The Madras Medical college Magazine

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The Madras Medical College Magazine

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The Madras Medical College Magazine

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Gandhiji

The angels of Heaven that sent you to emancipate us must be happy to get you back—

When the whole humanity was engaged in total destruction, was about to embark on a suicidal programme as a foolish experiment of the greatest discovery of the scientist and at a time the whole humanity was about to lose faith in civilisation, You beckoned us, You gave us the creed of Non-Violence - an invisible weapon in the hands of the strong and the united. When You lead us to the final stage of freedom-struggle without extracting a drop of blood from the enemy, some one called You the Soul of India, nay You were the Soul of Humanity. You made us Men 'out of Dust'. When we were in slumber You awakened us. When we were about to be lost in the wilderness of a pessimistic philosophy You patted us and gave us an ever-inspiring Mantra "Do or Die" You have left us a book of knowledge a directive in all the activities of life. We remember well Your dictim "SEE NO EVIL, HEAR NO EVIL, SPEAK NO EVIL" May we prove worthy.

Our New Principal.

DR. R. V. RAJAM, M.B., M.S., M.R.C.P.

The Retired Principal.

Dr. P. V. CHERIAN, M.B.E., F.R.C.S., (Edin), D.L.O., F.R.F.P.S. (Glas).

MESSAGE

FROM

Dr. CHERIAN.

I have great pleasure in writing these few lines for the Medical College Magazine on the eve of my retirement. In the first place I want to say how happy I have been to work for the students of this college. The last three years of my service have been the happiest. I have an unbroken service of 26 years in this college which I know is a record. To be associated with the Madras Medical College for such a long time is an enviable privilege which I am extremely proud to possess. The Madras Medical College has an international reputation both for the quality of its students and the academic attainments of its staff. This is the result of the work of my illustrious predecessors and I hope I have in some way strived to maintain this reputation.

I have always been proud of you, my students and I am extremely happy to have worked in intimate co-operation with you for your welfare. You have done well in your College courses. You have done well in Sports. You have proved yourself worthy of the confidence placed in you by your Principal and Teachers. Please keep this up and you will never regret. I will always like to hear of your rapid progress so that I along with you may be proud of our Almamater. So my last advise to you is; maintain the tradition of this college, be fair to one another, respect your teachers and be proud and worthy of the great inheritance you have come into by being students of this great Institution.

May God bless you; Good Luck.

The
Madras Medical College Magazine

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Short Biography.

OF

Dr. P. V. CHERIAN.

"There comes Dr. Cherian" some one says, and soon the atmosphere is stilled, almost electrified. There is a hush among the waiting patients with bated breath. Every neck cranes eagerly to look at this doctor. And soon he marches in with a swaggering gait, a smiling face and a smoking cigarette at an angle between his lips. The whole crowd of patients stand up as if spontaneously. I often wondered what is it that make these people to pay this respect. And the answer is soon found out than thought over. It is out of sheer admiration for his extraordinary abilities in his profession, out of love for his kindness and understanding of the suffering patients and out of that spirit of cheerfulness that he literally infects those who come in contact with him. His disposal of the cases is a sight to be seen than heard or read. He looks like a monarch who holds his "Durbar" and enquires into the complaints kindly and benevolently. He looks like a judge who puts on a serene face and gives his final verdict on difficult cases that has baffled many a medical man. And that is done in the twinkling of an eye and within that short space of time, his rich wisdom, his wide clinical acumen and his uncanny intuition are brought forth.

What a doctor he is!, that is what everyone gasps with satisfaction for his ready diagnosis and expert advice.

Dr. Cherian, his name has become a household word in this presidency. He has become a legendery figure elsewhere. How many have not made a pilgrimage with an aching head and a twisted nose to this specialist and got cured and gone back with a grateful heart.

If today the E. N. T. Department in Madras General Hospital is said to be the best in the East, is it any wonder that it should be so? The department was started by him, nurtured by him and brought to the present stature by him. He was the moving hand, the guiding spirit. By his zealous work and selfless devotion, he has made the department what it is-a centre of learning for post-Graduate studies, and he is rightly said to be "the Father of the Oto-Rhino-Laryngology in India".

If as a specialist he was outstanding he was equally so as a Principal of this College. With his genial temperament, his sympathetic consideration, and an understanding nature, he had endeared himself to the students. He was always ready by the students to give them a word of encouragement in their endeavours, a nod of approval in their efforts, a hand of help in their difficulties, a smile of satisfaction in their success or a word of chastisement in their waywardness. He was never a stickler for formalities. He was easily approachable at any time in his office hours, and not a one went out with a dispirited heart, be he under a load of difficulties.

And as an administrator it is needless to say any more. The very fact, that in recognition of his administrative abilities, he was appointed as the Acting Surgeon-General, a post that was jealously guarded and kept opened only for the I. M. S. speaks for itself. He was the first to occupy that coveted post from among the provincial men.

Dr. Cherian was born on July 9, 1893 at Alleppy in Travancore of respectable Syrian Christian family. He graduated in 1917 and was soon appointed Assistant Surgeon in the Maternity Hospital. But the "Masterly-Inactivity" which he had to cultivate there did not suit his temperment. His restless spirit for adventure goaded him to take up Commission in World War I. He was in the army for five years, out of which he spent three years in Iraq.

On his discharge from the army, he was for sometime working in the Biology Department as Assistant Professor. He soon-came under the scrutiny of Major (now Lieut-General) Ernest Bradfield, who took him as his assistant. Very soon by his zeal and enthusiasm and efficiency he impressed everyone.

In 1925 he was selected to go overseas for specialised training in ear, nose and throat diseases. He worked in London, Glasgow and Edinburgh Hospitals and secured D.L.O. (London) F.R.F.P.S. (Glasgow) F.R.C.S. (Edin.), and later worked under the celebrated Professor Ruttin.

Returning from abroad in 1927 Dr. Cherian took charge of the newly-born E. N. T. Department of the Madras General Hospital. After

a time, he was appointed professor as a personal distinction. By his skill in surgery and hard work he made the department attain popularity. Again in 1936 he left for Europe and visited E. N. T. Clinics in England, Austria and Berlin, where he attended the Clinic of the World-reknowned Professor Von Eicken.

In 1942 he was made the Member of the order of the British Empire and in 1945 he became the Principal of the Madras Medical College. On the first of March he was appointed the Acting Surgeon-General with the Government of Madras.

He is a member of the Syndicate of the Madras University, Chairman of the Board of Studies in Medicine, President of Madras Medical Association, President of Ear, Nose and Throat Association of India and a member of the Oto-Rhino-Laryngologist Association of Britain. He is a keen Rotarian and a good 'mixer' and one of the luminaries in the social circles.

It looks paradoxical that he who has risen to such eminence in the profession and life should retire because of certain regulations, at a time when his fund of knowledge and wide experience ought to be availabe to the young and eager students who want to follow his footsteps, and at a time when a medical man and an able administrator of his calibre ought to be present to guide the destinies of the profession.

Time must have its say and he has to retire. In his retirement, the Hospital has lost its skilled master in the speciality, the college its popular Principal and the colleagues their genial personage. Yet, we all hope he is always available to the enthusiasts, now that he is freed of routine officialdom. We all look up to him for his guidance and advice.

