 'Box of Spikenard' by
Ethel Bileau.*

"After all a woman doesn't get much else, even if she starts out with love, does she? I mean, she doesn't get much more than a roof over her head and meals on the table, and a man and children. No matter what she starts out with, that's what she ends up with-if she is lucky."

Faith Baldwin.

"No man does mind if his wife is jealous of another woman-at first. It only delights him."

"Are men sports where women are concerned?" No.

"Human nature, the moment it gets interested, becomes blind."

Politicians are more unreliable than women and not half so amusing."

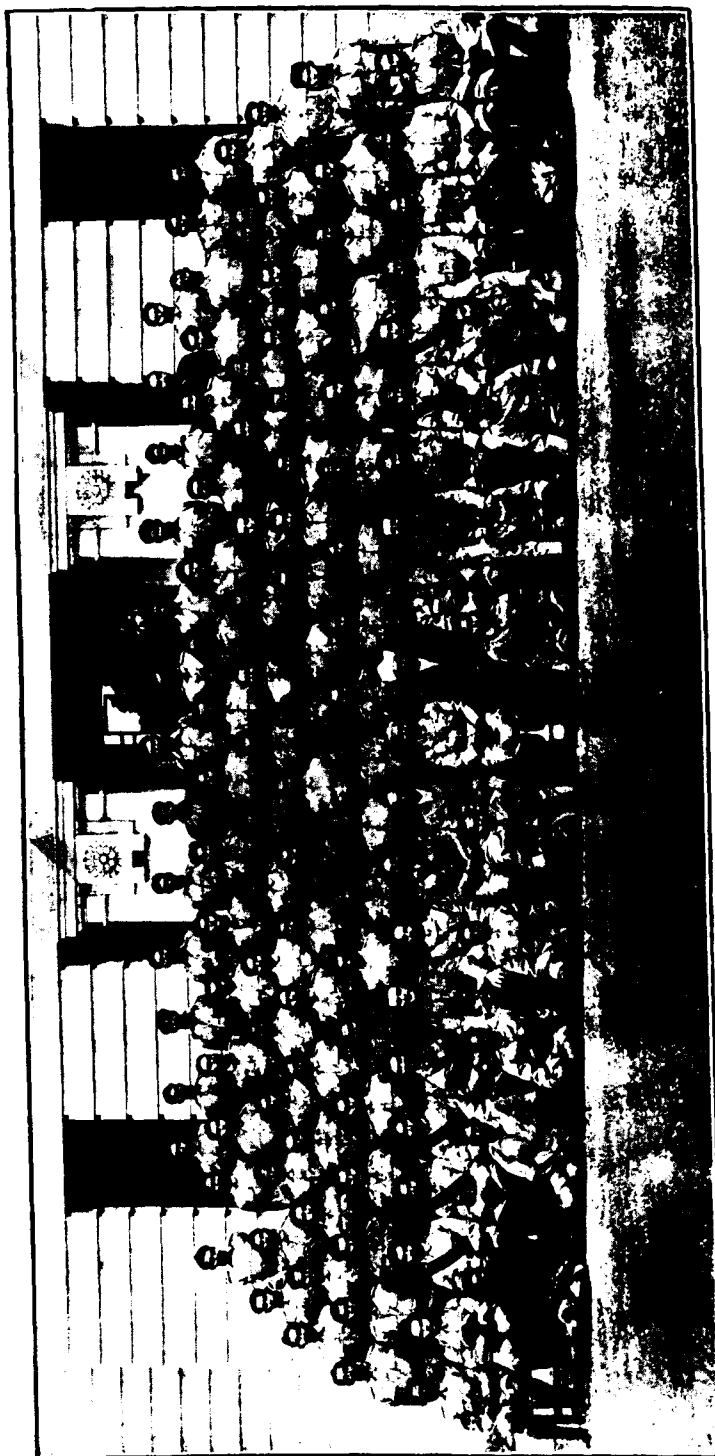
"Generalisation is the cloak under which a man speaks of himself."

"To be great is to be misunderstood."

"Emerson."

"Every hero becomes a bore at last."

"Emerson"



Annual Report of the "A" Medical Contingent

5th (MADRAS) Bn. U. T. C.

The current year brought good news along with it. The battalion expansion scheme was announced early in July, as a result of which our contingent strength of 81 was to increased to 119. This was indeed great news for us. Every year, due to the very limited number of vacancies, a large number of applications had to be rejected; but this year, with a vengeance the total permitted strength was filled up by 60 recruits, drawn from various classes of both the Medical College in Madras. These have shown extraordinary enthusiasm during their training both here and in camp. In spite of the very little time that can be spared from our arduous course of study, our contingent has carried out a thorough training. Our results in the various competitions in camp were not very encouraging and we were rather "unlucky" to have lost "our" Guard-mounting cup and Tug-of-War. These set-backs have not discouraged us because the whole battalion knows which contingent it is that can mount guard and do it well. Our greatest drawback is our lack of athletes and we sincerely hope a few of our "crack" sportsmen will join our ranks next July.

Our company parades are held in the college premises on Tuesdays and Thursdays every week, and our contingent join the Battalion Parades on Penultimate Saturdays.

Our results in the recent efficiency examination were very good. 49 members appeared of which 21 passed Lower efficiency and 23 the Higher 5 of whom gained distinctions. The contingent furnished a Guard of

Honour on the convocation Day and on the opening of the new Pachayappas College Hostel. On the 18th February, we had our Annual "Break-up" social Lt.-Col Chakko, our commandant presiding. The principals of both the colleges very kindly attended in spite of other engagements, a touch of colour was added to our social this year—many ladies accepting our invitations.

We wish to congratulate the following members on their successes in the annual Range:—

Part IV Sgt. Govindarajulu attendance cup. Trained Men: cadet Madhavan.

Part III cadet Ganti attendance cup. for Recruits Rec. Ganesh and Rec. Veera Reddy.

Part II cadet Madhavan.

Recruits Range

- 1st Siddhoji Rao
- 2nd Balamukanda Rao
- 3rd Padmanabha Reddy
- 4th Muthiah
- 5th Sambantham.

The various prizes and medals were distributed to them on sports day. We congratulate Sgt. L. Rajasekharan on his obtaining his Emergency Commission and he is now in training at Mhow. Many of our ex-members have been selected for commissions in the I. M. S. It does give us great pleasure to realise how much our unit is doing towards popularising military training and we hope that more and more students will join us to get this training which will be of such importance in the near future.

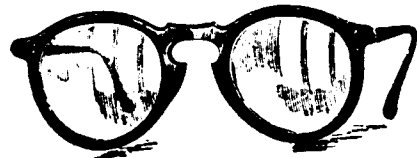
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