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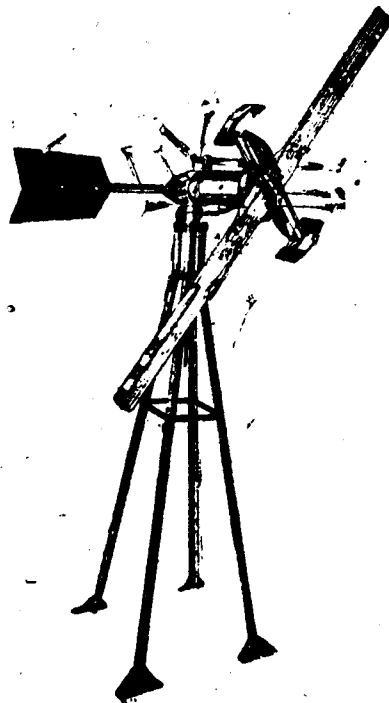
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The Madras Medical College Magazine

Vol. XXV

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No. 2

Lumps in the Neck

BY

DR. CHANDU NAMBIAR, F.R.C.S.

To understand the development of certain lumps in the human neck it is necessary to know the development of the neck. There are five visceral or branchial arches in man: the fifth is rudimentary. The first and second arches grow more quickly than the third and fourth. The latter two arches are hidden by the rapid growth of the second arch, so that the second, third and fourth clefts come to open into a common space termed the precervical sinus. The second arch, by its continuous rapid proliferation, converts the opening into a narrow channel called the precervical duct which eventually disappears, by the fusion of the ectoderm covering the second arch with the ectoderm immediately caudal to the fourth cleft. This fusion converts the original precervical sinus into the precervical vesicle which is lined by ectoderm. This enclosed ectoderm normally disappears but the persistence of any part of it leads to the formation of branchial cyst and fistula.

primitive pharynx immediately behind the tuberculum impar. It forms a thick walled epithelial vesicle imbedded in mesoderm which very soon becomes solid. As the vesicle grows, its distal end becomes bilobed and forms the two lateral lobes and the isthmus. A portion of the lateral lobe is also formed from the fourth entodermal pouch. This explains the aberrant thyroid often found in the posterior triangle. The tubular cranial portion of the diverticulum is called the thyroglossal duct. It disappears eventually. Sometimes it may persist giving rise to thyroglossal cyst. The thyroglossal cyst has plenty of lymphoid tissue in it and consequently becomes infected and the cyst may therefore break down, converting cyst into fistula.

The enlargement of lymph glands in the neck forms the most important single factor producing lumps in the neck. I deem it necessary therefore, to recollect briefly, the catchment areas which drain into the lymph glands of the neck.

The thyroid gland arises as a diverticulum from the ventral wall of the

(1) The lymph vessels from the anterior part of the nose and those of

the skin of the nose drain into the submandibular lymph glands. The remaining part of the nasal cavity, the paranasal sinuses, the nasopharynx and the pharyngeal end of the eustachian tube drain into the upper deep group of cervical glands. The lymphatics of the mucous lining of the tympanum and mastoid antrum pass to the parotid and upper deep group of cervical glands.

(2) *Lymph drainage of mouth, teeth, tonsils and tongue.*—The lymphatics of the gums end in the submandibular lymph glands, those of the hard palate end in the retropharyngeal lymph glands and upper deep group of cervical glands. Those of the soft palate end partly in retropharyngeal lymph glands and partly in the upper deep cervical glands. The vessels from the anterior part of the floor of the mouth pass into the submental group, but some of them pass directly to the inferior group of cervical glands—jugulo-omohyoid group. The vessels from the rest of the floor of the mouth go to the submandibular lymph glands and upper deep cervical glands.

The lymph vessels of the tonsil drain into the deep cervical lymph glands and specially into the jugulo-digastric glands.

Tongue—The lymph vessels from the tip of the tongue and the region of the frenulum end partly in submental lymph glands, and in part into the inferior deep group of cervical glands—jugulo-omohyoid group. Some from the margin enter the jugulo-digastric group, and submandibular lymph glands. Central lymphatics end in the superior deep group of cervical glands following the lingual vein. The lymphatics draining the dorsal surface cross the middle line

and drain therefore into the superior and inferior deep group of cervical glands, into the jugulo-digastric, jugulo-omohyoid and the glands between them.

Lips.—The central portion is drained by the submental glands. The rest of the lymphatics run along the anterior part of the face and drain into the submandibular lymph glands. Efferents from the occipital, posterior auricular and preauricular drain into the upper deep cervical glands.

Lymphatics of pharynx and oesophagus pass into the deep cervical glands either directly, or indirectly through retropharyngeal and paratracheal glands.

Lymphatics of the larynx are divisible into a supraglottic set and an infraglottic set. The former follow the course of the internal laryngeal nerve and end in upper anterior group of deep cervical glands. The infraglottic lymph vessels pass between trachea and oesophagus, close to recurrent laryngeal nerve and open into the lower anterior group of deep cervical glands. In extrinsic cancers, supraglottic lymphatics are involved but in intrinsic cancers, infraglottic vessels are involved.

Thyroid gland :—Lymph vessels drain into the prelaryngeal and pretracheal glands, and these into lateral deep cervical glands.

Supraclavicular glands have their afferents in the axillary, upper cervical and anterior jugular and infraclavicular glands and upper part of breast.

Having briefly dealt with the development and lymphatic system of the neck. I shall proceed to discuss the lumps in the neck.



Fig. 1. THYROGLOSSAL CYST.

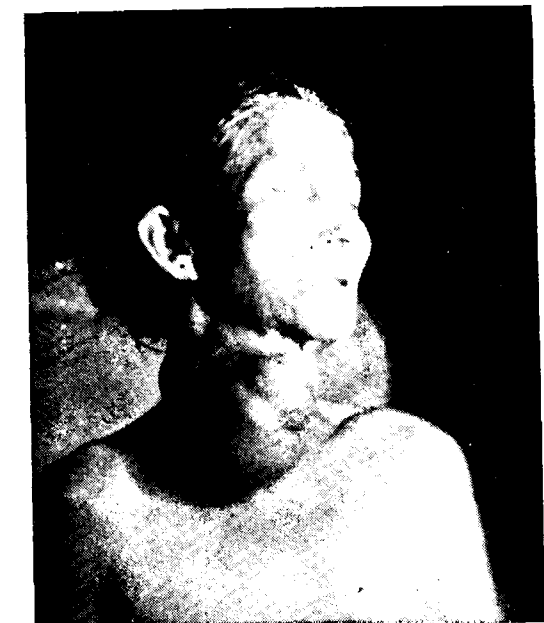


Fig. 2. GOITRE. (front view)



Fig. 3. GOITRE. (lateral view)



Fig. 4. GOITRE.



Fig. 5. GLANDS NECK.

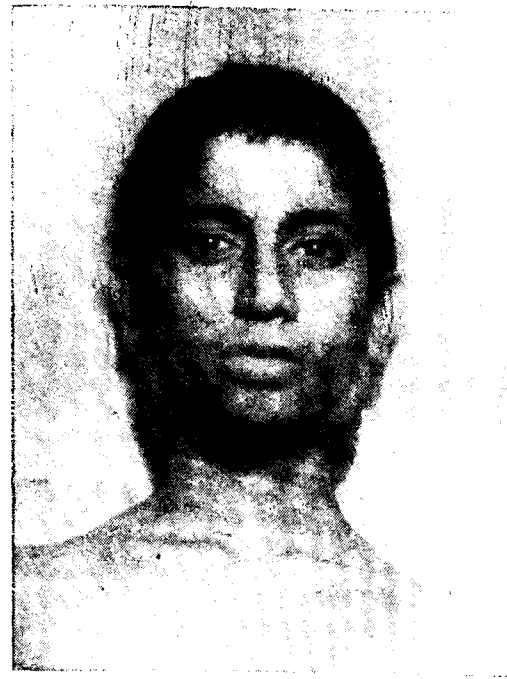


Fig. 6. GLANDS NECK.



Fig. 7. GLANDS NECK.



Fig. 8. GLANDS NECK.

Lumps in the Neck.

Every lump must arise from a pre-existing structure or tissue, and if this is borne in mind one would be able to make out at once what the lump is arising from. Beginning with the submental triangle in the middle line, the swellings of the lymph glands form the most important group. The commonest cause of glandular swelling in this region, as elsewhere in the neck is tuberculosis in younger people and malignant disease in the older. The general characteristics of glandular swellings, I shall discuss later, to avoid repetition. Next to swellings of the lymph glands the commonest lump in this situation is either a ranula or a dermoid cyst. A ranula has a bluish colour, arises from one or other side of the frenulum in the floor of the mouth, and pushes its way across the middle line to the opposite side. So the history as to where it started should be ascertained. It contains clear fluid, and is translucent. It is said to be of branchial origin.

A dermoid cyst on the other hand arises in the middle line and lies between the geniohyoglossal muscles. It is freely movable and the skin is not adherent. It is either congenital, or more often it makes its appearance in early adolescence. It is opaque and not blue—nor is it translucent. So the diagnosis between the two is not difficult. A sebaceous cyst may appear in this region as in any other part of the neck. It has the features of a sebaceous cyst elsewhere—viz., a putty-like consistency, a punctum or a dark spot in its centre and skin around which is adherent. It may be greenish around the punctum when the skin is stretched. Below the submental triangle, the commonest lump is a sub-hyoid bursa. It lies between the back of the hyoid

bone and the thyrohyoid membrane. It is loosely attached to the hyoid bone. It closely resembles a thyroglossal cyst, and like a thyroglossal cyst it will move with deglutition. But a sub-hyoid bursa appears late in life, its long axis is transverse whereas a thyroglossal cyst has its long axis vertical (Fig. 1). A thyroglossal cyst may appear anywhere between the hyoid bone and the thyroid gland, generally to one or other side of the middle line, commonly to the left. The cyst is generally translucent, moves with deglutition, and appears in early childhood. The aspirated contents often contain cholesterol. Since a thyroglossal cyst contains a lot of lymphoid tissue in its wall it is subject to inflammatory attacks, and thus a cyst may become a fistula by bursting.

Aerocele.—This is a rare condition formed by the projection of saccules of larynx or tracheal mucous membrane. If present, it can be reduced on pressure, and is resonant on percussion. It is seen in glass-blowers, players of wind instruments, and those suffering from chronic cough.

A pharyngeal pouch or diverticulum is another lump in this region. It is situated at the level of the cricoid cartilage, at the pharyngo-oesophageal junction. The symptoms are—gradually developing dysphagia, and regurgitation of food. The pouch may gradually bulge down into the thorax. The diagnosis has to be made from simple or malignant stricture. The slow onset of dysphagia and regurgitation of food is the guide to the diagnosis of the former condition. If the pouch is empty, swallowing of water will make the lump reappear. A barium swallow and X-ray is the only certain method of diagnosing this condition.

The next important group of swellings in the neck is in connection with the thyroid. These have distinctive features of their own i.e., they move with deglutition and occupy the position of the thyroid. There are several types of lumps in connection with the thyroid. But strictly speaking, most of them are merely enlargements excepting the adenomas and malignant thyroid. The following enlargements are met with in connection with the thyroid.

1. Parenchymatous, or colloid goitre.
2. Adenomatous or nodular goitre.
3. Toxic goitre.
4. Lymphadenomatous goitre. (Hashimoto's disease).
5. Ligneous thyroiditis or woody thyroid.
6. Syphilitic thyroiditis.
7. Malignant goitre.
8. Tuberculous thyroiditis.
9. Acute thyroiditis.

A parenchymatous or colloid goitre (Fig. 2, 3) is a diffuse soft swelling involving the whole thyroid, and is horse-shoe shaped. It occurs at puberty. It is painless, and when the enlargement is large, it may compress the trachea from side to side, — ("scabbard trachea"). It is mostly found in women, and the swelling may increase during menstruation in endemic areas. Colloid goitre is generally symptomless, and the patients seek the doctor's help on account of disfigurement. Rarely symptoms of hypothyroidism may be present.

An *adenomatous goitre* may be a (Fig. 4) true adenoma or of the nodular variety, which, though called adeno-

mas are not really such. Nodular varieties are the result of hyperplasia involution changes in the gland. A true adenoma is single and generally arises at the junction of the isthmus with the lateral lobes. The nodular variety is multiple. An adenomatous goitre develops in early life. It may be retrosternal. In such cases the lower border of the gland cannot be palpated, and it produces early pressure symptoms on the trachea and during the fits of cough to which they are subjected retrosternal goitre may bulge into the neck,—"plunging goitre."

Adenomatous goitre unlike parenchymatous or colloid goitre produces pressure symptoms whether it is in the neck or retrosternal; the trachea becomes deviated to the opposite side. Dyspnoeic crises are common, especially when the patients lie down. They are subjected to cystic degeneration and haemorrhage, and when haemorrhage takes place, the cyst may become large and tense. Then they complain of pain, and severe dyspnoea.

Toxic goitre primary This causes a moderate uniform enlargement of the gland. It is vascular, and therefore warmer. There may be a vascular thrill and a bruit may be heard over the superior thyroid; exophthalmos, tremor of hand and tongue, and tachycardia are present. The finger-nails occasionally undergo a change, which, if present is pathognomonic of exophthalmic goitre; the distal portion of the nail is separated irregularly from the underlying nail-bed, and there is a tendency for the nail turn up at the tip. This condition if present, is bilateral.

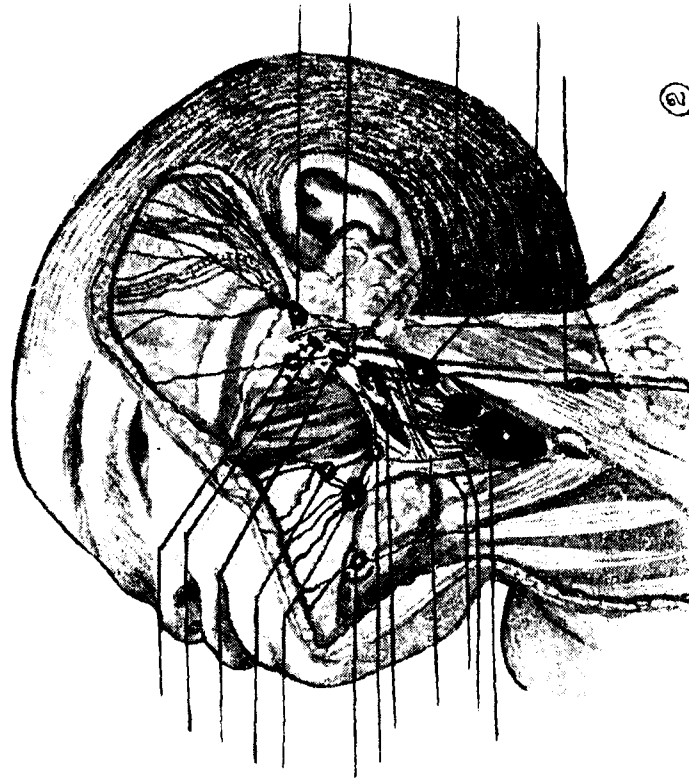
But in many cases, the clinical picture is incomplete for months. But



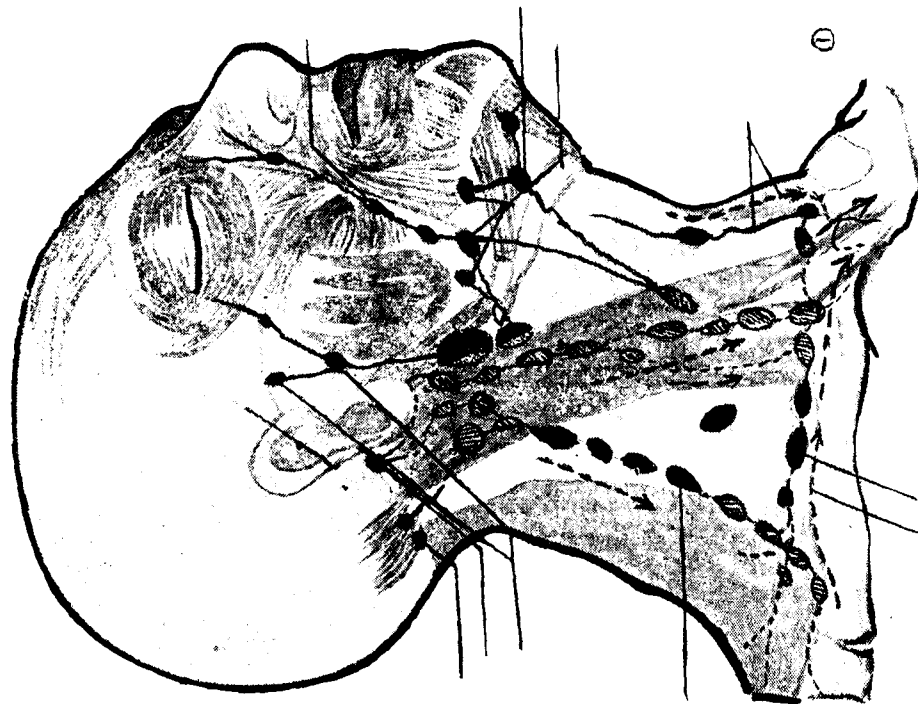
Fig. 9. MIXED PAROTID TUMOUR.



Fig. 10. CYSTIC HYGROMA.



Lymphatic drainage into Parotid and Submandibular glands.