MAY HE LIVE LONG AND HAPPY IN HIS RETIREMENT.

I am a great believer in luck, the harder I work the more of it I seem to have.

—*F. L. Emersion.*

He is a fool who cannot be angry but he is a wise man who will not.

—*Eng. Proverb.*

Life Sketch of Dr. N. S. Narasimhan, F.R.C.S. (Eng., Ire.)

BY

Dr. B. RAMAMURTHY, M.S., F.R.C.S. (Edin.)

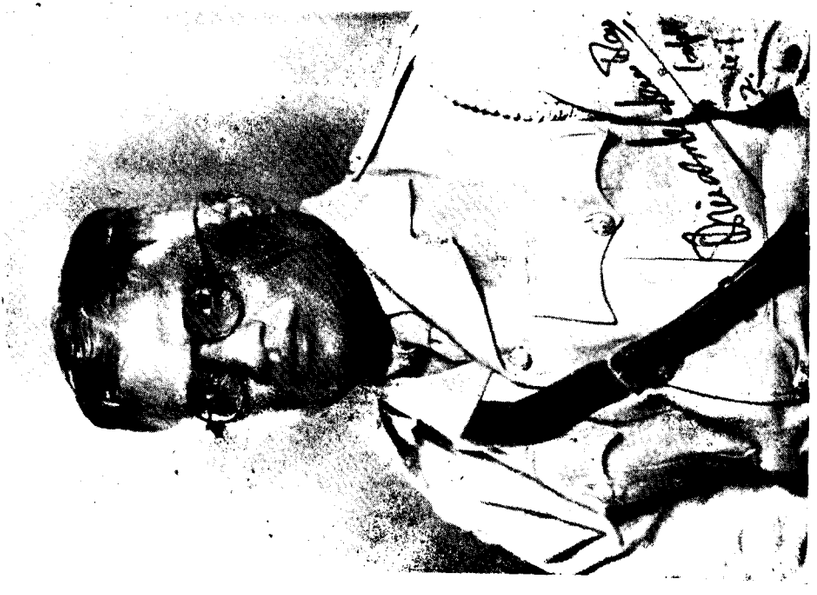
He rose from the lowest to the highest rung of the professional ladder by his indefatigable industry. Born and brought up not under very easy circumstances, he passed out of the Royapuram Medical School in the year 1913. After a successful professional career in Madras and in the mofussil districts he got his fellowship of Royal College of Surgeons of Ireland in the year 1929. Again, after seven years, by his inexhaustible craving for study he got the fellowship of the Royal College of Surgeons of England. He retired as the Professor of Principles of Surgery.

By his devotion to duty under all circumstances, by his very wide knowledge and by his ability to please his seniors and his patients he earned a great renown. His constant precept to his juniors was 'India expects everyone to do his duty'. He is an example to the younger generation who are keen on making India great.

Dr. N. S. NARASIMHAN, F.R.C.S. (Eng., Ire.)

The Ex - Vice - Principal.

Dr. Y. S. Narayana Rao, M.R.B.S., D.T.M. (Cal.), D.P.H. (Lond.)



Our New Vice - Principal.

Rao Saheb Capt. Dr. D. Sivasubrahmanyam, M.R.C.S. (Eng.), L.R.C.P. (Lond.)

The Madras Medical College Magazine

COMRADES, the academic year began as usual with the election of office bearers but the trend of elections was different from what it was. It looked as though we got rid of all competition and we did away with all that by nominating the right persons - it is all really splendid!!!

Every one must be wondering why we did not have the usual number of issues of Vol. No. XXVI. Some one of you may think that the intellect of our College has suddenly gone into masterly inactivity. Others might suppose that there is no hearty co-operation between the members and Editors. No, nothing of this at all. Only the office bearers know against what odds they had to fight. They were in financial distress. They were deeply immersed in sorrow at the disheartening news from the capital on 31st January '48. And so the absence of the other issues.

At the outset we must thank our predecessors who have handed over the charge to us. They had struggled hard and cleared away that large and innocuous debt which was handed over to them by their predecessors. We are told all the credit is mainly due to the untiring efforts of our treasurer Dr. Sivasubramania Mudaliar. Above all we must thank him for having accepted to shoulder the burden again.

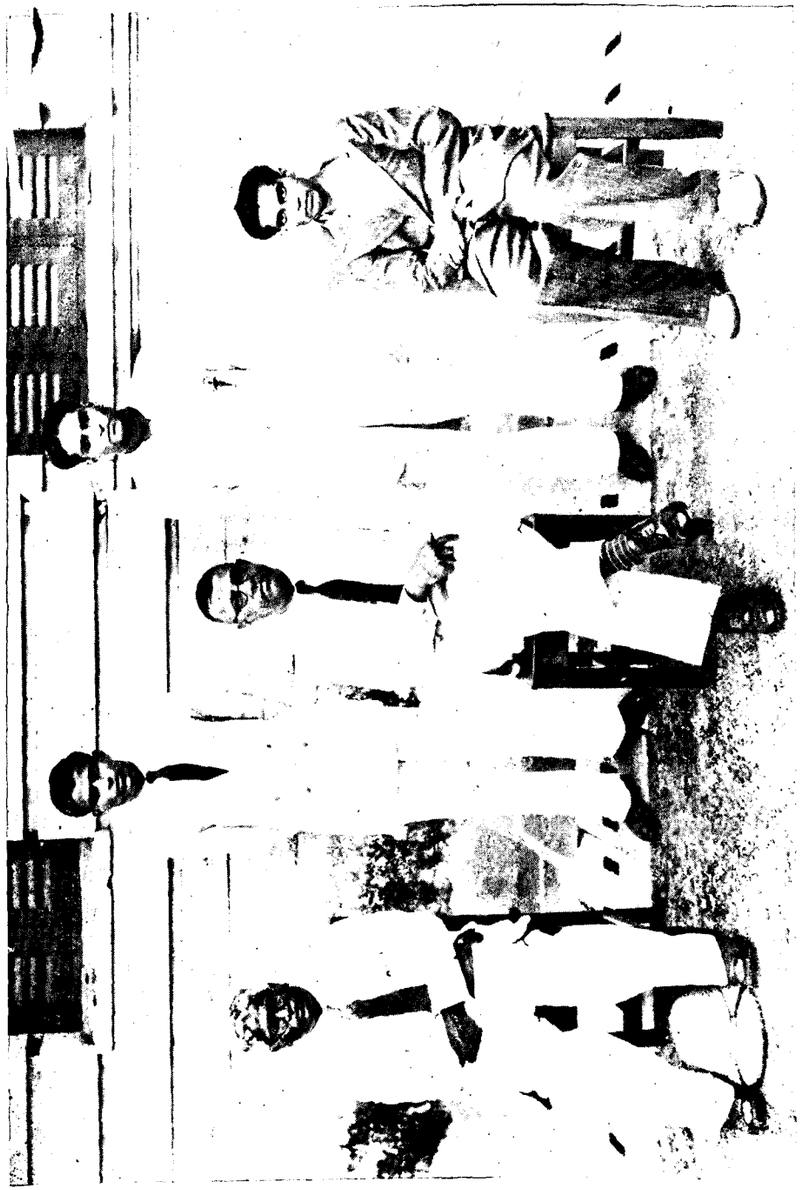
There was not much time to enjoy the newly won independence, for we had to find means to establish a new state according to our ideals and preserve it from being exploited by the external agencies which are always ready to divide and rule. India is being reborn - it has at once become old and young - old in history and young in spirit. At such a critical time when we wanted the guidance of the most learned and the most experienced of our land, The Mahatma an evil spirit took him away from us. The father of our nation was not spared to see his children live in peace and universal love. To us this is another instance when man in his desperate moods is driven to understand " we are to Gods as flies are to wanton boys ". The whole country was plunged in an indescribable sorrow and for a time every one felt no interest in life. He was noble in life but proved nobler in death. To an optimist he is alive. His spirit is with us. His teachings are engraved in our hearts and He has become universal. He was an Indian during life but now He is owned by all. Who is not proud to own Him for was He not a conglomeration of all the virtues? He tried His best to establish kingdom of Heaven on Earth but Earth remained as stupid as it was. Can the people in this planet ever realise the duty towards each other and establish a classless society and do

away with all the petty differences once for all. Oh, it is but a dream !!! At least let us bow to him in reverence and take to our normal work with an unswerving determination to follow as many ideals as possible in the brief span of our life.

Our general secretary took advantage of the opportunity of Acharya's visit to arrange for the inaugural address on 17th July, '48. Revered Acharya Kripalani addressed us in his own inimitable style " President and Friends, I wish to impress on you one thing : object of every association is not to indulge in unnecessary talk but to develop a spirit of co-operation ". This is really a splendid object. Any one who has attended the first General Body Meeting would have certainly thought in one's own heart that there is more sense in this sentence than in anything else !! " We have individual ability, we are able in all activities. We have keen politicians, great patriots, scientists, and Engineers of unusual capacity but the spirit of co-operation is not with us. That is why we do not progress. England with Sixty lacks - a population of one and a half districts of Madras could not be conquered. Reason is they have uniformity of opinion. English man is a dull person individually but he has a habit of co-operation. When there is a great national danger they all work together. If we are to prosper as a nation and community we must co-operate. I cannot imagine any profession that came into existence because of the needs of the individual. Needs of society created professions. Doctor is not created for himself but for the patient. But what have we done ? We have thought of these professions for our individual aims. Making money and making a living is nothing to be ashamed of. This is necessary for every worker but the end is different. The very philosophy or the very basis of profession we miss if we do not live as members of one society ".

" You must have clothes and food, bring up a family but remember the origin of profession. We are all brought up in an artificial atmosphere. A doctor who relies on pen is quack. Medicine is to prevent illness. Doctor must think of the living and not of the sick always ". Saying this he ended his brief but eloquent speech in the characteristic manner of an experienced professor " I do not know what I would have done if I had taken medical profession but the ideal is what I say ".

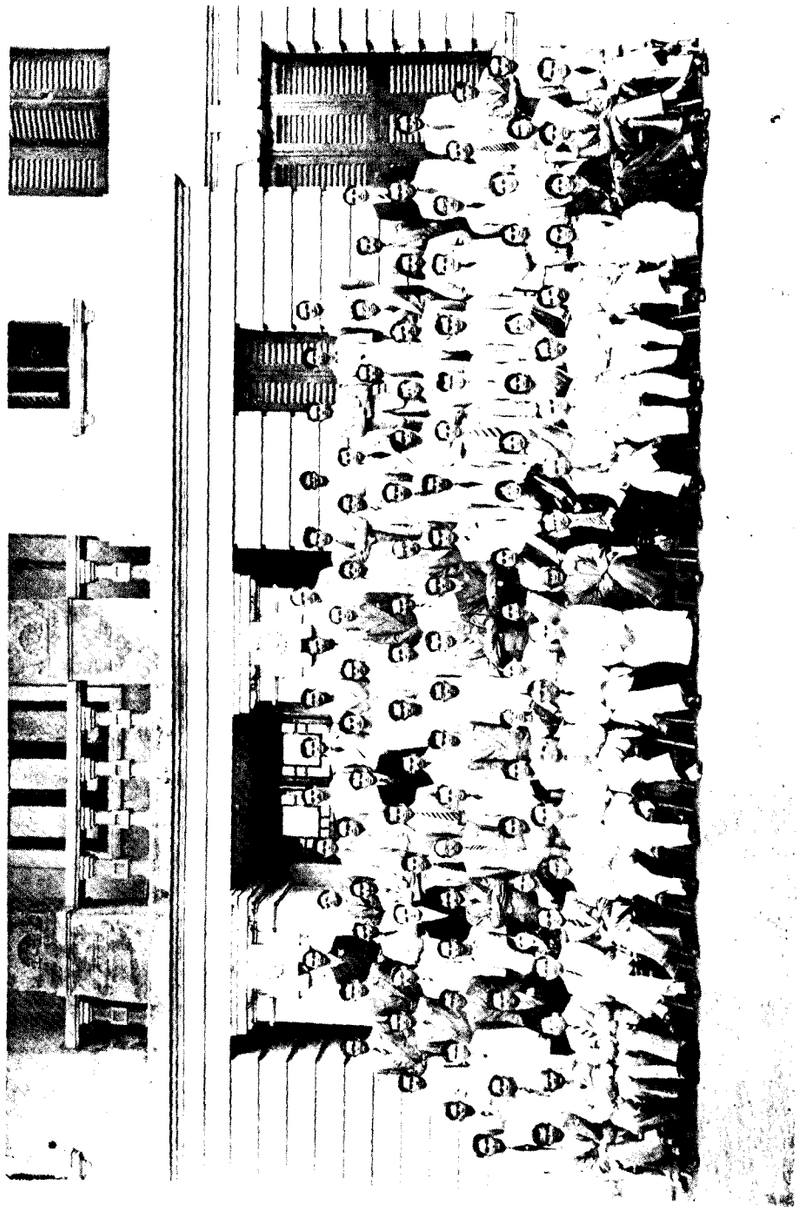
We really thank him very much for having reminded us of the origin of our profession just at the beginning of this academic year. Another day came - 6th of August - We had to say Good Bye to our most beloved Principal Dr. Cherian who had acted for a short time as the Surgeon General. We had in him a boss who identified himself with his students. It grieved us to miss him. But when we thought that he is getting rest we felt glad that at last he is getting rest after long continuous hard work for 26 years in this institution. A party was arranged on this



The Magazine Committee 1948-'49.

Sitting— Dr. Sivasubramania Mudaliar, *(Vice-Principal and Treasurer.)* Dr. R. V. Rajam, *(Principal)*, Mr. N. Krishnamurthy, *(General Editor)*.

Standing— Mr. P. P. Krishnan Unni, *(Associate Editor)*. Mr. C. Gopalan Nair *(General Secretary)*.



The Graduates of the year 1947-48.

day. Our student-president explained how at a time when there was a complete break between students and staff Dr. Cherian assumed charge and as though by a miracle he was able not only to re-establish but also to increase the bond of love and affection between the students and staff. He brought back Mr. Kabir (now Dr. Kabir) hero of 1942 struggle into the College. He had been a popular principal.

Then Dr. Narayana Rao, the Vice Principal told us that Dr. Cherian has had a long and varied service with eminence in every line. He concluded "Personally it is a very great loss but I feel very gratified that he will have a very well earned rest. Wish him the best of life".