Lymphatic drainage of the face.

wasting, increasing muscular debility, tremors, sweating on slightest provocation, and inexplicable diarrhoea are some of the early signs. A violent pulsation of the carotid arteries in such patients while at rest is very suggestive of toxic goitre. But if the pulsation is normal, the probabilities are against Grave's disease.

A malignant goitre is hard, irregularly nodular, localised to begin with, but later involves the whole gland, infiltrates into the trachea and oesophagus causing dysphagia and dyspnoea; and when this happens, the gland may not move with deglutition. Pain is an early symptom and may radiate towards the jaw, back of the neck and head, and shoulder. Hoarseness of voice from involvement of recurrent laryngeal nerve in the growth, may very soon appear. Later the sympathetic nerves may be involved producing contracted pupils and other symptoms of "Horner's Syndrome." Later the trachea is infiltrated, stridor is intense, and paroxysms of cough become severe. Secondary involvement of glands may be noticed early. This is the usual picture. But there is another type in which the first symptom noticed may be a distant metastasis in bone, or a pathological fracture in a long bone. In such cases, a very careful search may reveal a small nodule in the thyroid gland. I know at least two such cases: in one there was a lump in the skull thought to be a meningioma but after operation the pathologist found it was secondary thyroid; and in the other there was a pathological fracture of the left humerus and on careful search, a nodule of the size of a bengal gram was noticed in the thyroid without symptoms.

Lymphadenomatous goitre—struma lymphomatosa,—Hashimoto's disease

—This occurs exclusively in women past 45 years of age, and frequently ends in myxoedema—There is increased fibrous tissue formation leading to an exaggeration of the normal lobulation,—a very definite clinical sign which distinguishes it from other varieties of goitre. The gland may be harder in consistency.

Riedel's Thyroid.—Ligineous thyroiditis—woody thyroid. This is a chronic inflammatory condition of the thyroid leading to iron hardness. The gland is adherent to the trachea, and pressure symptoms are severe, and out of proportion to the enlargement. It may be mistaken for carcinoma, but the absence for secondary lymphatic glands or other metastases will distinguish it from cancer. Unlike in Hashimoto's disease, no myxoedematous symptoms develop.

Tuberculosis of the thyroid.—Rare. It is difficult to diagnose clinically. The gland is slightly enlarged, warm, and symptoms of hyperthyroidism may be present.

Syphilitic thyroiditis.—Rare. The gland is hard, moderately enlarged, and pressure symptoms on the trachea may be present and may be urgent. The case may be mistaken for malignant disease, but no metastases will be found. Other evidences of syphilis should be looked for.

In the middleline below the thyroid gland lumps are found in the suprasternal notch or Burns's space. The commonest swellings are tubercular glands and cold abscesses. In connection with this, the collar-stud abscess may be mentioned. This has the characteristic of tuberculosis elsewhere. The skin becomes adherent and is painful. Tubercular

gland is seldom single. There may be other glands enlarged. This may be mistaken for a dermoid cyst,—which commonly occurs in this situation. Dermoid cysts appear early in life or may actually be present at birth. They do not adhere to the skin, and are freely movable unlike cold abscesses. They are painless and solitary.

A *retrosternal goitre* is another tumour in this situation. This has already been dealt with. But it should be remembered that tubercular glands in the mediastinum may simulate a retrosternal goitre. Veins in the neck may be prominent but this condition may also occur in other types of lumps in the mediastinum.

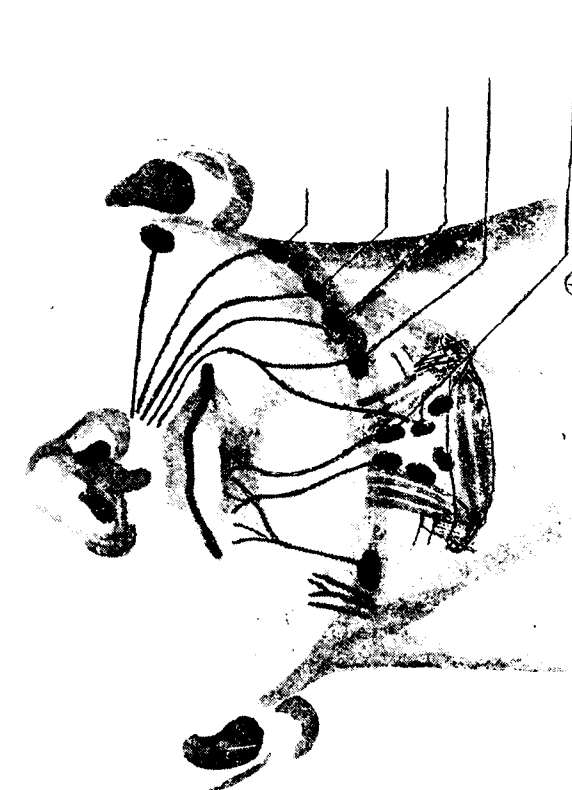
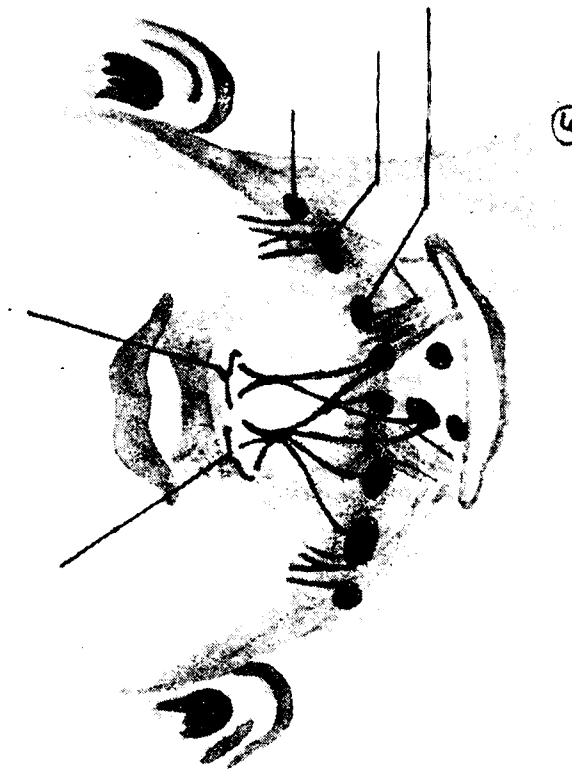
A *mediastinal lipoma* may sometimes project into the neck. It has the characteristics of lipomas elsewhere, and so is not difficult to diagnose.

II. I shall now consider lumps in the side of the neck. In the upper part of the neck perhaps the commonest lumps are those in connection with *lymph glands*. In fact this is the commonest situation in which glands in the neck are enlarged. This may be acute lymphadenitis which may culminate in an abscess. They have the characteristics of an acute inflammation. Examine the field of drainage for the primary source of infection the chronic enlargement is most difficult to diagnose. The causes of chronic enlargement of glands are:—

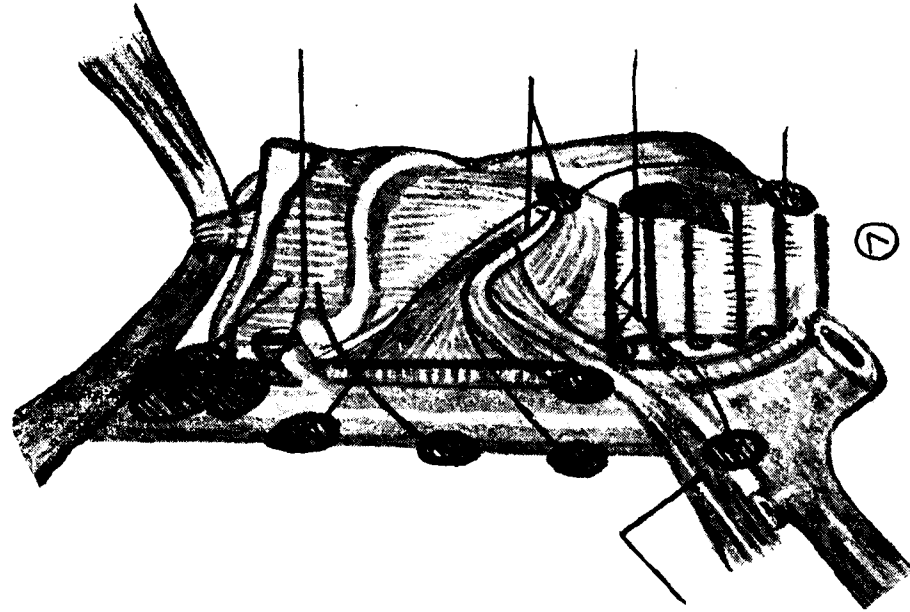
1. Tubercle—perhaps the commonest cause of enlargement of the glands.
2. Primary and secondary malignant glands (3) Lymphadenoma

or Hodgkins disease (4). Lymphatic leukaemia, and (5) Syphilis.

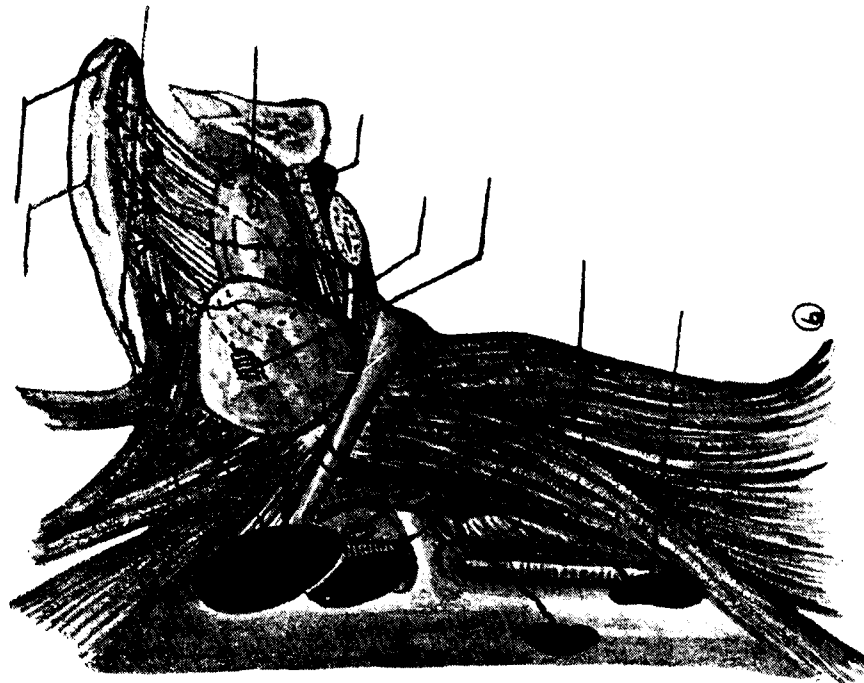
We may here discuss their general and distinctive features. In the first place we have to make sure that the lump or lumps in question are of lymphatic origin. The most important fact to remember in this connection is that enlargement of the lymph glands is seldom single except at the very onset. At that very early stage the patient is hardly likely to consult a doctor. Another feature of the enlargement is its shape. They are generally oval in shape though there are exceptions to this rule. Tuberculosis is the commonest cause of enlargement of glands in this region, nay in the entire neck. The jugulo-digastric group is the earliest affected in tubercular infection, being the group into which the tonsil drains. The tubercular lymph glands have characteristics of their own,—*viz.*, they are painful, and matted together on account of periadenitis. Since they tend to caseate and soften, their consistency differs in different parts of the same lump; some are firm, some soft, and they eventually involve the skin and break down and discharge pus and forming scars which are characteristic. While this is the commonest picture, there are non-caseating types of tubercle also, especially in adults. The glands of this type are painless, and mobile from absence of periadenitis. The skin does not adhere to the gland. These are particularly liable to be mistaken for lymphadenomatous glands and for final determination a biopsy may be required. But lymphadenomatous glands are less common and they are larger, generally speaking, though not so in the early stage, anyway, in such cases, the first place should be given to tuberculosis, and secondly to Hodgkin's gland. When in doubt a biopsy should be done.



Field of Lymphatic drainage into Submental and Submandibular Glands.



The Lymphatic drainage of Larynx.



Lymphatic drainage of margins of Tongue.

Hodgkin's disease—is also common. Their common starting point is in jugulo-digastric group. They are painless, rubbery discrete, and attain large size and, patients may have what is called Pel-Ebstein type of temperature. Later on other groups of glands get involved. Such as axillary, mediastinal abdominal etc. The spleen and liver may be enlarged later. At this stage diagnosis is easy but in the early stages, it is impossible to diagnose it from the non-caseating variety of tubercular glands except through a biopsy.

Lymphatic Leukaemia—Here the spleen is enlarged. Blood picture shows increase in lymphocytes. In all cases of doubt, a blood smear examination should be done.

Syphilitic glands—have special features.—They affect commonly the posterior superficial chain, and are symmetrically bilateral, shotty and painless. Other evidence of syphilis can be obtained. Epitrochlear glands are also commonly involved. While this is the general picture in a case of genital chancre, it should be remembered that there is such a thing as extragenital chancre, in which perhaps the upper lip is most affected, although any part of the mouth cavity may be involved as a result of what is called oral coitus which is not uncommon. In such cases, the appropriate glands will be involved. They are as usual, painless and shotty. Occasionally, a climatic bubo has been noticed in the neck as a result of oral coitus.

Finally there are the *malignant glands*. This may be primary or secondary. The primary malignant glands are lymphosarcomas. These occur in younger people. This is a rapidly growing condition forming

a mass adherent both to the skin and deeper tissues. Other glands get involved soon. Though the common situation is in the upper part of the neck, it may occur in any group of lymph glands in the neck.

More important and more common than the primary malignant glands, are the secondary malignant glands. Perhaps the commonest seat of malignant disease (Fig. 5 to 8) is the upper part of the alimentary and respiratory tract, and so secondaries in the neck are very common, and sometimes the first noticeable evidence of malignant disease may be the presence of these glands. These glands are hard, but discrete in the early stages, but later on they become adherent to the skin and deeper tissues, and still later, they break down. A complete and systematic search must be made for evidence of primary disease in all the different situations which drain their lymph into the cervical glands, such as nose, accessory sinuses, mouth, pharynx, epilaryngeal region, larynx etc. (Growths in the pyriform fossa are silent). Here it may be mentioned that bronchiogenic carcinoma may be an occasional primary tumour in this situation. This tumour appears between the ages of 40 and 60, and the tumour is partly cystic and partly solid. It is a rare condition, and until one has excluded secondary glands, one is not justified in diagnosing a lump as bronchiogenic carcinoma.

Having dealt briefly with lymph glands, I shall consider other common lumps in this region *i.e.* in the side of the neck. In the sub-mandibular and parotid regions, the commonest lump is the so called *mixed tumour*—(Fig. 9) *Sialoma*. The name is misleading because really it is not a mixed tumour.

It arises from the salivary gland—more commonly from the parotid, and less commonly from the submandibular glands. These are lobulated firm, circumscribed, freely movable tumours which grow slowly over a number of years. A fibroma arising in this region may be mistaken for a mixed tumour. But fibromas are hard, not lobulated, nor connected with salivary glands. Sometimes all the salivary glands and lacrymal glands may be enlarged—Miculiz' disease. Mickulicz disease affects adult males. Secretion of saliva is reduced and dryness of mouth may therefore be present, together with conjunctivitis and pharyngitis. The lacrymal glands are enlarged first and later the salivary glands. Mucous glands in the tongue and cheek may also be enlarged.

Occasionally, a diffuse lipoma may occur in this region in old alcoholics. It envelopes the upper part of the neck completely. In the parotid region, a malignant parotid disease may often be found. This is a hard tumour which very often involves facial nerve, producing facial paralysis. The parotid gland may also be affected with tubercle and might even be mistaken for malignant disease, but the facial nerves are not involved.

Carotid tumour.—Below, in the submandibular region, a carotid tumour may make its appearance. It occurs in both sexes and at all ages. It is slowly growing—spread over years. It is soft and elastic in consistency, and since it arises between the bifurcation of the common carotid artery, it has a pulsatile impulse. It is ovoid in shape and therefore called a potato tumour.

Branchial cyst.—This arises behind the upper part of the sternomas-

toid on a level with the hyoid bone, and under its anterior portion. It is a cystic tumour arising from a branchial cleft. It occurs at about the age of 20. It is liable to be mistaken for caseating tubercular glands. But tubercular glands are seldom single, and aspiration will show cholesterol in a branchial cyst.

Aneurysm.—This is another lump in the anterior triangle. It may arise either from the common carotid artery or from any of its branches. An aneurysm has an expansile pulsation. It has to be distinguished from a transmitted pulsation. In order to differentiate the two, grasp the lump with thumb and index finger. If these are forced apart in all situations and in all directions it is an aneurysm. But if the fingers are only lifted with each pulsation, and not forced apart, the pulsation is a transmitted one. The delay of the pulse in the temporal artery if present, is a good corroborative evidence. But its absence is not against an aneurysm. Aneurysm may also be present in the supraclavicular fossa. Weakening and delay of the pulse in the radial artery and pressure signs referable to the brachial plexus are the classical symptoms. In cases of aneurysm, look for evidence of syphilis and arteriosclerosis in the distal arteries. Arteriovenous aneurysm is another lump that may be found in the carotid region. Since it is the result of injury, a scar is visible. A low continuous systolic and diastolic murmur is audible over it, and an intense thrill is felt. The patient will often complain of disturbance of cerebral circulation and superficial veins in the corresponding side of the head and neck are dilated.