Principal in his reply said "I have been a popular principal. Your co-operation alone could make me so". Really great men are always modest. Finally he gave us a good advice "Be true to yourself, be worthy of the great institution. I hope you will have the greatest career in this College. I will go wherever you play and I like to see your sports activity. For it is only on the play ground the professors come to know of the students more intimately-not only the players but also the onlookers". And then he ended "The big gathering assembled here to-day will ever remain green in my memory". At the request, Mrs. Cherian came to the mike only to say "I am very very happy to have spent this evening amidst you". We thanked them both for having accepted our invitation and wished them many more years of happy life.

A day of utmost national importance, the first day of Indian Independence 15th August of this year is never to be forgotten. Our new Principal and new Vice Principal were there to hoist the proud flag, and remind us of the new responsibility to hold aloft the ideals for which this beautiful flag of ours stands and to lend all our efforts to bring this land of ours high in the comity of nations. We have all pledged ourselves to work, for hard and intelligent work alone brings us to the desired goal.

We were all glad to extend a hearty welcome to our new graduates with an address by Dr. Ernest Forrester Paton, on 25th August 1948. Dr. Paton who has done great and yeomen service to the rural population of Tirupathur, was good enough to give us first hand information of the conditions that exist in the villages of this province. Though rain troubled us yet all of as stayed in the open air to witness the grand entertainment. We thank all our guests who patiently stayed there inspite of all inconveniences and witnessed our programme.

We the editors, are now giving you the first issue of the Vol. XXVII of our College Magazine. We thank Dr. Narayana Murthy for his article information most useful for the young practitioner whose first case wi be ten to one a case of fever. We thank the clinical society of

General Hospital for having consented to give in short the proceedings of their fortnightly discussions thereby giving us a mine of information - which for all these days was a secret zealously guarded. We thank Dr. Victor, Dr. Govinda Reddy, and Dr. R. Subramaniam for having helped us in this effort of bringing the staff and students closer and closer. We are sure, every reader will be very happy to read the most valuable thesis on the most controversial yet with unsettled aetiology - Eosinophilic lung by Dr. Victor. It is really a credit not only to him but also to India.

The general articles published in this issue have a special hue in them, in that they are mostly thought-provoking and original. A healthy spirit is needed for a healthy criticism.

We will be failing in our duty if we do not make mention of our beloved professors who had to leave us after long association with us and retire. We will always remember them *Dr. P. V. Cherian, Dr. N. S. Narasimhan, Dr. K. N. Krishnan* with great honour and pride. As Dr. K. N. Krishnan's Photo is not available, it will be published in our next issue.

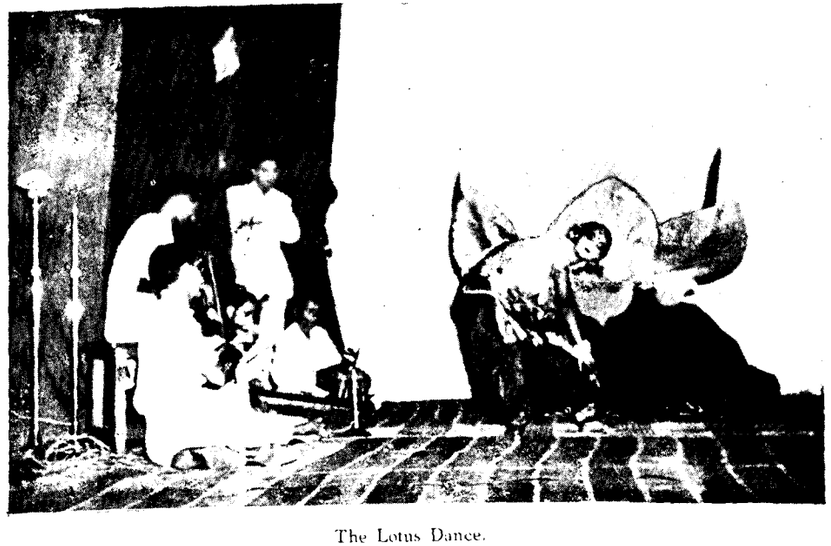
We hope we have done our duty. We have tried our best to place the best in your hands and we think you will all relish it. We do the best, we know how, the very best we can; and we mean to keep on doing it to the end. If the end brings us out alright, what is said against us will not amount to anything. If the end brings us out all wrong ten angels swearing we were right, would make no difference.

In every house where I come I will enter only for the good of my my patients, keeping myself far from all intenationol ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves.

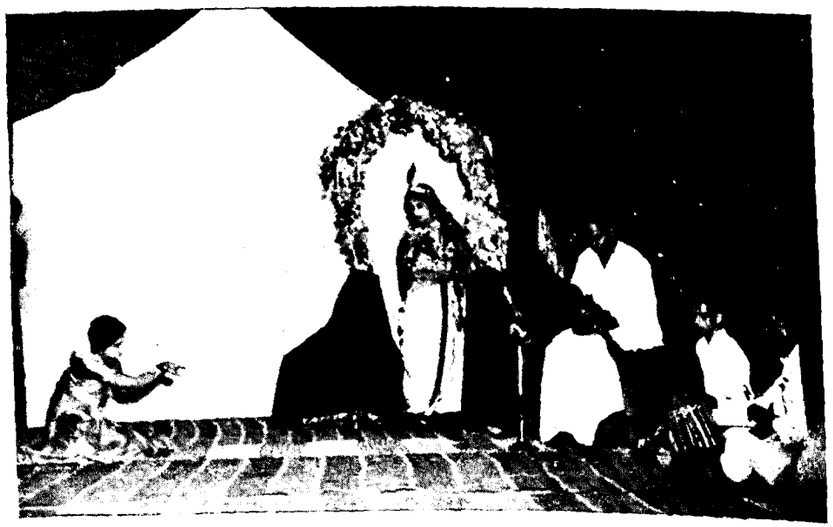
—*Hippocrates.*

GRADUATES RECEPTION.

Dr. Forrester - Paton Addressing the Graduates



The Lotus Dance.



She danced to the tune of Eternal Flute.

Queen Gulnar Finds her Rival.

Short Fevers in Madras.

BY

Dr. K. NARAYANA MURTHY, M.D.

(Under this group of fevers that occur in Madras acute exanthemata or eruptive fevers and the group of intermittent fevers which present no eruption are excluded).

The commonest fever that we come across is one of

1. *Febrile cold* which is always associated with a low temperature often lasting not more than two or three days if proper treatment is given. If no rest and treatment is taken patient can go on with work often inconvenienced by lassitude, headache and running from nose which symptoms are sufficient to inconvenience an individual. We can here draw a distinction between febrile and a simple catarrh or cold by the former being associated with temperature and that of generalised sort of systemic disturbance. It is always difficult to treat a common cold, as the etiological factor that brings about the disease has not been found out. The febrile cold comes under control by rest, and with such drugs as Salycilates, Quinine, Aspirin etc.