Another important tumour in the neck is a *Cystic hygroma* (Fig. 10). It is congenital and appears early in

adolescence. The cyst may be unilocular or multilocular. It is translucent, but if multilocular, opaque strands may be seen on transillumination. Its common situation is the supraclavicular fossa but it may be found higher. The one shown in the illustration is higher up and occurred at about the age of 20. I cannot emphasise too much the necessity for transillumination. The presence of transillumination clinches the diagnosis. I know a candidate who failed in a prize examination on account of failure to transilluminate the lump.

A hard bony lump may sometimes be felt in the supraclavicular fossa as a result of a cervical rib. Wasting of intrinsic muscles of the hand occurs—the most commonly involved ones being the abductor and opponens pollices. Less commonly it is of the ulnar type in which other intrinsic muscles of the hand are affected. There may be sensory symptoms. The volume of radial pulse on the affected side may be diminished but when the arm is lifted above the shoulder it becomes normal. Vasomotor changes such as coldness and pallor of the fingers, and even gangrene may occur. The cervical rib may be bilateral but symptoms are generally found on the right side. Symptoms generally appear in the 2nd decade, after the age of 14 years.

Occasionally an aberrant thyroid may be found in the posterior triangle. This is lobulated and has the consistency of the thyroid. It is liable to malignant changes and when it does undergo these changes, the gland proper also may be similarly affected. The aberrant thyroid may be affected when the gland proper undergoes disease changes.

Glands in the left supraclavicular of fossa may be affected in carcinoma

stomach. It may occur in carcinoma of any abdominal organ which drains its lymphatics into the cisterna chyli. The affection may be the result of invasion of the thoracic duct by cancer cells, or by cancer cells being carried as emboli. Occasionally the right supraclavicular glands are affected. The thoracic duct has communications with right sided lymph channels especially the right mediastino-bronchial lymph glands.

The commonest tumour in the back of the neck and in the middle line is a meningocele or a meningoencephalocele. These become tense when intracranial pressure is increased in and there may be paralytic symptoms. Occasionally a dermoid cyst may be found in the middle line in the back. The characteristic features of a dermoid has been dealt with already. (vide supra) The back of the neck is one of the commonest sites for a lipoma. Lipomas are lobulated and produce dimples when the skin is stretched. They are soft and may fluctuate. A diffuse lipoma encircling the whole of neck is sometimes found in elderly alcoholics.

In addition to these, lymphosarcomas are common in the neck. This is a rapidly growing tumour forming a mass adherent to the skin and deeper tissues. It is common in the young. Other glands also are involved. If there is a doubt in diagnosis, a biopsy should be done. Diagnosis is important because lymphosarcomata rapidly yield to X-ray therapy. Enchondromata and chondrosarcomata may also arise in the neck either from vertebrae or from remnants of branchial arches. They are extremely rare. They are hard tumours. Chondromata grow slowly and are painless unless they press on the nerves, in which case there may

be neuralgic pains. Chondrosarcomata on the other hand grow rapidly and are painful from the beginning.

Haemangiomas capillary, cavernous or cirroid aneurism may also be found in the neck. The last one espe-

cially, is associated with a similar condition on the face. They are purple or bluish purple in colour and show signs of emptying and will often exhibit bruits. They are congenital but may become manifest during adolescence.

We are very grateful to Dr. Chandu Nambiar for the pains he has lavished on this beautiful and instructive article. He has set an example to the other members of the staff in contributing an excellent scientific article.

Editors

SECURITY

The farmer's oldest son went into the office of the Weekly to have an obituary inserted.

"And what is the date of your father's death?" asked the editor.

"Well", said the youth, "Pa can't die yet, but he will be dead before morning and I thought you might get it in this week's paper if you put it down now."

"Oh, but that won't do at all" replied the editor. "Why, your father may be much better in the morning."

"No, he won't though", said the farmer's boy. "Our doctor says he won't, and our doctor knows what he is giving him."

LEST WE FORGET



DR. KOMAN NAIR

It is with regret we have to record the demise of Dr. Koman Nair who was the Professor of Ophthalmology, Madras Medical College. Dr. Koman Nair was known not only throughout India but had a great reputation abroad. Sweet and amiable by nature, kind to one and all, he was acclaimed by all as the 'great and kind ophthalmologist.'

—Editors.

IN MEMORIUM



DR. RAJAGOPAL NAIDU

It is with deep regret we record the death of Dr. S. Rajagopal Naidu who was till recently Professor of Chemistry, Madras Medical College and Chemical Examiner with the Govt. of Madras.

His death is an irreplaceable loss both to the Government and the College. His opinions and researches were famous and quoted in all text-books.

He was universally loved by his colleagues and students.

We offer our heartfelt sympathy to the members of the bereaved family.

—Editors.

Crohn's Disease—Regional Enteritis

BY
DR. RAMAMURTHI, M.S.

Introduction.—This topic, with a report of 2 cases, (one involving the sigmoid colon and the other the duodenojejunal flexure) with a short introduction is chosen because of the obscurity of the aetiology and other problems yet to be solved in this connection. The pathology is known as non-specific ulceration and the treatment is unsatisfactory. This requires further investigation and classification. The relation to tuberculous disease, and other varieties of enteritis and colitis and also the effect of various other drugs and treatment in the condition have to be evaluated.

This condition is known by various synonyms such as Crohn's disease, non-specific granuloma of the intestine, regional enteritis, etc. It is a chronic inflammatory disease of unknown aetiology which may involve any portion of the gastrointestinal tract though the terminal ileum is the commonest site.

Six hundred cases have been reported in 100 publications till 1938. After that hundreds of cases have been studied and reported upon. Combe in 1813 gave the first description of the condition. Crohn in 1932 described the disease in detail. Wilensky in 1934 said that it may extend into the colon or in rare cases into the duodenum and stomach.

The age incidence is between 15 and 40 i.e., the same age period as mesenteric adenitis and acute

appendicitis. Sex incidence is equal in both sexes.

Pathology.—(1) Diffuse ulceration of the mucosa, (2) Fibrosis which narrows the lumen and causes obstruction. (3) Thickening of the gut wall, and (4) Glandular enlargement.

It simulates chronic ulcerative colitis. The huge foreign body giant cells simulate those of tubercle. The idea that obstruction to lymphatics due to tuberculous disease of the gut, causes this disease is sponsored by some, but definite *proof is lacking*

The late sequelae are:

1. Obstruction.
2. Perforation.
3. Fistula formation.
4. Abscess formation.

The chief presenting signs and symptoms in early cases are:

1. Pain.
2. Diarrhoea.
3. Vomiting.
4. A palpable mass in the abdomen, and
5. Anaemia,

X-ray—In well developed cases the ileo-caecal region may show the Kantor's Ring sign with a barium meal.

Treatment:—Medical treatment only gives temporary relief. The best would be a wide resection. If this is not practicable short circuiting operations are the best.

Case Report 1.

Narayanan, Hindu, male, aged 22, was admitted on 18-5-44 for pain in the left iliac fossa with a painful lump that was constantly present. Patient was constipated and passing pus and mucus in the motion. He had no blood in the motion and gave no history of dysentery. Patient had lost weight. His appetite was poor and he had no vomiting.

On examination:—There was a firm lump in the left iliac fossa placed obliquely from above downwards and medially about 3" long and 2" broad, mobile to a small extent, indenting on pressure, not pulsatile, with no peristalsis and movement with respiration.

Barium enema:—Filling defect seen in transverse colon.

Motion:—No amoebae or cysts seen.

The patient being too young for diverticulitis, a diagnosis of chronic colitis of undetermined origin was made and the abdomen opened. There were considerable adhesions between the coils of ileum, transverse, colon descending colon and omentum which were all adherent to the abdominal wall anteriorly. They were separated and the thickened portion of the pelvic colon was exteriorised in the left iliac fossa and the abdomen closed. The mesenteric glands were not found enlarged. Post-operatively the patient was given emetine and the exteriorised lump got harder and smaller. A fortnight later the lump was resected and extra

peritoneal anastomosis of the gut was made. Pathological report of the specimen (see figures) showed ulceration of the mucous membrane with foci of suppuration in sub-mucous coat and marked thickening of non-specific origin.

The interest lies in the fact that the non-specific colitis had affected the pelvic colon which was rather rare and unlike the second case excision of the diseased portion was possible.

Case Report 2.

Motiah, aged 40, was admitted on 13-8-46 for pain in the hypochondrium on either side of the midline of 6 years duration. Periodicity was present in the initial stages with no relief of pain on taking food: appetite was good and there was no vomiting. Since recently (one month) pain was continuous and increased by food relieved by vomiting and the patient had a sensation of a ball rolling in the abdomen. Locally visible peristalsis of the stomach from left to right was present. Patient had local tenderness in the hypochondrium. A clinical diagnosis of duodenal obstruction was made. After preliminary investigation, under high spinal, the abdomen was opened by a right paramedian incision. The stomach, the first and second parts of the duodenum were normal. But the first inch of the jejunum and last part of the duodenum were oedematous and stippling was present. They felt firm. There were huge glands at the origin of the mesentery pressing on the duodenojejunal flexure. The glands were moderately firm with no softening. A diagnosis of non-specific ulceration of the duodeno-jejunal flexure was made. Because of the anatomy of the parts, a resection was not done. To relieve the obstruction; a post-

erior gastrojejunostomy was done and the abdomen closed. A gland was taken for biopsy from the mesentery at the duodenojejunal flexure. Pathological report was Sinus Catarrh.

The signs pointed to duodenal obstruction due to duodenal ulcer and though there was obstruction the ulceration was found only on the

duodenojejunal flexure. The diagnosis of the much commoner peptic ulcer with obstruction was made.

A short circuiting operation was the best under the circumstances.

The glands differentiated this condition from ulceration of heterotropic gastric mucosa in the flexure.

RADICAL CURE

"Well," said the doctor cheerfully, "how do you feel this morning? Any aches or pains?"

"Well, yes and no," answered the patient. "I feel a great deal better, but it hurts me to breathe. The only trouble seems to be with my breathing."

"Oh," said the physician still more cheerfully. "I'll give you something that will soon stop that".

Osteoclastoma of the Patella.

BY

MISS N. SANKARI, M.B.B.S.

Like some other subjects in the field of bone tumours, the subject of giant cell tumour of bone is a very entangled one. Osteoclastoma occurs usually above the age of twenty but in this case it has occurred in a younger age and the situation is also a rare one.

Case Report

A boy aged 15 years was admitted into the Government General Hospital, Madras on 2-11-'46 with the complaint that his left knee joint was swollen and painful since one year.

History:—Patient noticed a swelling 1 year ago over the anterior aspect of the left knee joint which has been gradually increasing in size. The joint was painless while at rest but on walking or on pressure over the joint there was pain. Two months later he came to this hospital for the above complaint. At that time the knee joint was swollen and the all signs of chronic inflammation were present. The X-Ray did not reveal any lesion. Hence a diagnosis of tuberculous disease of the knee joint was made and the patient was treated with plaster spica for eight months. He has low fever in the evenings and the general condition is poor.

Diet:—Non Vegetarian.

Family History:—Nil particular.

On re-examination at the end of 8 months, the left knee joint was swollen, the normal hollows being

filled. Swelling was maximum over the patella. The skin over the tumour was stretched. There was 1" inch of wasting of the thigh and leg muscles. The swelling was warm, tense and tender. Patellar tap was present. There was marked synovial thickening. The lateral border of the patella was tender. Both active and passive movements revealed that only 30° flexion was possible but full extension was present. The skiagram revealed that the outline of the patella was just visualised and rarification of the femur was present. His sedimentation rate was high

At the end of 1st time 65 mm.

At the end of 2nd time 98 mm.

Since the diagnosis was not clear, the knee joint was aspirated and 20 c.c. of blood-stained fluid were drawn out. Smear of the fluid showed malignant cells. X-ray of the lung did not reveal any secondaries.

On 15-11-'46 under low spinal, excision of the patella with wide area of soft tissues was done. Diffuse haemorrhagic growth on all sides of the patella with infiltration into the synovial membrane was seen. Patella with the synovial membrane was excised. The wound was closed after repair of the quadriceps.

Pathological report revealed it to be osteoclastoma of the patella—grade III (Fig. A & B) (X-ray of the specimen)—shows tumour of the patella. Limb was enclosed in plaster and the

OSTEOCLASTOMA OF THE PATELLA.



X-Ray Chest—No secondaries.

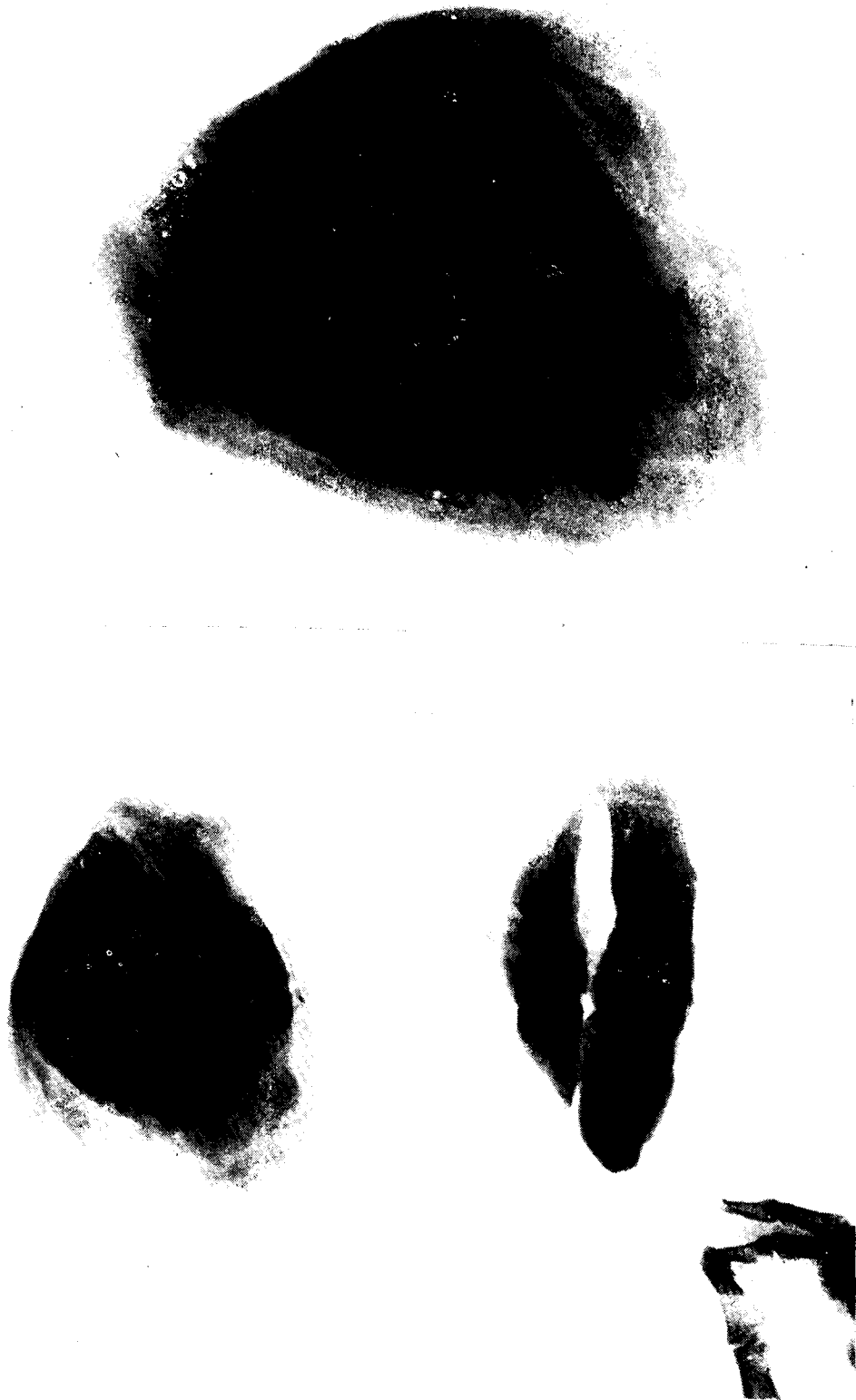
wound healed. He was discharged on 5-3-'47 with instructions to walk with the knee plaster for three months. Again an X-ray of the lung fields was taken and there were no secondaries.

A brief outline of the clinical and pathological features of the disease may not be out of place. Specifically this lesion is regarded as a neoplasm of a definite kind, arising apparently from the undifferentiated supporting connective tissue of the marrow and in any case clearly delimitable on the basis of its cytological details. In its essence the giant-cell tumour is composed of a more or less vascularized network of spindle-shaped or ovoid stromal cells and multinuclear giant cells. Though the giant cells form an obvious feature of the lesion, the stromal cells are really more significant. The stromal cells constitute the generitic foundation of the tumour, and it is their behaviour that gives the lesion much of its character. The term "benign" in connection with giant cell tumour is misleading because through it exhibits benign characteristics both clinically and pathologically, recurrence after initial treatment is not uncommon. It is being increasingly recognised, however, that the tumour takes on a malignant character either spontaneously or consequence of stimulation through injudicious therapy. These qualities consist of increased local aggressiveness or recurrence and certain changes in the cytological detail. There is now sufficient evidence to show that in such cases the tumours may eventually undergo malignant transformation and finally metastasize. Thus in studying the natural history of the genuine giant cell tumour of bone, one can observe all gradations from a definitely favourable type, through a more aggressive

type with a pronounced tendency towards recurrence, to a frankly malignant and metastasizing type.

The usual site of the tumour is an epiphysis or an epiphyseal end of some long bone. However, a bone cell tumour may take its origin in a bone which has no epiphysis, for instance, a maxilla mandible or talus. It may even originate in a non epiphyseal part of bone as for instance within the central part of a vertebral body. Both sexes are equally affected.

Earliest diagnosis is on the basis of roentgenographic finding. The description runs as follows. The epiphysial end, sometimes alone but more often with part of the adjacent metaphysis, shows a large and somewhat eccentric area of rarification. The involvement may extend to the articular cartilage, and occasionally an intra articular fracture line is visible. The bone cortex in the affected region is likely to be found thinned and expanded and may then show fracture. The distended area of rarification is generally further described as being traversed by delicate septa producing a multilocular cyst like effect in the skiagram. The multilocular appearance is over stressed and one may be led astray if the presence of this appearance is expected. It may be observed in angioma, enchondroma and various filarious lesions of bone. Far more important diagnostically are the location of the area of rarification in the end of the bone and thinning and expansion of the cortex, particularly on one side. The distended area is usually delimited by a thin shell of bone, over which periosteum is somewhat thickened. The thin bone shell represents newly formed bone which has replaced the resorbed original cortex. The tumour extends to the articular



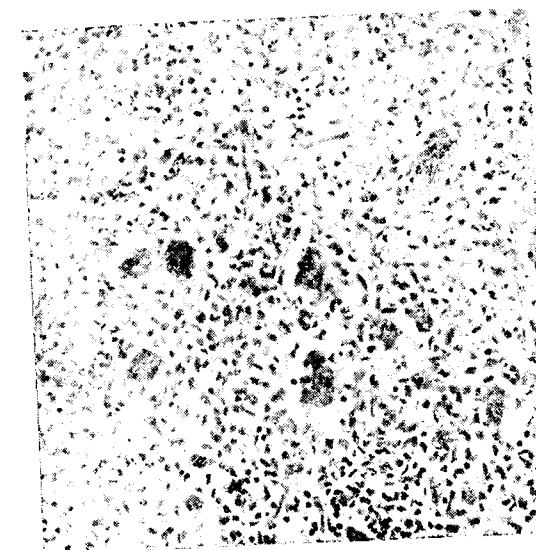
cartilage in some places. But cartilage is not usually perforated by tumour tissue. But a chondrosarcoma starting in the epiphysial end may resemble this tumour. The necessity for reservation as to the diagnosis until a biopsy specimen has been studied is thus apparent.

The gross appearance of the tumour depends on the degree to which it has already proceeded. In the early stages it is rather uniformly dark red or reddish brown, though the more richly cellular areas may be gray, and of a fleshy consistency though friable. The presence of hæmorrhagic areas is evidenced in spots or blotches of bright red or blackish red and in greater softness of the tissue necrotic areas appear yellowish and may even be liquified. It is after necrosis and hæmorrhage have taken place in a giant cell tumour that it becomes cystic. Spaces vary in size and contain hæmorrhagic fluid. If the tumour has been permitted to run its course after repeated pathological fractures, the tumour may be found to have disrupted the periosteal cuff and perhaps grown along inter-muscular septa. It may even have advanced into a neighbouring bone, either by invasion into the joint space or by extending through, an interosseous membrane. These changes are seen in malignant transformation also.

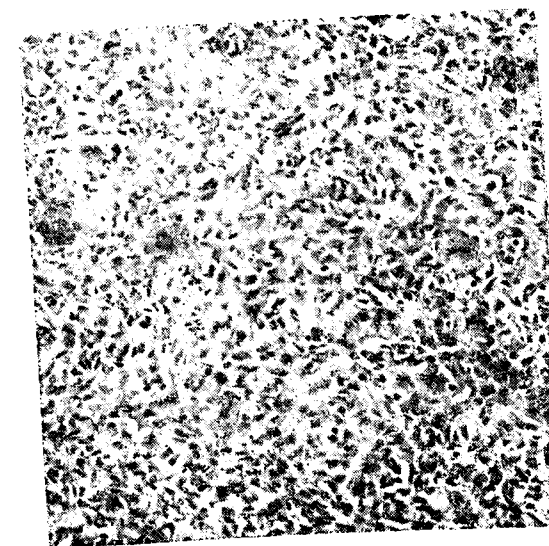
On microscopic examination, the tumour consists of a moderately vascularized network of stromal cells and multinuclear giant cells interspersed with collagenous fibrils. The stromal cells are mononuclear and in general resemble young connective tissue cells. They are spindle or ovoid in varying proportions. Correspondingly, the nucleus, which occupies much of the cell body, is longish or roundish. It contains a

moderate amount of chromatin and a more or less central nucleolus. The outlines of the individual stromal cells may present evidence of mitotic division. The stromal cells of the tumour seem more plausibly explainable as arising through proliferation of the mesenchyme-like supporting connective tissue of the marrow. The multinucleated giant cells are found irregularly distributed between the stromal cells. The nuclei tend to be conglomerated toward the middle of the cell. They are round or oval and each has a nucleolus. The cytoplasm is usually considerable in amount and frequently granular and vacuolated. The cells, too, apparently have cytoplasmic processes, and some workers have shown that these processes anastomose with those of the stromal cells.

It is essential that in addition to making a diagnosis of giant cell tumour of bone, we should attempt to grade the lesion with a view to predicting if possible, its clinical course and suggesting appropriate therapy. Grading is based on variations relating mainly the stromal cells. There are three grades. The grade I tumours are those in which the cytological features indicate the lowest degree of aggressiveness and hence a relatively favourable prognosis. The tumours delegated to the other two groups show successively more ominous cytological features, these of grade III being definitely malignant. To belong to grade I, the lesion must show no appreciable atypism of its stromal cells. Though these cells are abundant, they are not densely compacted in a tumour of this grade. In the majority of cases they are predominantly spindle-shaped, whilst in the rest they are predominantly polygonal or ovoid and are of uniform



Photomicrograph of tissue from a giant cell tumour of the patella—The stroma is formed mainly by spindle cells and giant cells.



Photomicrograph of tissue from the same tumour from a different site showing sarcomatous stroma and a few giant cells with a lesser number of nuclei. The cells are arranged in irregular whorls.

THE FIRST STUDENT PRESIDENT



As the First Student President he did his duty without fear or favour. His way of conducting the college functions and meetings were unique.

We thank him for all his services to the Association.

size. One finds only an occasional stromal cell that has a hyperchromatic or abnormally large nucleus or two nuclei. The tumours of grade II constitute a somewhat varied group, ranging from these in which the stromal cells show only slight (though definite) atypism to these in which they are strikingly atypical. The stromal cells are abundant and closely compacted and many even show plainly an irregular whorled arrangement. In certain areas stromal cells are predominantly plump or ovoid and their nuclei are large and swollen in proportion to the cell as a whole. The fibrillar stroma shows no appreciable tendency toward collagenous differentiation. The giant cells are abundant. Their nuclei may show atypism. As to prognosis this tends strongly towards recurrence and some eventually undergo malignant transformation. The tumours of grade III constitute a small group

which are frankly malignant, possessing a sarcomatous type of stroma and a capacity for metastasis. Stromal cells are abundant and closely compacted and tend to present an irregular whorled arrangement. Their nuclei exhibit atypism uniformly and are likely to be unusually large and anaplastic. The giant cells tend to be dwarfed and to contain few nuclei and the latter to be likely to show atypism. This type metastasizes sooner or later, particularly in the lungs.

I am grateful to Dr. N.S. Narasimhan for permitting me to report this case. I thank the Pathology Department for the kind suggestions and help.

Reference

Archives of Pathology No. 1940 Giant cell tumour of Bone by Henry L. Jaffe, M.D.,
Lorus Lichtenstein and M.D.,
Robert B. Portes M.D.

HOPLESS CASE

Doctor : "How is your appetite?"

Patient : "Rotten! Not even what you forbade me appeals to me."

Patent Ductus Arteriosus.

By
E. SANKARALINGAM, III year.

(From Maitland Ward under Dr. A. Srinivasan M.R.C.P. (Lond).)

A boy, Nageswara Rao, by name aged nine was admitted on 23-1-'47 in Maitland Ward under Dr. A. Srinivasan and was discharged on 6-2-'47.

Leading symptoms. Breathlessness on exertion, palpitation and generalised oedema of the face.

Duration. 15 days.

History. The symptoms developed insidiously 15 days ago. On exertion the boy became breathless and developed palpitation sometimes associated with a dull pain over the precordial area. All these days he noticed oedema of face after sleep.

Previous illness. The patient did not give any history.

Family History. Nil. particular.

Physical Examination. The boy was well nourished. His weight was 48 lbs. Anaemic. Not jaundiced. The lips were cyanosed. There was no clubbing of fingers. The skin was healthy. There was no enlargement of glands. There was puffiness of face and slight oedema of both feet, pitting on pressure.

Cardiovascular System. Pulse 100 per minute. Rhythm was regular. Volume and tension good. Vessel walls soft and supple.

Blood pressure: Systolic—100 mm.

Diastolic—? (could not be taken).

Inspection: Apex Beat visible at the 4th. left intercostal space in the mid-clavicular line. It was diffused about 1 sq. inch in area around the left nipple.

Palpation: Apex beat palpable at the 4th. left intercostal space in the mid-clavicular line. Thrills—systolic and diastolic are felt outside the pulmonary area, about 1" lateral to the left sternal line.

Percussion:

III left intercostal space.

Right lateral sternal line.	1" lateral to the left mid-clavicular line.
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Auscultation:

(1) **Mitral area:** First sound: Feebly heard. Followed by a systolic murmur which is conducted towards the axilla to about an inch from the left mid-clavicular line.

Second sound: Heard. Followed by a diastolic murmur.

(2) **Pulmonary area:** First sound: Not heard. Replaced by a murmur.

Second sound: Heard, but very much accentuated. Followed by diastolic murmur, conducted towards the left clavicle. The region of maximum intensity was 1 inch lateral to the sternum in the second left space.

Respiratory System. Rate 24 per minute. Regular rhythm.

Inspection. Both sides of the chest move freely with respiration.

Palpation. Confirms inspection. V.F. heard.

Percussion. Nil abnormal.

Auscultation. Breath sounds diminished at the bases,

Alimentary System. Normal.

Central Nervous System. Normal.

Laboratory Investigations.

1. **Blood.** R.B.C. Count—4.1 millions.

W.B.C. Count—6800.

Hæmoglobin—80%

Differential Count.

Polymorphs—66%.

Lymphocytes—20%.

Eosinophils—9%.

Monocytes—5%.

2. **Urine.** Sp. Gravity: 1020. Acidic. No albumin.

No sugar. No deposits. Culture sterile.

3. **Blood Pressure.** Systolic—100. Diastolic—? (could not be taken).

4. **Pulse.** 100 per minute.

5. **Motions.** Nil. abnormal.

6. **X-Ray chest.** The heart shadow was enlarged. The right ventricle was enlarged and a prominent pulmonary conus was seen. The aortic shadow also was enlarged.

7. **Electrocardiogram.** was not taken as apparatus was not working.

Diagnosis. Characteric loud continuous systolic diastolic murmur in the second left intercostal space with associated thrills and the accentuated pulmonary second sound have to be considered.

Differential Diagnosis.

1. **Patent Ductus Arteriosus.** Seems to be the most likely diagnosis. In this connection Shapiro has written in "Lancet", May '44 the following:—

"According to Shapiro, two types of the ductus arteriosus occur.

(1) Failure of closure may accompany a developmental defect of the heart and the open ductus may be the only possible escape for the abnormal circulation. In such instances the flow of blood usually continues as in the foetal circulation; that is, blood flows from the pulmonary artery to the aorta, thereby resulting in cyanosis.

(2) The other type of patency occurs as a simple failure of closure and is unaccompanied by other cardiac abnormalities. It is this type of case which leads itself to surgical ligation.

The author lists the following diagnostic criteria of patent ductus arteriosus:—

(1) History of heart disease from birth or early childhood.

(2) No cyanosis or clubbing of the fingers.

(3) Stunting of growth in a small percentage of cases.

(4) Probable thrill over the pulmonary area.

- (5) Characteristic machinery murmur.
- (6) Increased pulse pressure.
- (7) Enlargement of pulmonary artery and branches.
- (8) Normal electrocardiograph.
- (9) Probable enlarged heart.

The great majority of patients with patent ductus arteriosus develop some cardiac difficulty in early childhood. It is quite rare to examine a patient with patent ductus arteriosus over the age of 40. When the diagnosis of uncomplicated patent ductus can be made, surgery should be seriously considered particularly in patients showing cardiac strain...."

So here the patency of ductus arteriosus has to be considered because of the following findings:—

(1) A loud rough murmur continuous during systole and diastole heard in the second left intercostal space 1" outside the pulmonary area and conducted towards the left clavicle.

(2) Accentuated second sound in the pulmonary area.

(3) X-Ray examination shows enlargement of the right ventricle and the concus arteriosus.

II. *Haemic Murmur*. Heard at the second left intercostal space over or external to the pulmonary area, systolic and disappears or becomes indistinct when the patient assumes an erect posture and is not conducted.

III. *Pulmonary Stenosis*. Characteristics are cyanosis, clubbing of fingers, polycythemia and defective growth. There is a rough systolic

murmur (often with a thrill) in the second left intercostal space which may be conducted upwards and outwards towards the the left shoulder with faint or absent of clubbed fingers and presence of accentuated second pulmonary sound.

IV. *Co-arctation of the Aorta*.

A long systolic murmur at the base of the heart, with enlargement of the ascending aorta, large arterial pulsation and high blood pressure in lower limb and dilatation of collateral arteries of the chest are characteristics of co-arctation of aorta. This is ruled out by the low blood pressure (especially diastolic), enlarged aortic shadow and absence of dilatation of the intercostal arteries.

Treatment and Progress.

Date.	Treatment.	Progress.
24-1-47.	(A). Conc. Mag. Sulph. oz. $\frac{1}{2}$ Tr. Digitalis m.xx.	
	(B). Mist. Calcium Chloride oz. $1\frac{1}{2}$ oz. $\frac{1}{2}$ T.D.S.	Pulse. 100. B. P. 100?
25-1-47.	Rpt. A & B.	
26-1-47.	Rpt. A & B.	
27-1-47.	Rpt. A & B. 9 P.M. Haustus Paraldehyde oz. $\frac{1}{2}$.	
28-1-47.	Rpt. A & B.	Pulse. 80.
29-1-47.	Rpt. A & B.	B.P. 80/?

Liver was enlarged slightly. Palpable to about a finger's breadth below the costal margin.

- 30-1-47. Rpt. A & B.
- 31-1-47. Rpt. A & B.
- 1-2-47. Rpt. A & B.
- 2-2-47. Rpt. A & B.
- 3-2-47. Rpt. A & B.
- (C). Tr. Digitalis. m. xxx. Aqua Chloroformi. oz. iii. 3 oz. ii T. D. S.
- 4-2-47. Rpt. A & C.
- 5-2-47. Rpt. A & C.
- 6-2-47. Discharged.

Admitted again on 13-2-47.

- 13-2-47. (A). Tr. Digitalis. m. xx. Pot. Citras. oz. t 1
Pot. Bicarb. oz. t 1
Liq. Ammonium acetatis dilutum. oz. ii 2
Aqua ad. oz. iv
oz. t 1 every 6 hrs.
- (B). Conc. Mag. Sulph. oz. $\frac{1}{2}$
early morning

- 14-2-47. Rpt. A & B.
- 15-2-47. Rpt. A & B.
- 16-2-47. Rpt. A & B.

(C). Mist. Ammonium chloride oz. $1\frac{1}{2}$, oz. $\frac{1}{2}$ t. d. s.

- (D). Mersalyl $\frac{1}{2}$ c. c. I. M.
- 17-2-47. Rpt. A B & C.

- 18-2-47. Rpt. A B & C.
- 19-2-47. Rpt. A B & C.
- 20-2-47. Digoxin tablets 3. one t. d. s.
Insulin (aqueous) one bottle. 5 units daily.
Leeches. 6.
- 21-2-47. Mist. Ammonium Chloride. oz. iii
oz. i t. d. s.
Mersalyl $\frac{1}{2}$ c. c. (I. V.)
9 P. M. Haustus Paraldehyde oz. i
- 22-2-47. Died at 3 a. m.

The boy was discharged on 6-2-47 against medical advice. Again on 13-2-47 he was admitted with congestive failure and with puffiness of eyes and face generalised oedema of the whole body. The boy died on 22-2-47.

My thank are due to Dr. A. Srinivasan, for his kind permission to publish this case report and also Dr. Anantharaman and Capt. V. P. Naidu for their valuable and kind help in bringing out this Case Report,

PSYCHIATRY LECTURE

"This man has a religious mania and thinks' he cannot die. It is our task now to convince him of the contrary."

The Madras Medical College Magazine



THE preceding academic year has been full of activities and it is difficult to give a full review doing justice to all concerned. Nevertheless we will try to review the more important events.