2. The next commonest fever is *Influenza* which may be associated with that of bronchitis and fever with a considerable amount of prostration. The tempertaure very seldom goes beyond 104° F. and it is attended by severe headache. The fever ends in 2 to 5 days with profuse perspiration. It is attended by pains in the limbs. It is one of the fevers which give rise to very great systemic disturbances, that of Cardio-Vascular system, respiratory system, the nervous system - giving rise to depression and prolonged mental dullness. Premonitory symptoms like sudden fever without sore throat and cough which is always short and dry are common in influeza. Sore throats, laryngitis, bronchiolitis, pneumonia are common in influenza. The etiological factor in the causation of this wide-spread fever is now supposed to be a virus, and not the specific microbe which we now consider to be a secondary invader. Age, nor sanitary conditions have any influence on the attack of influenza. Though we presume that it is caused by virus, it does not confer any permanent immunity. It occurs in pandemics. Then the mortality rate will be high. The disease itself most often passes unnoticed and it is usually trivial in nature. Its relapses are too frequent. However the disease though of a short duration has many complications and sequelae such as tremors, otitis, meningitis, mental depression, orchitis and

prolonged weakness are the most destressing features. Treatment consists in simple rest and fluid diet with administration of salycilates and aspirin. The complications like pneumonia etc. can be treated with sulphonamides. The vaccines intended for prophylaxis are unreliable.

3. *Rheumatic fever* :—It is an acute fibrile disease associated with painful swellings in joints fleeting in nature with a market tendency to affect the heart. It runs a prolonged course if it is untreated and followed by a great tendency to relapse. It occurs in children above the age of two up to the age of twenty five and it is capable of giving rise to many manifestations. The fever is always preceded by acute tonsilitis and in the course of next 24 hours, we find the joints painful, swollen and tender. The fever continues at 120° F. degrees or 103° F. degrees and hyper-pyrexia is a rare event. There will be profuse prespiration which is acid in reaction, and disagreeable in odour. The fleeting nature of the pains in the joints and asuppuration are the characteristic features. Pericarditis, endo-crrditis and myo-carditis are commonly present in children when the heart is chiefly affected. Rheumatic nodules are occassionally seen symmetrically on bony prominences and prominent tendons such as knees, occipital bones, posterior spinous processes of the vertebrae and knuckles. Chorea is one of the sequale of rheumatism. It is not associated with temperature. Pneumonia, pleurisy, periostitis and peritonitis are some times found to occur. In untreated cases the fever and pains might come down within 5 or 6 weeks with a liability to reoccur, which is a special feature of this disease. In no other disease the blood condition deteriorates as in this fever possibly with the exception of Diptheria. The diagnosis of rheumatic fever is not often very difficult in elders. There are ever so many conditions like acute rheumatoid arthritis, septicemia, pyemia, actue poliomyelitis, gonorrhoeal arthritis, dengue, ulcerative endo-carditis, osteo-myelitis, syphilitic epiphysitis are the other diseases which have to be differentially diagnosed. If the heart is involved the prognosis is always grave, but where the joints alone are involved it does not involve danger. The younger the patient, the greater will be the chances for relapses. Hyperpyrexia, involvement of the heart, and visceral manifestation, cerebral symptoms and nodules are of a serious nature. We do not know as yet the etiological factor in the production of the disease though often exposure, fatigue, tonsilitis may determine the onset of the disease. Though it is a specific infective disease and a diplococcus is isolated from the blood, it is not definitely understood if there could be a virus also. It is also thought if it could be allergic. Treatment : rest, copious fluids and salycilates with double its dosage of the quantity of sodium bicarbonate-20 grains if given every second hour within the next 72 hours the temperature settles down to normal. Salicylate is a therapeutic drug which controls rheumatic fever and if it fails to respond with this therapy it may not be possibly rheumatism. Blood sedimentation rate is of a great prognostic value. Though the temperature comes down very easily with salicylates during

convelasence, treatment is necessary to avoid relapses and second attacks. Repeated attacks of tonsillitis in childern must be viewed with suspicion of an early onset of rhemmatic fever.

4. *Pneumonia* :—The fever of pneumonia is of an acute and sudden onset. The temperature and the pulse-respiration ratio 2½ to 1. instead of the normal 4 to 1, About the 5th, the 7th or the 9th day temperature coms down by crisis. There will be no difficulty in diagnosing a lobar pneumonia. Treatment of recent date, has become simpler by the administration of Sulfa-group of drugs.

5. *Filarial fever* :—Rigor, temperature, adenitis and sometimes associated with oedema of one leg is suggestive in our country of Filarial fever. Micro-filaria in night blood may be found. It is to be remembered that the existence of micro-filaria does not necessarily give rise to symptoms. There are other causes of lynphangitis which may be non-filarial.

The treatment is not satisfactory. Relapses and recurrences are common. Different organs in the body may be affected, mostly the scrotum. Sulpha drugs and a diaphoretic mixture will bring down the temperature within two or three days. Very seldom the fever persists more than a week unless there are complications.

6. *Acute Polio - myelitis* :—Fever is of a sudden onset resulting in the loss of muscular power in one or two or all the limbs on one single day, and on the subsequent days there is gradual regaining of muscular power. It is in the paralytic stage when wasting occurs we often recognise the disease when it is afebrile. Usually children are affected between the ages of 2 and 5 years. The fever seldom lasts more than a week. Careful clinical examination combined with that of L.P. one can make a diagnosis. There is no difficulty in the diagnosis of the case when flaccid paralysis occurs in a group of muscles in one limb.

7. *Diphtheria* :—Is a contagious fever characterised by a membrane occurring on the conjunctivae, nose, larynx, genitals and wounds of the skin. The fever is of a sudden onset very seldom exceeding 101°F. unless associated with secondary infection with that of streptococcus. Characteristic membranes and the finding of the klebs-loefflers bacillus in swabbings taken from the seat of the disease clinches the diagnosis. Treatment consists in giving antitoxin in large doses by intramuscular injection (at least 80 thousand units per day, 40 in the morning and 40 in the evening) and to maintain the general health of the individual.

8. *Mumps* :—It is an infectious fever characterised by inflammatory swelling of one or both parotid glands which rarely suppurate. There is moderate fever, which subsides within a week. The disease is confined to

children and the young between 5 and 20 years. It is very rare in the old. The mortality rate is very low and very often the patients recover.

9. *Glandular fever*:—It occurs in a sporadic form and it is very rare. A single case of glandular fever is reported from my wards in a girl of about 15 years. The axillary glands were enlarged with fever. There was leucocytosis with mono-nuclear increase and Paul-Bunnells test was done. It was reported to be positive from Guindy. The glands decreased in size and within ten days the temperature came down.

10. *Plague*:—Temperature and enlargement of the glands in the axilla or groin associated with intense prostration occurring in an endemic locality clinches the diagnosis of plague. Peri-glandular swellings and haemorrhages under the skin and mucus membranes are common. The glands rarely suppurate. Not commonly seen in Madras, but sporadic cases did come under my observation (A clerk contracting plague, septicaemic form from Coimbatore and returning to Madras was admitted under my care). Hyderabad, Salem, Coimbatore, Bellary, Anantapur, Nilgiris and Mysore borders are all infected areas. If a patient is found to have enlargement of glands which are painful, temperature and intense prostration occurring at any of the above places, where there was an epidemic, diagnosis becomes easy.

11. *Cerebro spinal fever*:—(Meningo-coccal Meningitis) The prominent feature in this disease is temperature with rigidity of the neck, headache and occasional rose red spots. Lumbar puncture indicates turbidity of the fluid, which reveals on culture (fluid ought to be collected at bed side) the existence of meningo-coccus.