First of all we have to congratulate the new office bearers, the General Secretary and the Student-President. We commend the spirit in which the elections were conducted and we know they will do their jobs efficiently and without fear or favour. The outgoing Secretary and President have been very energetic and introduced very many new activities like the Provincial Medical Students Conference and we hope they will be carried on. Some of the activities like the Fine Arts Society did not last out even during the term of office of the inaugurators, but we hope they will be revived as soon as funds permit.

The sports day was an exciting event as usual. There were several items of interest. Dr. Kutumbiah presided and Mrs. Sangham Lal distributed the prizes. We congratulate those who organised it.

One of the highlights of the Silver Jubilee celebrations of the Magazine was the Intercollegiate Debate conducted for the first time by this college. It is very beneficial to the Medical Student to mix with the students of other colleges instead of remaining aloof, and intercollegiate debates are ideal for this purpose. We can learn from others and

exhibit our talent as well. The debate was a great success and we again thank Dr. Cherian for the rolling shield presented by him. We hope that the future office bearers will carry on the debate every year.

Turning from the college to the political arena, we find much to disturb us. The general public supported a change in the ministry in the hope that the policy, especially with regard to the Public Health and Textile policies, would be changed. But it seems now that these hopes were false, and if so, we do not consider the new ministry an improvement on the former, and there was no point in the mere change of personnel. We want the ministry to give a clear statement with regard to the Ayurvedic and Western systems of medicine, so that we know where we stand. We appeal to them not to continue their peurile support to this bastard child of an outmoded system. If they have no compunction in disregarding the opinion of the scientific world, a so called "popular" ministry should at least have regard to the fact that the general public has no faith in this system—indeed it has often been proved that the Honourable Ministers themselves are not unlike the general public in this respect.

This is the last magazine that we are editing. We have always tried to do our best and we have not spared time nor effort in doing our duty, especially in bringing out a fitting Silver Jubilee Number. Our sins have been more of omission than of commission, and if we have so offend-

EDITORIAL

ed or slighted anyone, we would like to say that it was not intentional but because of human lapses of memory. If we have succeeded in maintaining a high standard for the magazine, and not let down the honour of the college we are more than satisfied.

We thank all those who collaborated with us—the other members of the Magazine Committee, the members of the College Association and the contributors. We wish all the best to the future editors.

Editors.

HORS D'OUVRE OR DESSERT?

Doctor: "If you want to reduce you must eat only fruit, toast, lean meat, raw vegetables and drink only orange juice."

Fat Woman: "When must I take that, before or after meals?"

“ Cherchez Le Femme ”

“ . . . I am going to tell you a thing that I am sure will make you wish yourself here. The small-pox, so general and total among us; is here entirely harmless by the invention of “ingrafting”, which is the term they give it. There is a set of old women who make it their business to perform the operation every autumn in the month of September when the heat is abated. People send to one another to know if any of their family has a mind to have the small-pox; they make parties for this purpose and when they are met the old woman comes with a nutshell full of the matter of the best sort of small-pox and ask what veins you will please to have opened. She immediately rips open that you offer her with a large needle, which gives you no more pain than a common scratch, and puts into the vein as much venom as can be on the head of her needle and after that binds up the wound with a hollow bit of shell and in this manner opens four or five veins. The Grecians have commonly the superstition of opening one in the middle of the forehead, in each arm and on the breast to mark the sign of the cross; but this has a very ill effect; these wounds leaving little scars, and is not done by those that are not superstitious, who choose to have them on legs or that part of the arm that is concealed. The children or young patients play together all the rest of the day, and are in perfect health till the eighth. Then the fever begins to seize them and they keep to their beds two days very seldom three. They have very rarely

above twenty or thirty in their faces which never mark and in eight days time are as well as before their illness. Where they are wounded there remain running sores during the distemper which I don't doubt is a great relief to it. Every year thousands undergo this operation and the French Ambassador says pleasantly, that they take small-pox here by way of diversion as they take the waters in other countries. There is no example of anyone that has died in it; and you may believe I am very well satisfied of the safety of the experiment since I intend to try it on my dear little son.

I am patriot enough to bring this useful fashion into England; and I should not fail to write to some of our doctors very particularly about it, if I knew any of them that I thought had virtue enough to destroy such a considerable branch of their revenue for the good of mankind. But that distemper is so beneficial to them not to expose to all their resentment on the hardy wight that should undertake to put an end to it. Perhaps if I live or return, I may however have courage to war with them. Upon this occasion, admire the heroism in the heart of your friend ”.

Dated Adrianople April 1717.

[Above is an extract from a letter written by Lady Mary Wortley Montagu to Mrs. Sarah Chiswell. This talented woman's observations first gave the scientific world the idea of protection by vaccination.]

Mother Ind

By

ANANTH (2nd Year).

O, Mother! How well, dear mother mine,
Didst thou in past history shine,
With such grandeur, and a glory so fine!
An honour that was entirely thine.

How high wert thou by others esteemed!
The very queen of the earth thou wert deemed!
Distant historians did travel over miles,
To write of your glory and honour their files.

Thy gallant armies didst march far and wide,
Like the mighty billows of the ocean tide;
O'er distant corners of the world thy flag hath flown,
The frozen poles didst resound thy trumpets blown.

While the white western savage did tear his hair,
Skinclad, and club-handed, in deep despair,
The caves his abode, raw flash his feast,
No whit better than the lowly beast;

Thou hadst then in civilisation so advanced,
Literature and Arts with you so romanced;
Such haloed glory didst thou radiate,
The world's humble offerings were at thy gate.

Such was thy greatness; the wheel of fortune
Hath roll'd over and brought you down to misfortune;
The reverse of time hath done its spoil,
And brought sorrow and slavery o'er thy soil-

O Mother, what change the world hath seen;
From thy high pedestal thou hath been
Rolled down into the mire of shame,
Thy honour is shattered, gone is thy fame.

Under the foreign yoke do thou now groan,
Thy sad plight there is none to mourn,
Thou art trampled under whiteman's feet,
Like cattle thy children doth he treat.

Alas, shame unto thy children's disunity !
 Their feud over religion and community
 Hath been the bane that wrought this havoc,
 That none is able to revoke.

Thank Heaven ! Thy children have understood,
 At last their blunder ; they brood
 O'er the past with remorse and shame,
 Their hearts are ablaze with Freedom's Flame !

Brothers ! Discard all your differences ;
 Let not the past sad remembrances
 Deter you ; march as one man to the field ;
 Fight your might, the enemy 'll sure yeild.

Arise, brothers ! to shatter the shackles of slavery,
 Muster all your strength courage and bravery ;
 India shall still be yours and free,
 Heavens shall shower all honour unto thee !

First Nurse : " She is only an X-ray technician "

Second Nurse : " Yes, she sits in a dark room and awaits developments."

" Facts "

By

" DUBLIN "

(Women are more ticklish compared with men—women, on the average).

Are shorter in height by	...	...	4½ inches.
Are lighter in weight by	...	...	15 pounds.
Have lighter brains by	..	...	140 grams.
Live longer by	...	...	4. 2 years.
Eat less food daily by	...	...	500 calories.
Get second teeth earlier by	...	...	3 months.
Hearts beat faster per minute by	...	...	8 beats.
Have fewer red blood corpuscles by	...	...	25,000 million.
Have lower blood pressure by	...	...	10 points.
Have less breathing capacity.	...	...	1050 c.cms.
Outnumber by	...	...	1 in 125.
Commit suicide less often by	...	...	1 to 4.
Go mad less often by	...	...	25 to 27.
Have appendicitis less often by	...	...	1 to 2.
Are less color blind by	...	...	1 to 10.
Are born albino less often by	...	...	2 to 3.
Are deaf and mute less often by	...	...	79 to 100.
Get drunk less often by	...	...	1 to 7.
Have weaker handshakes by	...	...	33%
Have better sense of smell by	...	...	10%
Recover better from operations by	...	...	6%
Are more inclined to blush by	...	...	17%
Are, one more ticklish by	...	...	12%

The Denouement

BY

"JASON"

I was in bed reading up to a late hour. It was not any of the text books prescribed by an unsympathetic University for the persecution of the poor medico but a novel—a super shocker, thriller and whatnot—where the hero and the heroine undergo every danger under the sun and containing a particularly malignant fate in the shape of the villain of the type who twirls his pointed waxed moustache and shows large white teeth while laughing "Ha! Ha! Ha!!!" in a deep voice. There was battle, murder and sudden death enough to satisfy the most ardent lover of six-penny shockers. The hero had been thrown off horses, had swum through rapids, had escaped miraculously from a burning building and from a buzz-saw. In short the only thing that had not yet happened to him was the exit from this vale of sorrow. The heroine was of the conventional type with a decided will of her own and with a brain no bigger than a mosquito's.

Consequently the hero had greater additions to his list of miraculous escapes for no sooner did he free himself from the clutches of the villain than did he have to rush to the rescue of the girl who would never stay at home as bidden by the hero or the father who doted on her and spoiled her thoroughly. I had come to the stage where the hero was fleeing towards danger while the heroine closely followed him. The lights in the room appeared dim and so did the pages of the book.....

Suddenly the hero's face became clear. Lol it was my own and there was I running up the slope of a hill. Behind me came—not the villain—but

the heroine. Many of the readers would no doubt welcome the prospect, but this heroine was not the heroine visualised by the author of the thriller. The heroine had suddenly turned to vast proportions. She was well over fifteen feet tall and more than proportionately broad with biceps that Samson might have envied. The nose was broad and played across the hideous face. The eyes were large, protuberant and fiery red. The hands had turned to claws with wicked looking sharp nails. What was most horrible were the two long projecting canines. This creature, despite her size, came bounding after me with great agility. Every one knows I am no sprinter but I broke all records as I sprinted up the bill. There was ~~some one else~~ in front of me doing better. (That was the cowardly villain) My breath came in gasps and my chest was heaving painfully. The creature was gaining on me making raucous noises. Suddenly I stopped dead for there in front of me the path abruptly stopped short and the side fell sheer to over a thousand feet. The white faced craven villain was staring behind me at the pursuing creature. I was most unheroically petrified with fear. The female creature had come to within twenty yards of us when the villain suddenly leaped over the cliff. After a momentary hesitation I followed suit pursued by the harsh croak of the baffled creature above. I fell down, down..... I yelled with all my might but emitted only a squeak..... down, down and the Earth came nearer.....and I landed with a painful thud on the floor of the room. The crow sitting near my window croaked again and flew away.

The "If" of House Surgency.

(With apologies to the late Rudyard Kipling)

BY

T. R. PAI.

1. If you can keep your temper when folks above you
Are growling at you and taking a biased view;
If you can keep your head when your boss is banging you
And make allowance for his cursing too.
2. If you can work and not be tired of working,
Or flirting, hold your own against other housemen;
Or being beaten, never once stop trying,
And yet don't think you must retire at ten.
3. If you can keep awake through the long long night,
And not mind the unpleasant memos that flow;
And yet in the morning look so bright,
And still do your work without being slow.
4. If you can continued to live in that overcrowded room,
And yet not dream of your sweet old home;
And provide food for all the bugs in the room.
But still not think of sealing their doom.
5. If you can continue to work on so meagre a pay,
And yet not be so bold as "Oliver" to ask for mere;
But patiently wait for that jolly old day,
When the postman with the M.O. comes to the door
6. If you can wait and not be tired of waiting,
If you can patiently watch the flies that buzz around;
If you can eat the food that the mess is supplying,
And yet not mind the indigestion and diarrhoea that abound.
7. If you can think and not make thoughts your master,
If you can laugh and yet be serious too;
If you can banish worries and disaster,
And make your friends think your cares are few,
8. If you can fill every hour of your waking time,
With 60 minutes worth of work well done,
You never get anything worth ever a dime,
And what is more—you are only a Houseman my friend.

Quoting Odds

BY
M. K. R. KRISHNAN, M.B.B.S.

1. "Lunatics are kept in asylums only because they are in the minority. The moment they become the majority, they will put us in asylums." (*Nat Gubbins*)

2. According the show:—

"Every man over forty is a SCOUNDREL."

3. The reason why:—

"The fundamental reason why women do not achieve all that men do is because women don't have wives. So, until Society or Science changes this fundamental blunder of Nature, I am afraid we must remain the inferior sex." (*A Woman*)

4. E. Psm:—

"Old men love, while young men DIE." (*Rudyard Kipling*)

5. Did you know?

"A smooth faced man shaves a distance of twenty miles in an average life time." (*New Health*)

6. Let's all be reasonable and be

"The reasonable man tries to adapt himself to the world, whereas the unreasonable man tries to adapt the world to himself. So all progress depends on the unreasonable man."

7. Perfect health:—

It is reported that a man died at the ripe old age of ninety and five and his last illness was the first.

8. Parental:—

"No parent wants to talk about anybody else's child. His own sons adenoids are far more charming than any other infant's achievements." (*Beverly Nichols*)

9. A bloody fact:—

You shall live till you die:

10. Which is it?

"When a woman leaveth things undone, it may be carelessness, but it may also be sex-appeal."

(*F. Murray Milne*)

11. So we needn't:—

"When you ain't no eddicated, you've just gotta use your brains."

12. Flirting:—

"She hasn't any one particular man in mind. She just goes for the whole damn lot."

13. Our Prayer:—

"Give us, O' Lord, a bit O' Sun,
A bit O' work and a bit O' fun

Give us sense, for we're some of us
DUFFERS,

And a heart to feel for all that
suffers."

Good-Bye

We appeal to fresh blood to come forward and give their best efforts feel assured that in most of the young ones burns the FLAME of literary genius which needs very little fuel to flare forth into great dimensions. It will be no exaggeration and impertinence on my part to remind these that the medical students from time immemorial have always risen to the occasion especially when it is demanded of them to uphold these noble tradition and customs of our college which has made its name IMMORTAL. Shall we on this occasion beseech the fresh addition of staff and the newly stepped in doctors to contribute articles of interest both medical and general as frequently as possible which will also help them to be in touch with ALMA MATER.

In thanking the members of the staff for the enthusiasm they have shown and for the advice given, may we solicit them to continue their

zeal and interest and benefit us by their mature experience. We take this opportunity of sincerely thanking those who have kindly contributed articles willingly to our Magazine and confidently believe they will keep it up.

Dr. Janardanam the Honorary treasurer was always ready to help us. In the matter of finance, he had to exhaust almost all his reserves but all the same the Silver Jubilee of the Magazine was rightly celebrated with a fitting souvenir. We also thank the Principal and Dr. Narayana Rao for their valuable suggestions and ready help.

We wish to say Good-Bye to all our readers, Contributors and other patrons. We deem it our sweet privilege to have been connected with the Magazine and we hope always to watch its progress with interest.

General Editor.

SERIOUS CASE

Doctor: "How is the patient today? How has his heart been functioning?"

Nurse: "His heart is over active. He has already proposed to me twice today."

Whither Medicine?

"I balanced all, brought all to mind.
The years to come seemed waste of breath,
A waste of breath, the years behind,
In balance with this life, this death."

The impressions set down in this article are entirely personal and I do not claim to be original or representative. These are the feelings that have been evoked in me during my five years of undergraduate study in this college. Perhaps some of them may be wrong sentiments; some may be even attributed to morbidity of mind. Whatever it may be they are the uppermost impressions in my mind and as all human beings have their foibles and virtues, my feelings are also a mixture of both. Let me begin with the beginning of the course.

Pre-registration:—My first reaction to this needless grinding was one of complete apathy and disgust. In this course what is taught is a faithful reproduction of what is already taught in the intermediate. When my mind was cudgelling itself to understand the Newtonian rings and the mysteries of Tesla currents with their terrifying formulas and equations and when my imagination was stupefied by the recondite laws of physical chemistry I could not even in my wildest of dreams, scent an iota of connection between what was taught then and the Medicine that was going to be taught to me. I felt to the very marrow of my bones that this is an intellectual torture to which the students are needlessly subjected.

The only justification for the existence of this anachronism is that those who have not taken biology in their intermediate may be helped by a few lectures that are given in this course. An average student with average intelligence can easily assimilate the necessary knowledge in biology without undergoing this needless and deliberate waste of six months. In the West, so I am given to understand, a candidate with literature M.A. can take to medicine with no restriction what so ever. For people similarly placed in India, Medicine is a closed temple. I cannot think of a system more rigid in its outlook and vision than this. Perhaps herein we may detect however vaguely it may be, the reason why some of the Western medical writers possess the enviable gift of poetic fluency of language. It is absolutely foolish to deny that language moulds scientific thought.

Anatomy:—In the beginning I was overjoyed because for the first time I was breathing the air of something so essential to our career after a stifling existence of six months in an atmosphere surcharged with unnecessary details and sometimes nonsense too.

Anatomy and Physiology are rightly regarded as the fundamentals of Medicine. As I journeyed through

those two years when those 'fundamentals of Medicine' were taught, my earlier impressions and hopes suffered bitter disappointments. Very gradually the feeling came to me that Anatomy was taught to us in a way not calculated to equip the future surgeons and physicians. Those fundamentals of anatomy so essential to a surgeon (these assume in final year, the garb of "Surgical Anatomy") and a practising physician, are buried and lost sight of under a morass of unnecessary details constantly dinned into our ears all along those two years which, for many a medical student, are years filled with gristly memory of menacing events. The reasons are not far to seek. Anatomy is usually taught by academical professors who never see the inside of an operation theatre or establish a liason with the surgeons and ascertain the essential facts to be taught. Anatomy should be taught by surgeons. No one can know better the applied part of Anatomy than a surgeon who is always exploring the living but diseased human frame. The division of the first two years as pre-clinical and the rest clinical is, to my mind highly proposterous and is calculated to do immense harm, for it gives the idea (at any rate it has given me the idea) that Anatomy and physiology are isolated in lands separated from the vast mainland of Medicine by a wide gulf of meaningless sea.