Treatment consists in isolation, and the administration of sulphapyridine, sulpha-thiazole or sulphadiazine by injection or my mouth. Ferry's anti-toxic serum is reported to be of great value. It is given in fulminant cases 20,000 to 30,000 units well diluted with normal saline and glucose 10% intravenously. The dose may be given one in the morning and another in the evening. For diagnostic purposes a lumbar puncture may be done, but is seldom necessary to repeat it.

12. *Relapsing fever*:—This is a rare disease. A few cases were reported from Tanjore by Dr. Guruswami and later one case was diagnosed in my wards. This one is of louse borne variety. Fever, headache, and pains in the limbs are common. The temperature rapidly rises and remains at fastigium for 6 days and returns to normal by crisis. Next follows a period of apyrexia for a week. Spironemata are found in the blood during the pyrexial period. The characteristic temperature clinches the diagnosis and the finding of infected lice on the head or on any hairy surface of the body.

The Physician Struggles with death to save a human life.

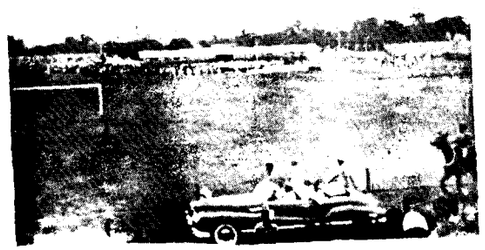
(Copied From "Ivy Salliver")

Ahuja Murali

15th August 1948.

Balaram

Our Party to Dr. Cherian.



Srinivasan

Nehru at the Corporation Stadium.

Ulloor

Hon. A. B. Shetty at Unveiling Ceremony of Dr. Cherian's Portrait.

13. *Phlebotomas fever*:—This disease not commonly seen among Indians. It is caused by a filterable virus transmitted to man by the bite of phlebotomus papatassi. The patient has severe headache, severe pain in the eye balls, vomiting and bradycardia. It is difficult to diagnose from influenza and dengue. There is no rash in sand fly fever. Treatment is symptomatic.

14. *Rat bite fever*:—Fever of a relapsing nature (the fever occurs at intervals of 6 days) enlargement of the lymphatic glands and erythematous erruption all over the body are sufficient to make a diagnosis particularly, when there is history of a bite. The place, where there was bite becomes tender. The disease is caused by Spirillum minus. Interesting point about this is that the fever subsides with single injection of any arsphenamine group of drugs.

15. *Heat stroke*:—Where temperature and humidity is unduly high hyperpyrexia occurs. Fever, fits, coma, giddiness and dyspnoea often occurs. Fibillary twitchings of the muscle are found to occur. Fortunately South India is comparatively free from cases of heat stroke. Very often debilitated patients die from cardiac failure whatever might be the line of treatment adopted. Children and aged are more Susceptible.

The other fevers which are associated with certain amount of inflamation and temperature are (1) Acute Appendicitis (2) Acute Arthritis (3) Salpingitis (4) Sinusitis (5) Pneumonias (6) Lymphangitis (Filarial or non-filarial) (7) Tonsilitis (8) Pharyngitis (9) Poliomyelitis. The characteristic signs and symptoms in all of them are the inflamation of those specified tissues associated with high temperature. If diagnosed and early treatment is instituted, very seldom these fevers last more than a week. The other common diseases which are associated with temperature are dysentry, and cholera in the reaction stage, though malaria, blackwater fever happen to be fevers of short duration they cannot be included under this group of short fevers because of their regular and intermittent character. Erysepilas and dengue though common in our country are left out from the list of group off short fevers as they are associated with rash.

Acute haematogenous osteomyelitis.

BY

Dr. N. S. NARASIMHAN, F.R.C.S. (Eng., Irel)

A bacteraemia necessarily precedes the localisation of infection in the osseous system.

The first skeletal manifestation of the disease is constantly localised in a single metaphysis of one of the long bones of the extremities or in the juxta-epiphyseal region of other bones of the growing skeleton. The primary bone involvement is not in the medullary cavity or cortex of the main shaft of a growing bone. During the early acute stage of the disease the infection is limited to a single metaphysis. However, subsequent to direct or haematogenous spread of the infection and in the subacute and chronic phases of the disease, the main shaft, the neighbouring joints, and the medullary cavity may be affected. If the infection is not in the medullary cavity during the acute stage, there is no reason for their surgical exposure. The surgical attack is limited to the site of infection or metaphysis.

Patients with acute osteomyelitis may be divided into three separate age groups *i. e.*, (1) Under 2; (2) between 2 to 12 and (3) Over 12 years of age.

Under the age of 2:—The calcified portion of bone takes no active part in the process, but it suffers secondarily from the loss of blood supply Signs and symptoms: History of acute sudden onset with severe constitutional reaction with high fever, rapid pulse, restlessness, loss of appetite, irritability, delirium and great prostration. Dry skin, sunken eyes, blueness of facies or extreme pallor, general tenderness on handling which may be localised finally. Swelling and pain is seen near a joint - aspirate joint when in doubt.

Treatment:—Urgent operation is required. Immobilisation of the limb, sulphathiazole, treatment of dehydration is required. Staphylococcal anti-toxin is used in America. In a patient with Septicaemia who develops an abscess within the substance of the bone, the operation to be done is to let out the pus - no tourniquet is to be used, anaesthetic local or minimum general. Post-operatively the patient is given penicillin, intravenous fluids and if the Red Blood Cell count is low repeated small transfusions. The first dressing is done in 10 days and later once a week. Sulphathiazole is used locally with Vaseline gauze. The part should be immobilised until the wound has healed and there is evidence of healing

in the X-rays. If the infection is very severe, all the osteoblasts may die, so that no new bone is formed. Bones developed in membranes as flat bones of the skull and upper jaw are not reproduced. Osteomyeltis due to haemolytic streptococci differs from the staphylococcal from in (a) the sequestrum formation is rare (b) there is no chronic phase of the disease (c) the infection does not reappear later in other bones, so that the prognosis is better (d) flat bones are often involved.

Between 2 to 12:—Symptoms similar to first group but less fulminating.

Treatment:—Most operators bring about adequate drainage of the focus within the bone. They cut a small window from the cortex of the bone, the bone is not curetted. Immobilisation in plaster, sulphanilamides, blood transfusion and Vaseline gauze dressing.

Over 12 and in adults:—Onset insidious, development of the lesion gradual. Pain is not so acute as in children and not so well localised. The X-ray picture may be confused with that of endothelioma. Temperature and Blood Cell Count is not so high. Lesion involves principally marrow and periosteum. There are spotty atrophy of cortex and formation of light new periosteal bone if lesion is in the shaft. The lesion tends to be localised, without formation of sequestrum or involucrum. Operation is indicated as soon as one suspects the presence of acute osteomyelitis.

Treatment:—as in between 2 to 12.

Osteomyclitis of mandible

This may arise from blood borne infection after extraction of teeth. The cause of this second condition is said to be

(*a*) Diminution of local immunity

(*b*) Specific organismal infection, but there is no proof of either as the same organisms are found as in normal mouth.

What is the explanation?

The local vascular system is the key to the mobilisation of the defence mechanism. Thrombosis is the important factor. This may be caused either by direct trauma to the inferior dental vessels during the removal of a tooth or by the central extension of thrombosis in the vessels supplying either a tooth root or the surface structures. Occlusion of the main vessels will create a large central area of bone of reduced vitality in which the secondary bacterial invasion is incapable of being withstood.

The farther back along the vessel this thrombosis extends the greater will be the disaster. It is difficult to say whether the thrombosis has preceded or followed the infection and it can be seen at operation.

The probability that thrombosis is primary is for the following reasons :—

(1) Mandibular bone infection is rare after the extraction of incisor teeth and in this area it is usually localised. As one goes further back along the tooth bearing ridge both the probability and the severity of infection increases. This variation is dependent upon anatomical consideration of the vascular distribution.

(2) The extraction of temporary teeth is seldom followed by infection not because of any difference in the bacterial flora of the mouth in early life but because damage to the inferior dental vessels is unlikely. The roots of the children's teeth are not in close approximation to the vessels and may be separated from them by the upgrowing secondary dentition.

(3) Osteomylitis of superior maxilla is not common after dental extraction (it is met with after cancrum oris in the premaxillary part of bone; the whole of palate of both sides has sequestrated in Kala-azar cases).

Thrombosis is common in cancrum oris in K. A. Cases.

The blood supply of superior maxilla is segmental and vertical and is incapable, in its periphery, of complete occlusion. Stripping of the periosteum is not the cause of necrosis which is caused by direct damage to the cells or by widespread embolism and thrombosis of the blood vessels.

Progress of infection :—infection of bone may arise from

(1) Syphilis (2) Tubercle (3) Phosphorus, Mercury, arsenic, (4) Radium, Deep X-ray, *i.e.* Periostitis and Osteomyelitis may arise by their direct action or by the lowering of resistence of tissues. (5) Commonest cause-local infection, dento-alveolar abscess, stomatitis or fracture.

(*a*) The pus of a dento-alveolar abcess instead of making its exit through a perforation in the bone near its point of origin spreads through the cancellated tissue of the mandible causing osteomyelitis,

(*b*) The periosteum may be stripped off the bone thus endangering the vitality of the bone.

(*c*) Hypodermic injection of local anaesthetic into the inflamed tissues may carry infection ahead of it thus leading to periostitis and osteomyelitis.

(*d*) injudicious extraction of a tooth in the very acute stage of peric-ementitis especially when there is considerable trauma. Sequestration in 6 to 8 weeks occurs, pathological fracture may occur, quite frequently in the mandible, however, an involucrum of new bone is formed which preserves the continuity of the jaw. Regeneration of bone after necrosis is much more common in mandible than in maxilla.

Treatment of infection of lower jaw :—Remove the de-vitalized, thrombosed and infected medullary bone, eliminate that part of the dense cortical bone which cannot resist the spreading infection, and leave behind only those areas which have an adequate blood supply to enable them first to deal with residual organisms and later to regenerate new bone.

Operation therefore consists in sub-perosteal excision of the lower border of the bone together with the outer plate and all the infected medullary area. This frequently leaves a lingual plate less than 1/8 in. in thickness and only about 3/8 in. in vertical extent; further osteomyelitis does not occur in the mandible if only vascular bone is left behind.

Sulpha drugs are recomended as prophlactic before dental extraction.

Pathology in acute osteomyelitis

It is impossible to say if the process begins as a result of the deposit and multiplication of organisms in the bone or whether the infection begins as one or more infarcts secondary to emboli and thrombosis. The very rapid and extensive involvement of the bone indicates emboli in the larger branches of the nutrient artery or in the blood vessels at or near the epiphysial line.

Avenue of spread of infection in the long bones :—

(*a*) The infection begins in the marrow of the cancellated bone of the metaphysis, spreads along the epiphysial line to the periosteum, elevates the periosteum, extends along the surface of the cortex through which it invades the Haversian system and reaches the medulla. The medullary structure is the last to be invaded.

(*b*) Primary acute periostitis is a local process associated with trauma and confined to the periosteum and a thin layer of the cortex. In this there is a very severe type which may spread and sequestrate the entire shaft.

(c) Localised infection after compound fractures and open operations is not so virulent, rapid or destructive as the haematogenous type. (An Acute Infection.)

Type of organisms and where to look for them.

(*a*) Streptococcus	....	M. M. Tonsil, Sinuses.
(*b*) Staphylococcus	....	Skin, Boils etc.
(*c*) Pnemococcus	....	Lungs.
(*d*) Colon bacillus	....	Suppuration in the abdomen.

Note-Fibrosis and its resultant avascularity are the determining factors and not the infection in the healing. The pathology during the acute stage is a determining factor *e.g.* stipping of periosteum, the length of medullary canal invaded, and the amount of bone involved.

Principle of drainage in acute osteomyelitis.

As little destruction of the bone as possible, with as little spread of infection as possible and saving of periosteum is the aim. The medullary canal is involved later than the cancellous bone and periosteum and should not be opened unless it is already infected. Exposing the medulla to infection may lead to extension of the infection along this canal.

A Surgeon is slow to criticise others, yet tolerant of those who criticise them.

A case of Co-arctation of Aorta.

BY

Dr. V. JAYARAMAN, M.B.B.S.

(By resection of the constricted segment of Aorta, which is then reconstructed by a continuous everting silk suture drawing intima to intima it has been possible to save the patient of congenital defect known as Co-arctation of Aorta if discovered early when the arteries are young and resilient and the proximal Aorta is unencumbered by atheroma, local calcium deposition or diffuse degenerative changes. Hence the increasing knowledge of diagnostic points. We hope a day will come when Madras can be proud of a separate department of Thoracic Surgery).

—*Editors.*

Mr. C - 27 years - weaver - Admitted: 14-6-1948.

Complaints:—Distension of Abdomen - 9 months.
Breathlessness
Swelling of the legs } — 12 days.

Family History:—Not married - Two elder sisters both died of TB - Two younger brothers hale and healthy.

Previous Illness:—Diarrhoea and vomiting - 5 years back.
Fever - 1½ years back lasting 3 weeks.
Haematemesis and malena - 14 days back. lasting a day.

Present Illness:—From his previous attack of fever, patient used to feel feverish and was not keeping fit. For the last 9 months patient noticed his abdomen gradually becoming distended and is also feeling a mass in the left side of his abdomen. 12 days before admission, he became breathless and noticed the swelling of his legs. He has no cough. Since 6 months he is having the enlarged and prominent veins over his abdomen. Had no attack of pain in the splenic region except for the vague pain that he is having for past 9 months. Micturition normal, bowels regular.

C. O. A:—Moderately nourished - Anaemic - Not cyanosed, - Teeth dirty and some are carious - No enlarged glands - No petecheal spots - Pulsating vessels in the neck - Soft pitting oedema of the legs - Temperature of 101° F.

C. V. S. Inspection :—No distended veins in the neck - Carotid and innominate pulsations seen - Apexbeat 4th left inter - costal space ½" lateral to mid-clavicular line - Enlarged veins over the chest wall - No deformity of the chest - Tortuous and Pulsatile arteries in the inter-scapular region.

Palpation :—Inspection confirmed - Occasional slight systolic thrill in the pulmonary area, well marked thrill in the 3rd left inter costal space in the anterior axillary line.