The degree to which I understood human embryology makes me ashamed of myself. In spite of an admirable museum filled with exquisite wax models of His, an intelligent grasp of the subject became increas-

ingly difficult. The importance it bears to proper diagnosis and treatment of many congenital abnormalities we come across in our surgical wards cannot be over emphasised. If we are to do justice to the subject, there must be a whole-time professor zealously devoted to it. No where in the entire curriculum of medicine does it require a gifted and well qualified teacher as in Embryology. It is a complex subject and teaching of Nature's modus operandi in making life must necessarily demand new and special methods.

It is sad to note how little we have done in finding ways and means to preserve bodies which are dissected. In a tropical country like India where decay, both in the material and metaphorical sense of the terms, is rapid the need for such a research, or at least application of newer methods of preservation found in the West is obvious. Obviously the way to understand the glories of human anatomy is not to dig through a mass of dead decomposing flesh. Dry and mummified joints can never reveal, their sublime anatomical beauties and cast an indelible impression on the dissector. In 1943-44, war was an excuse a for the inefficient way in which bodies were preserved. Formalin became as rare as gold. In those days of war only one thing was cheap—human life.

Physiology:—No where in the entire field of science do we find a subject approaching life and its problems in such a human way as physiology. We study it to understand medicine. After all medicine

is a world of disordered physiology. Naturally practising physicians should know how much of essential physiology should be taught to students so that they can grasp intelligently the facts of disease. Here again we find the error of teaching too much of that does not help one to solve an every day problem in his general practice. I remember an eminent examiner asking me in all solemn seriousness the carbonic anhydrase content of the various animals' blood. Like an automaton I vomited out the figures I have managed to mug up—but to what purpose? To understand the world of disordered physiology that lies behind the dyspnoea of a patient in the throes of an acute pneumonic process is much more useful and profitable than to pretend to appear scholarly by knowing the quantitative variations of an obscure and debated enzyme in different species of animals.

Any system of education will fall into this error of teaching if it allows the subject to be taught by persons who never apply the practical principles of it in their work-a-day life. A physician is continuously seeing, reacting to and treating human beings whose normal physiology is thrown out of gear by various morbid processes. It stands to reason that no person is more fitted to teach physiology than the practising physicians.

Academic physiology is good in its own way so long as it contributes to the progress of greater science. But academic physiologists divorced as they are from the practical side of medicine, may in my opinion, fail to

equip the students with necessary and essential facts to combat practical problems. These people constantly forget that they are teaching a band of students of whom 98 per cent are going out into the world as men and women to grapple with stark realities of disease and only 2 per cent are going to spend their mid-night oil in trying to do research into purely academic regions of the subject. What we suffer from is emphasis on wrong places. A change here may do a world of good.

Pharmacology :—The paramount importance of this subject cannot be questioned.

Who is a doctor without drugs? It is surprising how scant attention this subject has received in India both as a national industrial problem and as a factor in medical education. The number of unemployed graduates in pharmaceutical science is by itself an unimpeachable proof of the imbecility of the system under which medical education and services are run. It is sad and painful to remember the utter dependence of India on foreign drugs.

As for the place of pharmacology in medical education, will it not be convenient, and perhaps thereby more useful, to allow the subject to be taught from the beginning by the physicians in the wards where the students can simultaneously see the therapeutic side of it? To study pharmacology as rigid and isolated subject and take an examination at the end of third year and look at the therapeutic side of it in the final, is a very unhealthy system beset with dangerous consequences. By

the time the therapeutics are begun, posology has been cast into the limbo of oblivion and perhaps has taken a deep dive in the stream of Lethe. The subject must be taught all along the course of medicine so that it runs as an imperceptible stream, and not as a separate and distinct rivulet which we cross in the third year and forget all about. So long as we in our lack of imagination stick to a system of teaching subjects in their rigid isolation. Tincture digitalis will appear as new to us in the final year as it did when we began the clinical course.

Pathology :—An imaginative friend of mine compared this supremely important subject to the statue of Freedom in New York port guiding ships of all nations safely into the harbour. It is a veritable search light on Medicine. To possess a sound knowledge of pathology is to possess X-ray eyes peering deeply into the depths of the diseased human frame. Not to possess it is to grope blindly in the dark. Here too the rigid isolationistic method of teaching plays its evil role. The examination in pathology can be combined with good results with the final year subjects but there need be no separate paper on pathology. Each subject will take one question in pathology. There cannot be any undue enlargement of the burden because studying such an inter-related subject as pathology along with other final year subjects, and that too spread over a period of three years will not only lessen the burden but also contribute to a greater practical understanding of the subject in all its true ramifications

(instead of rushing through it in the fourth year. The consequences of such a system of examination is that the noble subject receives an undeserved burial in the depths of forgetfulness and neglect.

The canker of an ill-planned teaching system starts in the first year eats its way like a rodent ulcer right till the end of the course and there you behold a student emerging with all the imperfection that inevitably follow a rigid and secluded type of education.

Some professors who taught the subject are men of deep vision and great potentialities. Some of their ideas and plans for effecting revolutionary changes both in the teaching of pathology and in its vaster relation to medicine in general, are too far advanced to be readily grasped and given effect to by the authorities concerned because the powers with whom the sacred trust of medical education is entrusted lack utterly the titanic imagination to tackle the great problems that are facing India. Even to the most superficial observer it will be easy to comprehend the almost phenomenal strides with which Western Medicine has advanced especially in pathology. That makes one in India feel small and humiliated. We have talents and a rich mine of clinical material. If England and America with all their high standard of public health and dearth of clinical material could make such a wonderful progress how much more could we in India, the home of tropical diseases achieve.

The ideal is as vast as it is ambitious. What we want is that men with deep penetrating vision, inexhaustible courage and almost a titanic will to raise the country's medical science from its present state of dereliction, should direct and control the medical services of this country. "The scientific temper points out the way along which man should travel. It is the temper of a free man. We live in a scientific age. So we are told, but there is little evidence of this temper in the people anywhere or even in their leaders." What I have quoted are not the words of a snobbish foreigner whose vision is clouded by the poisonous fumes of racial arrogance but they are the sad words expressed by one of the greatest and ablest sons.

India has produced-Pundit Nehru. Yes. The temper is not in the people or its leaders.

The noble edifice of Medicine will turn out to be a flimsy house of cards built on sand if we, the members of medical profession, do not lift up pathology from its state of utter stagnation and decay and enlarge it to the heights of an All-India central institute of pathological research dedicated to whole time work in doing research into those fell disease like Cancer, Malaria, Tuberculosis and a host of others which are taking a heavy toll of life annually. It is a sad commentary on the medical civilization of our country in which there are millions of lepers stalking the land yet not a piece of vigorous and powerful research in that subject has been done.

Hygiene:—It is very painful to think of the abysmal degradation into which this subject has sunk in India. Taking our own Alma mater, the very site and buildings of the Hygiene Department are unimpeachable evidences of the utter imbecility of the authorities. There must be something utterly rotten in a system which has become so decadent and stagnant that it allows things to drift on unheeded.

If at all this war has done one good thing, it is cataclysmic change that has been brought over the social values of our time. Out of this mad red drama has been born the new conception of individual and his relation to society. The society in which a tuberculous individual moves is viewed upon with more anxiety and care than the individual himself. Medicine has shifted her emphasis from the individual to the group. The West with its characteristic genius for practical wisdom and adaptability to changing times has become fully conscious of this revolutionary change and has embraced with open arms the child of Social Medicine.

On the other hand we in the East are slow to realise the immense importance of this changes. Centuries of tradition still whisper into our ears; the wheels of progress are clogged and the caravan that started for the dawn of a glorious future staggers, totters and finally is buried under the sands of centuries of stagnation and decay. A civilization which refuses to respond to the pulsating and convulsive changes in the world's social fabric must perforce die. It cannot.

WHITHER MEDICINE?

"Allow the legions thunder past,
And plunge into thought again."
The East can no longer "bow low
before the blast."

We as a nation are limited by economic, social and political disabilities and loathe revolutionary changes. Our moorings in the past are very strong and often very sentimental too. But when the problems facing India today are mighty and demand a heroic solution, when disease, famine and epidemics are dancing with diabolical glee to the tunes of of a decadent Time, the only logical procedure that India can do and should do is to cut off those moorings and march ahead with times. Action is life. Stagnation is death. No part of the world needs preventive medicine more than India.

Surgery:—Surgeons are to medicine what stunt actors to a drama. They fill the stage with ecstasies and thrills, raise the audience to a pitch of frenzied fear and then bring them down to a sea of mirth and laughter. But surgery is not always mirth and laughter. It has its tragedies too—tragedies that are almost Grecian in their quality.

Never in a system of education one finds so much strange and almost terrifying divorce between practice and theory as we find in surgical education imparted to us. It is truly amazing how soon one forgets the obvious fact that surgery is as much a practical art as that of a barber's or a goldsmith's. From the third year till the candidate emerges out legally qualified, he is expected only

to see the operations and instruments used. Is there not a world of difference between merely seeing an artery forceps for years from a venerable distance and making a swift approach to it, grasping it firmly and applying it to a bleeding stump? Certain fundamental minor surgical procedures as suturing a skin wound, applying a ligature, releasing an artery forceps and a host of others should be done *by the student while he is a student*. This will train the young lumbricals and interossi and key them up to a high pitch of deftness and alacrity so that his success as a surgeon may be assured.

It is sad to note how widely this system is absent in country. Surgeons are conservative and show the feelings of an offended orthodoxy at these pagan suggestions. Perhaps their minds have become as inelastic as their arteries. Certain Western Universities give a course in "dog-surgery". Certain important operations are performed on dogs under anaesthesia with all due antiseptic precautions. These are done by students under the supervision of a surgeon who guides them. It gives an idea of the instruments used, the way they are sterilised, the feel of an organ with a gloved hand and certain fundamental surgical techniques as suturing, dividing a vessel in between clamps etc. It is obvious that the best way to learn the use of an instrument is to use it and not memorising their names and shapes form a long inventory towards the end of the final year as is often done under this unimaginative and almost puerile system of education.

It is no exaggeration to say "Learn the use of Giggly's saw by trephining a few dogs' skulls. Boldly catch an artery with the forceps and you know for ever what a forceps is and how it is used." That is the practical way to learn a practical art. All other ways are self-delusions.

Clinical Medicine:—One harrowing feature of this hospital is its clinical laboratories both in the O. P. and in the main buildings. If the former is managed by a third rate technician with dubious claims to the knowledge of clinical laboratory procedures, then the latter is a veritable Madame Tussaud's chamber littered with instruments and microscopes that have long outlived their utility. It is a matter for profound sorrow and even in many cases a personal regret the hospital clinical laboratory should in the year of grace ninety forty-seven possess microscopes that would have made Antony Von Lewenhock, its discoverer turn in his grave. Is it not time for the authorities to bestir themselves and sweep away these cobwebs and dust that are disfiguring our medical service due to years of callous negligence and sloth, and blow in the invigorating fresh mountain breeze of efficiency and love of service?

The Problem of "Additional."—Like all other ill-planned systems of education full of lacunae and obviously remediable weaknesses our system of medical education has produced a set of students dubbed as "Additional" as if they are unsavoury and unwanted accretions of the past on the corpus medici. If one

could find an educational system wherein certain percentage of students are failed for the twelfth or even fifteenth time in the same subject, there must be something wholly rotten at the basis of such an educational programme. Either the teacher or the taught does not know his job. Usually the latter conclusion is arrived at peremptorily by the Olympian Gods who decide the destinies of these unfortunate victims and condemn them year after year, to the eternal perdition of sickening failures. It is preposterous and almost criminal that in this year of 1947 when the understanding of educational psychology has been so much perfected, the teacher nurtured in the best of scientific traditions does not care to find out why a particular group of students have a refractory encephalon.

If one wants to deny his senses, then he can refuse a psychological solution to this problem. The only scientific method of approach is to appoint a special wholtime staff with qualifications in medical and educational psychology to deal with this unhappy student group. The department must have unrestricted access to the university answer papers of these candidates, point out to them where they have erred, correct their methods of study, open new angles from which the subject can be viewed and above all teach them the art of rationalised study of a subject, to wit, the faculty of deriving the subsequent from the precedent. For each subject such lectures are necessary. Repeated failures in a subject cause certain deep, gashing wounds in the mind. They can never

healed by subjecting them to another dose of failure. The pathogenesis of this morbid state is not far to seek. Each failure causes a psychological trauma which inaugurates conditions conducive to still further difficulties for a proper understanding of the subject. A mind smitten by a grand succession of failures and benumbed by frustrated hopes can never hope to focus a healthy attention on the subject concerned.

Epilogue:—After all this is said and done, human nature being what it is, is very liable to twist what is set down to suit its own sweet fancies or what is worse may even misinterpret them.

Some of my impressions may be wrong. Some may be right and some wholly sentimental. Looking at the placid surface of the murky waters of our educational system what we do we detect? We see sombre remains of a civilization that has cracked up under its own weight of superannuation and decay. Blind admiration tinged with chauvinistic pride for a dead past, complete inaction to the present and a deep rooted pessimism for the future are not the healthy signs of an enduring type of culture and civilization. Susruta and Charaka were the brains of their times and they satisfied the needs of those ages. But to-day our problems are different and therefore the methods to meet them must of necessity be novel and effective.

Medical science as is taught and made use of at present is wholly barren of utility and service. It has failed miserably to face the exigen-

cies that are confronting India to-day. It does not take a Machivelli's political sagacity to realise that real India lies in her villages where modern medicine with all its brilliant rationalism and therapeutics has failed to reach and much less bring succour to the millions devastated by famine, slowly decimated by poverty, swallowed by epidemics and gradually ground by chronic diseases. It is a huge problem making its inroads into the politico-economical structure of a vast subcontinent.

The seeds, at least a part of them, lie in the system of medical administration and education. To create artificial struggle for existence in the profession to place unthinkable restrictions on the proper recruitment of men into medical services, establish privileges and luxuries for city practices, foster a system that produces men of poor calibre and yet expect the doctors to flock like frenzied missionaries into the lonely villages is, to put it mildly, an example of sophistry in excelso. Such imbecile thinking can never solve the grave issues facing us in India when she is about to emerge from that putrid lake of three centuries of foreign maladministration and exploitation.

Something that gives meaning to life and very vital to existence is lacking in the minds of medical men and students of to-day. The vacuum is making us restless and like Nature we abhor it. What we need is revitalization of the medical services of our country. Let new breath be blown into the dying medical science. Let us strive for a group of men who

have the boldness of execution, breadth of imagination and above all a burning zeal to raise India from her present depths of degradation and despondency. Let us not forget the clarion call of the wise Upanishads, "Arise! Awake! Stop not till the goal is reached." Only then can India produce towering personalities in modern medicine and surgery. Otherwise she has to go shamefully naked to the Western doors and beg for alms of knowledge at the cost of her glory and dignity.

We have printed this article as an example of the very serious thought which a medical student nowadays gives to his education. In it is expressed all the idealism of youth and we hope the young author will work for his ideals. It remains to be seen whether he, and others like him will, like others before them fall into the rut of ancient custom, from which there seems to be no escape. The unexpressed opinion of all the older men seems to be—"What was good enough for us is surely good enough for them", and so they will not take any steps for improvement, beyond deploring the general ignorance of the present generation.

Editors.

Professional Brotherliness

Dr. A. (Struggling for life in the river). "Help I can't swim. Drop me a line"

Dr. B. (Facetiously) "Sure, and you write to me occasionally too."



The Annual Report of the Madras Medical College Association for the year 1946 - '47.

President Sir, Members of the Staff, Ladies and Gentlemen:

It is with great pleasure I present to you a review of the proceedings of the Association for the year 1946-'47.

In the beginning of the year we were all very busy electing the Office-bearers for the following:—Vice-President, Assistant Secretary, Lady Representative, Class Representatives, General Editor and Associate Editor. This year has been unique in that we were the first to work under the constitution that was based entirely on democratic ideals. Needless to say, the activities of the Association have been varied and interesting, all the time striving to improve the lot of Medical Students. Our principal Dr. P. V. Cherian, has always welcomed us with open arms and did everything whenever we sought his help. It is perhaps superfluous on my part to tell this house, how ably our First Student President Mr. E. Balakrishnan has conducted the various meetings. If this year has been a great success it is because, there was a keen understanding and sincere co-operation among the members of the Executive Committee, and the other members in general.

The Association not only took a keen interest in satisfying the needs of the students but also it had its watch over the developments in the field of politics. The following

important resolutions were passed in the meetings held.

1. A new Hostel is to be provided immediately.

On this, the members of the Executive Committee waited on a deputation on the Hon'ble Minister for Public Health and she consented to our request.

2. With regard to the removal of the declaration forms it has been cancelled as per our request.

3. We had asked for better pay for House Surgeons and now the pay has been increased, but not to our satisfaction.

4. As per our resolutions we managed to get a new Dining Hall and a certain number of beds reserved for us in the special wards for which we are thankful to Major. Sangamlal.

Two other resolutions have been passed with a bearing on the political situation in the country, one congratulating the Interim Government and the other condemning the action of Kashmir Government in arresting Mr. Shiek Abdullah. Our Students rightly protested against the recent police repression on the fellow students of other Colleges.

Our Activities :—The Inaugural address of our Association was delivered by Sri C. Rajagopalachariar, when he upheld the claim of Modern Medical Science amidst thundering ovation.

In the month of August we met the Graduates of the year, at the Reception arranged in honour of them. It was a grand day in the history of our college and under the circumstances that existed then, we could not arrange tea in the usual style. Anything that is given with love and affection will always be welcomed warmly. The success of the entertainment was mainly due to the talented many we have in our midst.

The Hon'ble Mr. V. V. Giri addressed the graduates of the year, when he said that doctors should build up not only the individual character in their profession but also the National character by which great Nations have advanced.

We had four extra-ordinary meetings when the following of great repute addressed us. The great Mrs. Aruna Asaf Ali, Mr. and Mrs. Ballinger from South Africa, Dr. Oscar Riddle from U.S.A. and the International Youth Delegates, namely Miss. Olka from Soviet Union, Mr. Olesen from Denmark, Mr. Jean Lautissier from France and Mr. Rajka Tom Vie from Yugoslavia. We also had a symposium on Interim Government by many party leaders.

On the eve of the graduates reception we had a lively debate on "Birth—Control" when the staff and students took part. Mr. S. Kameswaran, Mr. P. Krishnan and Dr. Warriar won the prizes that were awarded.

I need not tell how vital a part of our Association played in making a thorough success of the Provincial Medical Students Conference. In the debate conducted during the con-

ference our students Mr. Sampath and Mr. K. A. Krishnamoorthy won the first two prizes.

Unfortunately this year we had to record the sad demise of four of our staff members Dr. S. Rajagopal Naidu, Professor of Chemistry, Dr. Koman Nair, Professor of Ophthalmology, Dr. Rajasekara Reddy and Dr. Sarvabotlu and three students Dr. Rajagopalan, Cap. Krishnaswamy and Miss. Bharathi Devi.

Our Magazine:—This has added colour to our achievements this year, more so because for the first time it is being edited by the students. The first issue was brought out in October by which you can yourself know how far the standard is maintained. Of course another unique event was the 'Silver Jubilee' of our college Magazine. In connection with that a special souvenir number was brought out and it was very much appreciated in all quarters thanks to the efforts of the Editors Mr. M. Chidambaram and Miss. P. T. Sreedevi. The third issue is under print and is expected soon.

Dr. P. V. Cherian Rolling Shield:—In connection with the Silver Jubilee of the College Magazine we conducted an Inter-colligate debate. Our then Principal Dr. P. V. Cherian presented the Rolling Shield which will enable us to conduct the Inter-colligate debate year after year.

Fine Arts Section:—The Fine Arts section was revived in the month of September. In the beginning there was great enthusiasm among the members. The inaugural address was delivered by Dr. Roy Choudry which was followed by a variety of entertainment. The Fine Arts sec-

tion staged another entertainment for the Provincial Medical Students Conference. We are greatly indebted to the College Orchestra which has played a brilliant part on more than one occasion thanks to the efforts of Mr. G. V. Ramani and Mr. S. Ramaswamy.

In the Bharathi Music competition conducted by the Vivekananda College our students Miss. N. R. Ranjini and Miss. T. N. Vijayalakshmi won the Rolling shield for our college. We have erected an imposing stage for which all credit goes to our brilliant architect Mr. S. C. Muthu- mani. With a little more enthusiasm the joint secretaries could have staged a benefit show which would have improved the finance of the Fine Arts section. If I am allowed to say so, the infant is rickety and is not having reserve.

Among our other activities I must make mention of the various social functions and excursions arranged by the various class representatives, when all students enjoyed in their own way and all together. Last month we arranged a Farewell Party to the following members of the staff who have either retired or have been transferred. They are Dr. Thambiah, Satagopan, Sreenivasalu Naidu and Chandu Nambiar.

The valedictory address of the Association was given by Dr. A. Ananthanarayana Iyer.

Our Finance:—This year inspite of its varied activities the Association was able to manage within its own collection aided by the liberal donation from our generous staff members. With regard to the Magazine Fund, after a lapse of nearly four years we made attempts to collect advertise-

ments and collected nearly Rs. 1,430. As we had to bring out the Jubilee number we had to cash one of the fixed deposit certificate to meet our expense. I am sure, if my successor continues the enterprise in the collection of advertisements, the same amount can be deposited again very soon.

Now it is my pleasant duty to convey my heartfelt thanks to our ex-principal Dr. P. V. Cherian, our vice-principal Dr. Y. S. Narayana Rao and our Treasurer Dr. T. Janardhanan for their valuable support and services rendered to this Association. I also thank the other members of the staff who have helped us at all times. To the members of the Madras Medical College Association who reposed confidence in me and gave me their valuable co-operation when I needed it, I offer my sincere and grateful, thanks.

I take this opportunity of welcoming our New Principal and Ex-officio President Dr. A. S. Mannadi Nayar and congratulate him on his new appointment, I am sure under his able guidance our Association will continue to be progressive and achieve greater strides.

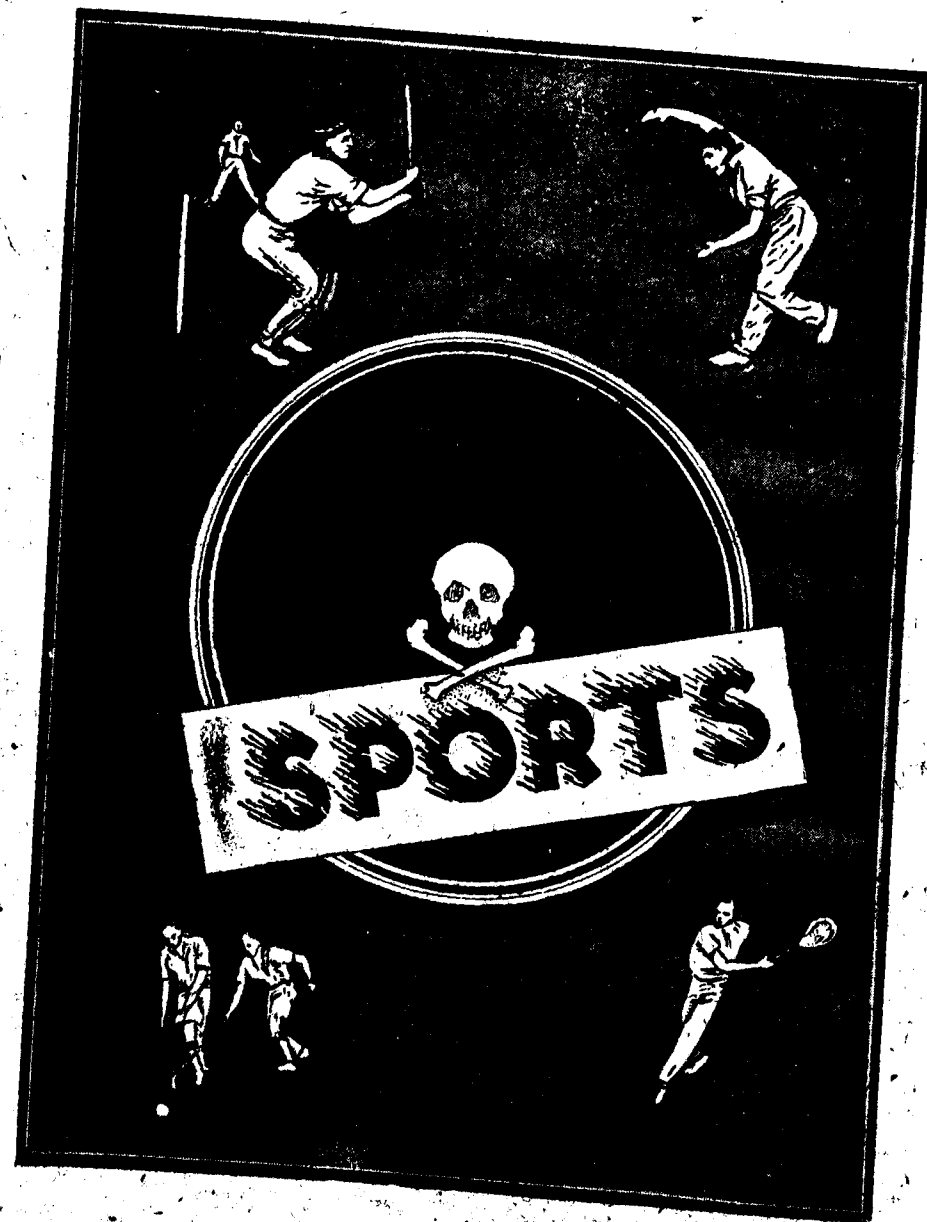
Now ladies and gentlemen, I have come to the end of my report and before closing, on my behalf and on behalf of our Assistant Secretary Mr. Mohamed Koya, let me wish the best of luck to you and also to my successor to whom I know you would extend your hand of help and give a smile of encouragement.

THANK YOU,

S. V. K. S. THANGARAJAN.

General Secretary.

MADRAS,
1-3-'47.



Annual Report of the Madras Medical College Athletic Club for the Year 1945-'46.

It is with feelings of great pride and joy that we present this annual report. There has been a great improvement in the success attained by our teams this year. In the inter-collegiate tournaments we have won the championship in Cricket, Football and Volley-ball in spite of the handicaps our players have had for want of time compared to the students of the other colleges. Thanks to the keen interest evinced by our enthusiastic and generous president, Dr. P. V. Cherman the standard of games continues to maintain the usual high standard.

Committee.—In the sports committee Major. Sangamlal succeeded Dr. David as Vice-President. We thank Dr. David for his invaluable services as Vice-President of the Association for the past years.

Cricket:—Our Cricketers did very well this season, although practically they fielded the same team as last year. Appearing for the first time we won the Ebdon Memorial Tourney at Vizag in September 1946 and after a lapse of 4 years we won the inter-collegiate championship outright although we lost to Loyola and drew with Law College. To Narayan Rai the Captain goes the credit of having infused enough confidence into his team-mates and to have succeeded in once again enabling our college cricket to enjoy the eminence it held some years ago. Special mention may be made about Brian Shortt and

B. B. Shetty who won at Vizag the cup for the highest individual score and for the best bowling performance respectively. Conspicuous was the improvement in fielding this year which was mainly responsible for our success. Batting and bowling honours went to Bhaskar Rao and B. B. Shetty respectively. It is hoped the same enthusiasm will continue to be shown by our cricketers in future also.

Our staff cricketers played two matches with Stanley Staff and won both the matches. Dr. C. P. V. Menon's bouyant spirits and enthusiasm added much to the keenness with the matches were played.

The Carnival cricket match between the Pre-Clinical lady students and Clinical lady students was one of the unique events this year. The Pre-clinical XI captained by Miss. C. Radha deservingly beat the Clinical XI captained by Lalitha Loganathan by 3 runs after a very close fight. Special mention may be made about the brilliant bowling of Lalitha Natesan of Pre-clinical team and good batting by C. Tapsall for the clinicals.

Foot-ball:—With the inclusion of Madhavan ex-Christian College player our forward line functioned better this year. Otherwise the same team as last year took the field. After a rude shock in the opening match of the inter-collegiate championship at the hands of

ANNUAL SPORTS DAY

Pachiappa's we finished the season winning the rest of the encounters and won the championship sharing with the Engineers. We however beat Pachiappa's in the May and Baker Tourney convincingly by 5.0 and thus avenged our defeat in the inter-collegiate league. We beat our sister institution in finals by 4.1 and thus won the shield for the 3rd time after its inception 4 years ago. Madhavan, Viswanathan and Ramachandra Reddy were selected to represent our University which won for the 1st time the All India Inter-varsity Tourney at Lahore. Kappini, Mustafa and Jacob will be leaving us after graduation and we wish them a bright future.

Hockey:—Our Hockey team though not so strong as it was in the past, is much better than most other college teams. But its performance was below expectation.

P. Bhaskara Reddy and I. M. Appayya deserve special mention for their uniformly good performance during the season. It is a serious loss to the team that D'Brass our centre half has graduated.

Tennis:—The standard of tennis in general in our college has gone down considerably, due to the retirement of A. L. Sampath, our star player, and the indisposition of Pooran, our college representative this year. Lack of enthusiasm is also a great factor which constitutes the deterioration in the standard. Our college was represented by A. Pooran in the South Indian Tennis Championship where he defeated the inter-collegiate champion. We wish

more students will take keen interest in tennis next year and bring our college tennis to the higher standard, we have been maintaining the previous years.

Volley-Ball:—As expected we won inter-collegiate championship. We entered for Father Bertram Memorial Tournament conducted by the Loyola College but unfortunately we lost in the finals to Saidapet Y.M.C.A. Our team is strengthened by the inclusion of Mohammed Unni. Chumar and Kirupa Rao deserve special mention for their brilliant display.

Basket-Ball:—This year's admission contributing two new players Ganesan and Ranganathan, has strengthened the team considerably. Though we had a reverse in our first intercollegiate fixture against the Christian College—a definitely superior team—we have been able to beat all the rest so far. This year we entered for the Madras Olympics and we lost in the semi-finals to the champions.

Boxing:—This year the college organised a boxing team which started very successfully. We are sorry to say, that due to unforeseen circumstances we were not able to enter the Inter-collegiate Boxing. D. Ashe and Nipps were the outstanding boxers. Ashe won his weight in the open Tournament.

Swimming:—This year for the first time, the college formed a swimming team. We entered for the inter-collegiate swimming sports. Last Saturday the heats concluded. Bagga and Desmond did well, and



POTATOE RACE.



THE TRADITIONAL TUG.



VICTORIOUS & HAPPY.



UNDER THE FLAG OF VICTORY.



THE MERRY WIDOW.



THE REWARD OF VALOUR

managed to get the college team into a secure position for the finals. Thanks must also be given to the other members of the team who helped to make our endeavours a success.

Athletics—There were new talents like Mohammed Unni and Madhavan to add to our old stalwarts like R.F. D'Costa, J.D. Rozario, J.W. Desmond, Shanmugasundaram, Balram etc. As many as six athletes from our college were selected to represent the Madras Division in the interdivisional sports meet held at Tambaram.

Our athletes did very well at the sports festival held in connection with the opening ceremony of the new corporation stadium. Special mention must be made about Ramalingam

for winning the polevault amidst thundering applause for he went over the crossbar every time like a strawbit in spite of his 160 lbs!

At the inter-collegiate sports we came in second for the championship. J. W. Desmond, doing the 110 metres hurdles for the first time after his unfortunate mishap last year won it with a brilliant finish at the tape. Our Relay Teams won the open relays held at Christian and Loyola Colleges.

This year there was very keen competition for the championship. It was impossible to decide the winner till the last moment.

JOSEPH ANTHONY,
Sports Secretary,

OUR COLLEGE CHAMPION ATHLET.



Shunmugasundaram.



GREAT STYLE.

Ladies' Annual Report for the Year 1946-'47.

The activities of this year commenced with the Intercollegiate League matches in Throw-ball and Tennikoit. Though time and circumstances did not permit much practice, our team excelled itself in throw-ball winning the shield for the first time. Individually our Tennikoit players Miss. P. J. Thomas and Miss. C. Radha are good, but due to lack of practice they did not continue well and so met with failure.

During the second term of the year we played our Badminton matches losing only to the Women's Christian College due to sheer ill-luck and not bad play. In this case also we had very good players but the team invariably played with substitutes. We have yet to play our inter-collegiate Tennis matches of which we have been the winners for the past 10 years, and hope to continue for the next two years at least. This hope may not be fulfilled in future unless the junior players start

taking an interest in Tennis immediately.

On the whole the lady students of this college have shown very little interest in sports. For the past three years the standard of all the games has declined rapidly. The courts being in college was a great disadvantage, no doubt, but now that the hostel grounds are being used, there is some chance that the interest may revive. Almost all games inter-collegiate and otherwise are played only by a few all rounders of the fourth and final year classes. Judging from matters as they stand the college will be left without a single competent team very soon. I sincerely wish that all the lady students will co-operate in future and make the job of coming Secretary a pleasant one.

MISS LALITHA LOGANATHAN,
Ladies Sports Secretary.

Annual Report of 'A' Company (Medicals) 1st M (Bn) U. O. T. C. for the year 1946-47.

After the usual discharge and fresh recruitment, the strength of the Company was 162 in August 1946. Recruitment was mainly due to the valiant efforts of the existing members of the Company. All praise and thanks to them.

In August 1946, many members of our Company took part in the Guard of Honour provided for His Excellency the Governor of Madras, Sir Archibald Nye at the 1946 Convocation of the University of Madras.

Four N.C.O's from our Company attended the Cadre Camp during Michaelmas Holidays as Medical Orderlies and did yeoman service.

Suddenly in October 1946, our Officer Commanding Rao Sahib Capt. D. Sivasubramania Mudaliar retired after a period of distinguished Service to the 'A' Company. My grateful thanks are due to him for his help and guidance which are always available to me. I am certain that with the co-operation of all the members of the 'A' Coy., I will be able to uphold the high reputation of the Company.

About 102 men attended the Annual Camp at Arkonam. Besides the regular Infantry training 'A' Company men were employed in Welfare work. The Medical and sanitary staff did excellent work.

In the competitions held at the Annual Camp 'A' Company did very creditably and came off with flying colours as winners in Cross-Country, Battalion concert and Foot-Ball competitions. In February 1947, we won the Athletic Championship and the Tug-of-war competition. On the day i.e. the Battalion Sports Day we

distinguished ourselves by sweeping through practically all the events and won the Athletic Championship for the Second years in succession. It is up to the Medicoes to win it for the third time also and keep up their own reputation and that of the institutions to which they belong. Towards that end the best Athletes and Sportsmen must join the Medical contingent in large numbers to keep up the prestige and retain the honour. My hearty congratulation to the members of the 'A' Company who took part in all the competitions and gave their best to keep up the reputation of the company. I believe that we were runners-up for the Willingdon Shield this time. I am sure, with a little more keenness and enthusiasm on the part of every single member of the company, by being regular from the first Parade, Ranges and Camp, it will be very easy for us to win all the competitions, and win the Willingdon Shield outright. If the Medicoes take a vow right now that they should win the Willingdon Shield next year at any cost, there is nothing that can prevent them from doing so. I have great pleasure in thanking the Under Officers, N.C.O's and all the men of the 'A' Company for their willing co-operation and sincerity. They deserve all congratulations for maintaining the high standard and efficiency of the 'A' Company (Medicals). All credit goes to them.

On the 19th February 1947, we had a combined Annual Day and Farewell Party to our Officer Commanding Rao Sahib Capt. D. Sivasubramaniam, L.R.C.P., F.R.C.S., under the distinguished Presidentship of our

Vice-Chancellor Lt.-Col. Diwan Bahadur Sir A. Lakshmanaswamy Mudaliar, B.A., LL.D., D.Sc., F.R.C.O.G., F.R.C.S. We are grateful to him for having consented to preside over that occasion. We are also very thankful to Dr. P. V. Cherian, M.B.E., the present Surgeon General with the Government of Madras and Dr. P. Kutumbiah, M.D., M.R.C.P., Principal, Stanley Medical College and members of the staff of both colleges for having graced the occasion. It was very largely attended. We went through a grand and entertaining Programme. Starting with tea, followed by unveiling of the portrait of Rao Sahib Capt. D. Sivasubramanian and then a Prize Distribution to the members of 'A' Company, and a meeting, the function finally ended with an interesting and well brought up Variety Entertainment. I am very thankful to all those who took part in this function and made it the grand success that it was.

On 18th of March 1947 we had another pleasant and grand function to congratulate and honour our distinguished Surgeon General with the Government of Madras Dr. P. V. Cherian, M.B.E., M.B.B.S., F.R.F.P.S., F.R.C.S., D.L.O., R.C.S. The Programme started with a group photo, tea, music and ended with a meeting. We are really proud of this event which is unique in that this is the first time an Indian Surgeon-General is being appointed in this Province. We owe a deep debt of gratitude for all his help and guidance which have been invaluable to 'A' Company Medicals.

On behalf of 'A' Company Medicals I wish him a long life, a still brighter future and the best of luck.

We are highly grateful to our present Surgeon General with the Government of Madras, Dr. P. V. Cherian, M.B.E., and Dr. P. Kutumbiah, Principal, Stanley Medical College for their benevolent gift of a Rolling Silver Shield which has been earmarked for the best platoon in an Inter-Platoon competition for all-round efficiency within the Company. This competition will start I wish to express my grateful thanks to them for their unstinted support and keen interest taken in all the activities of the Company.

On behalf of 'A' Company (Medicals) I would like to take this opportunity of congratulating our new Principal Dr. A. S. Mannadi Nair, M.B., P.H.D., and hope that his help, sympathy and guidance will always be available to us.

We thank our C.O. Lt.-Col. S. Paul and our Adjutant, Capt. V. R. Naidu for the keen interest they have taken in our activities and help. We also thank all the members of the Battalion Head-quarter's Staff individually for their kind co-operation and help.

In conclusion I hope the 'A' Company (Medicals) will grow from strength to strength and prove to be the best in the Battalion by winning Shield in the coming year. Wishing you the best of luck.

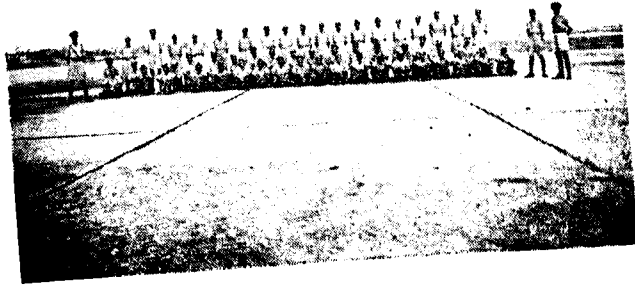
K. P. SARATHY,
Lt. O.C. 'A' (Coy. Medicals.)



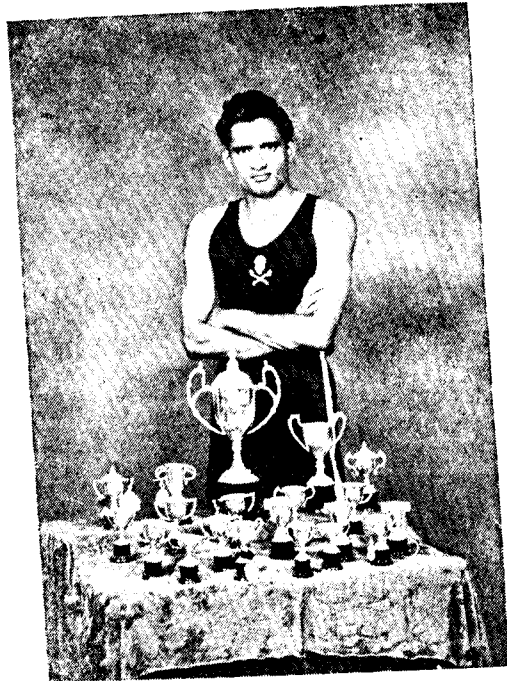
'A' COMPANY and Battalion HEAD QUARTERS.



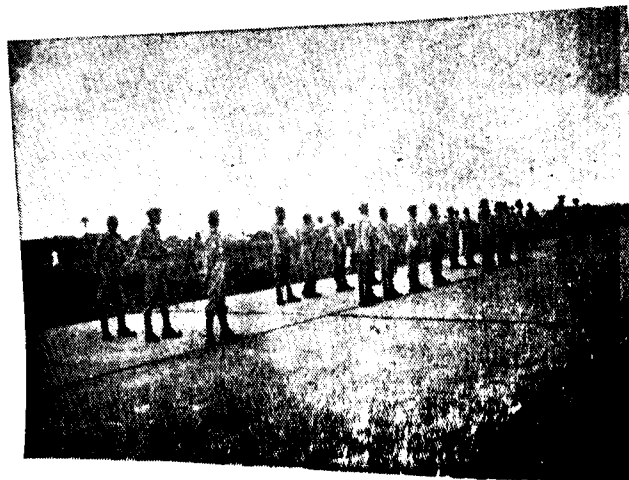
'SALOME'—She won the Cup for us



'A' MEDICALS at the 'RUNAWAY' at Arakonam Aerodrome.



OUR HOSTEL ATHLETIC CHAMPION.



GUARD MOUNTING TEAM waiting for the 'ZERO HOUR'



TO THE MEMBERS OF THE MADRAS MEDICAL COLLEGE ASSOCIATION

Dear friends,

With this issue of our Magazine my responsibility in its publication and other affairs of the Association comes to an end.

I must thank you all for electing me as the General Secretary and co-operating with me in all the work connected with the Association.

Finally, I must thank all the Members of the Committee, all contributors to our Magazine, and the printers, Messrs. Gordon & Co. Ltd., for helping me in conducting the Magazine.

Yours sincerely,

(Sd.) S. V. K. S. THANGARAJAN.

MEDICAL COLLEGE, }
8-3-1947.. }

EDITORS' FAREWELL

Goodbye to correction of Ms and proof.
Ma foi! They'd chase the most cool to the roof.
Crabbed hands to decipher,
Worse than code or a cypher.
So here's to the pleasure of standing aloof!

* * * * *
Fare-well to the hallowed precincts of the press,
A dark donky hole where we spend our recess.
And is there an "ism",
Worse than plagiarism,
The editor's nightmare and publisher's distress.

* * * * *
Promising authors—(or so they're deluded),
Insist that their work cannot but be included;
If a essay or story
Is not printed with glory
Prefer editors than the articles excluded.

* * * * *
Adieu to the task of convincing young Johnsons,
Their work if but shorter would seem less like nonsense
Omitting a line
Will make milder ones pine,
While bolder ones loudly conclude you are dense.

* * * * *
The bosses with short hair round the brim of their topees
And tempers far shorter—they give us no peace
They roar like the furies
You've forgotten their degrees
Worse still—quite forgotten to hand them their copies.

* * * * *
An editor's life and work it is such
People scarcely can praise it or blame it too much
There's all kinds to be had
There's good and there's bad
So dear reader, goodbye, and successor good luck!



The Madras Medical College Association

RULES AND BYE-LAWS

(Revised on 1st March 1947)

1. Name:—The Association shall be styled "The Madras Medical College Association."

2. Aims and Objects.—To foster a spirit of Co-operation and brotherhood among the students of the College, and to promote their social, intellectual, moral and physical welfare by:—

- (a) arranging for lectures on subjects of general and scientific interest
- (b) arranging for debates, social entertainments, games, etc.;
- (c) receiving the Graduates of the year at an "At Home";
- (d) conducting the College Magazine and
- (e) conducting the Inter-Collegiate Debate for Dr. P. V. Cherian's shield

3. Membership and Subscription.—Membership of the Association is compulsory to all students of the College for which they shall pay an annual subscription of Rs. 2 payable at the commencement of each year (*vide* the Principal's notice of the 7th September 1925).

4. Life Members.—Any member of the Staff on payment of Rs. 20 if a Professor, or Rs. 5 if an Assistant Professor or an old boy of the College shall be considered a life member.

5. Constitution.—The affairs of the Association shall be managed by a General Executive Committee for the Association and a special Magazine Committee.

(a) The Executive Committee shall consist of:—

- (1) A President (Ex-Officio Principal).
- * (2) A Student-President elected from the Senior Students (final or fourth year Senior) of the College.
- (3) A student Vice-President (fourth year).
- (4) A Secretary (Student final or fourth year).
- (5) An Assistant Secretary (Student, any year).
- (6) A Treasurer (One Assistant Professor).
- (7) (i) One representative from each of the six classes (Pre-Registration I, II, III, IV and V year).

* The Student-President shall ordinarily preside over all meetings of the Association, Executive Committee Meetings included.

THE MADRAS MEDICAL COLLEGE MAGAZINE

- (ii) One representative from B.Sc. (Pharmacy) class.
- (iii) One representative of the Lady Students.
- (iv) Secretary of the Madras Medical College Athletic Club (co-opted), to be elected by the members.

(b) The Magazine Committee shall consist of:—

- (1) A President (Ex-Officio) Principal).
- (2) A Vice-President (one Professor to be elected by the General Body), who will also operate on the accounts of the Magazine,
- (3) A General Editor elected from among the Senior students (fourth or final year).
- (4) An Associate Editor (Student : fourth or final year).
- (5) The General Secretary of the Association shall be the Secretary of the Magazine Committee. He shall also be the Publisher of the Magazine.

6. Elections, Committees, etc.—The Student-President and the General Secretary of the Association shall be elected (voting by closed Ballot) towards the end of the Academic year (about the last week of February).

The rest of the Committee including the Magazine Committee shall be elected, voting by closed ballot, in the beginning of the College Sessions (2nd week of July).

Interim vacancies in the Committee shall be filled by the remaining members of the Committee, subject to ratification by the General Body within not more than a month.

No act done by the Committee shall be deemed invalid by reason of any vacancies existing in the Committee, provided the vacancies are not more than one-third of the original number.

Any member absenting himself for three consecutive meetings without any valid reason shall cease to be a member of the Committee. The vacancy thus created shall be filled by a fresh election.

Committee Meetings.—The Committee shall meet once in three months or earlier if occasions arise.

Quorum.—The quorum shall be five for the General Executive Committee and four for the Magazine Committee.

7. Procedure in convening Extraordinary meetings.—The General Secretary or the Student President of the Association shall call for a General Body meeting after informing the Committee members or:—

- (i) A written requisition from 150 members or 30 per cent of the members, whichever is less;

- (ii) A written requisition from five Committee members. The Committee shall then meet and call for a General Body meeting.

8. Powers of the Committee.—The Executive Committee shall have the power to make such bye-laws as it may deem necessary from time to time for the management of the affairs of the Association provided they are not inconsistent with

the spirit of the Association, such bye-laws to be brought up for ratification at the next General Body meeting.

The Executive Committee may appoint a Sub-Committee from among themselves or a special Committee from the members of the Association for transacting any particular business and may delegate any of its powers to such committees.

9. The Working of the Association.—(i) The General Executive Committee shall have control over all the affairs of the Association including the supervision of the policy of the Magazine, but the details of the latter shall be worked out by the Magazine Committee.

(i) The Secretary of the Association shall be directly, responsible for arranging the details of the social gatherings, including the Graduates' Reception, and the periodical lectures; and for the maintenance of the books of the Association.

The Secretary to the Magazine Committee, who is also the Secretary of the Association, shall be responsible for the regular publication of the Magazine and for the proper maintenance of the books concerning the Magazine.

10. Finances.—This shall come under two heads:

(i) Funds of the Association. (ii) Funds of the Magazine.

(i) Funds of the Association.—These shall consist of (a) Subscriptions paid by the students at the commencement of the year; (b) Donations from Professors, Assistant Professors and old boys; (c) Special subscriptions raised from students on special occasions, if any. The Executive Committee shall have control over the Finances, the Treasurer being authorised to operate on the account and being responsible for maintenance of correct accounts. The accounts shall be passed by the Executive Committee once in two months and be audited at the end of each year by an independent auditor appointed by the committee. The auditor's certificate with his remarks shall be appended to the Balance Sheet in the Annual Report. The funds of the Association shall be deposited with the Post Office Savings Bank or any other recognized Banking institution in the name of the Principal—Ex-Officio President (separate from the Magazine Fund)

(ii) The Magazine Funds.—These consist of (a) a compulsory subscription of Rs. 2 per annum raised from the students of the I, II, III, IV, and V year classes (b) Subscriptions from other students either of this college or other institutions, (c) subscriptions and donations from others, and (d) income from advertisements. The Magazine Committee shall have control over the finances of the Magazine. The Treasurer of the Magazine Committee shall, with the aid of a paid or Hony. Clerical Assistant* who may be given an honorarium, maintain a register of the names of subscribers, be responsible for all receipts, and maintain an accurate account to the expenditure, with all the vouchers and counterfoils,

The accounts shall be passed by the Magazine Committee once in two months and shall be audited at the end of each year by an auditor appointed by it. The auditor's certificate with the remarks shall be appended to the annual report.

*N.B.—The services of one of the clerks attached to the College may be engaged to help the Secretary in maintaining the registers and other papers and for the other clerical work. It shall be his duty to see to the proper distribution of the Magazine and maintaining file, books (business file, books, auditor's file, Minutes Book, etc.) He shall not be entrusted with any direct financial responsibility.

A peon from one of the College menial staff will also be engaged to help in distributing the issue to the members. The remuneration for these will be fixed by the Magazine Committee.

The receipts of the Magazine shall be deposited just as the Association Funds, but separately.

11. The Magazine.—(1) The Magazine shall be called The "Madras Medical College Magazine".

(2) (a) It shall be issued four times during the year (from July to April) or oftener as considered expedient by the Committee. The 25th of every 3rd month being fixed as the date of issue.

(b) Articles of a controversial nature shall be approved by the Committee before publication.

(3) Subscription:—(a) Rs. 2 from students, House Surgeons, and House Physicians, (b) Rs. 4 from others, in each case excluding postage.

(4) Advertisements:—It should be the aim of the publisher to get as many advertisements as possible for which he may, subject to the approval of the Committee appoint agents, on reasonable commission.

The nature and rates of advertisements shall be left to the discretion of the publisher subject to the approval of the Committee.

12. Miscellaneous.—(1) The annual meeting shall be held towards the end of February before the College closes, at which the annual report of the year shall be presented and passed and a Secretary for the next year be nominated.

(2) The quorum of a General Body meeting shall be 30 percent or 150 whichever is less.

(3) The new Secretary shall take charge soon after the election.

(4) The Secretary shall record the proceedings of meetings, business, general or committee.

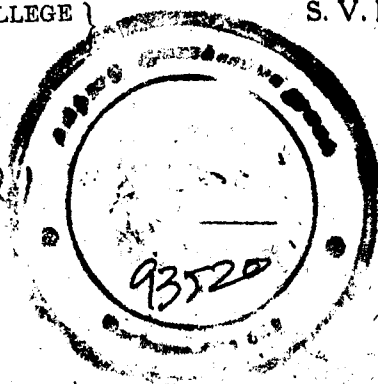
(5) Not less than three days notice shall be given for all meetings.

(6) Any amendment of the rules or any other matters concerning the Association proposed by any member shall be considered at the next business meeting by giving 15 days notice to the Executive Committee.

(7) These rules shall not be altered in any General Body Meeting, unless 40 per cent of the members are present.

MADRAS MEDICAL COLLEGE
March 1947.

S. V. K. S. THANGARAJAN
General Secretary.



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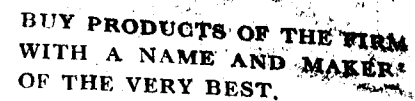
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