Percussion :

3rd left rib.

Right lateral sternal border	½" lateral to mid-clavicular line.

Auscultation :—Mitral Soft systolic murmur replacing 1st sound - 2nd sound normal - Murmur not conducted to the axilla.

Pulmonary :—Loud and harsh systolic murmur replacing 1st sound - 2nd sound accentuated - Murmur conducted to the left clavicle.

Aortic :—Loud and harsh systolic murmmr replcing 1st sound - 2nd sound not well heard - Murmur transmitted to the carotids.

Tricuspid :—Systolic murmur replacing 1st sound - 2nd sound not well heard. The intensity of the murmur is maximum in the anterior axillary line in the 3rd left space. Murmur well heard in 2 areas in the back (1) 2½" lateral to the 3rd Dorsal spine (2) 4" lateral to the 6th Dorsal spine, both on the left.

Pulse :—92 per minute - Regular - Volume good - Tension high - No pulse deficit. Femoral pulse felt feebly.

B. P. :—Right arm 140/75 m.m. of Hg. Left arm 145/75 m.m. of Hg. Legs 100/70 m.m. of Hg.

Respiratory system :—Movement equal on both sides. V. F., percussion note, V. R., and breath sounds normal.

Abdomen :—distended - Umbilicus everted - Distended veins coursing vertically below the umbilicus emptying downwards - Fluid thrill and shifting dullness elicited. Spleen enlarged downwards and to the right 7 fingers below the costal margin - No tenderness. Liver not palpable - Upper border in the 5th rib in the mid-clavicular line.

C. N. S. :—No evidence of any nervous lesion.

Laboratory reports and Investigation.

Urine :—S. G. 1014 - No albumin - No sugar - No deposit - No R. B. C., on repeated examination. Culture : Sterile.

Faeces :—No ova, No cyst, Few R. B. C.

Blood :—Hb. 30% - R. B. C. 1.6 millions. W. B. C. 4,200. D. C., P-81, L-12, M-2, E-5. Microcytic picture. No M. P. Gel and Chopra :—Negative. W. R. and Kahn - Negative. Van Den Burgh - Indirect Positive. Icteric Index - 4 units. Bleeding time - 1 minute and 3 seconds. Coagulation Time - 3 minutes and 10 seconds. Blood culture for organisms other than enteric group (repeated) - No growth.

X'Ray Chest :—A.P. Enlargement of the left side of the heart. Enlarged aortic shadow. Erosion of the Ribs.

Oblique :—Enlarged Aortic shadow.

E. C. G. :—Left ventricular preponderance and auricular extra-systoles.

Progress :—14-6 to 4-8 : Patient running an irregular temperature. With general and symptomatic treatment, patient was progressing well, his Hb. had risen from 30 to 70%, R. B. C., from 1.6 millions to 3.5 millions. Oedema of the legs subsided - Breathlessness relieved and ascites gone down to some extent.

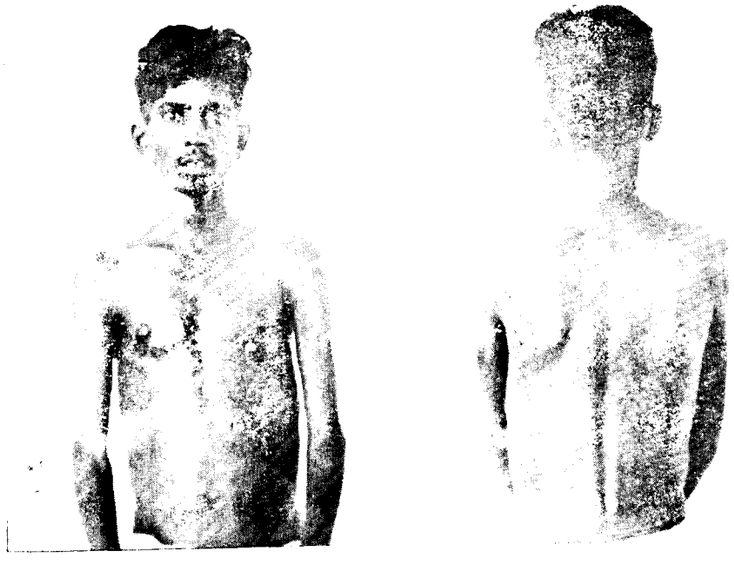
5—8—48 - Patient had 4 tarry motions. 6—8—48 - Patient vomited large quantity of blood with clots. Spleen came down in size from 7 fingers to 2 fingers below costal margin. Distended veins over the abdomen not prominent. General condition became rather worse but patient did not get into a condition of shock. 7—8—48 - Patient vomited about 10 oz. of blood with clots. Hb. 25% R. B. C. 1 million. 8—8—48 to 16—8—48 - Abdomen is gradually getting distended again - Spleen is 5 fingers below costal margin - Veins prominent, slight pitting oedema of the legs.

Summary :—Co-arctation of Aorta is made out by the following : (1) Pulsatile arteries in the neck. (2) Tortuous pulsating arteries in the Inter - scapular region. (3) Femoral pulse felt feebly. (4) Long systolic murmur round about the pulmonary area. (5) High B. P. in the arm and low B. P. in the legs. (6) Erosion of the Ribs in the X-ray (Rosler's sign) (7) Aneurysmal dilatation of the aorta.

In this case, the systolic murmur in the aortic area is due to the aneurysmal dilatation of the aorta. The thrill and murmur in the axillary line may be due to a communicating artery in that situation. Whether this

patient is having a patent ductus in addition is rather doubtful, since there is no positive evidence for making such a diagnosis. The cause of anemia, ascites and splenomegaly with which the patient sought admission and his subsequent development of haemetemisis and malena is to be decided between any of the complications of co-arctation of Aortoa as Bacterial Endocarditis and heart failure, and a separate disease entity as Banti's syndrome (splenic anaemia) absolutely unrelated to the congenital condition that the patient is having. After carefully going through various points in favour and against of each, it was decided that the case is one of Co-arctation of Aorta with Splenic anaemia.

(I thank Dr. K. N. Murthy, M.D., for having kindly given his permission to publish this case report. My thanks are due to Dr. Y. S. Johnson for having guided in the preparation of this case report, and also to the various departments for their kind co-operation).



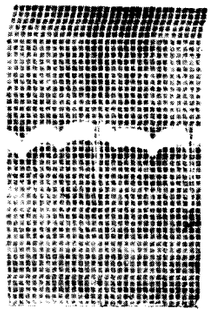
Front and Back views of the patient with co-arciation of Aorta.

A. P. View.

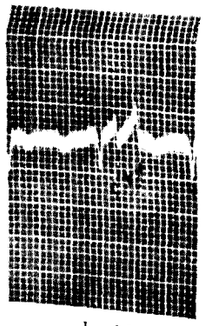
'Why the devil should we do all the good?' objected Budd. 'A butcher would do good to the race, would he not, if he served his chops out gratis through the window? He'd be a real benefactor; but he goes on selling them at a shilling the pound for all that. Take the case of a doctor who devotes himself to sanitary science. He flushes out drains, and keeps down infection. You call him a philanthropist! Well, I call him a traitor. That's it, Doyle, a traitor and a renegade! Did you ever hear of a congress of lawers for simplifying the law and discouraging litigation? What are the Medical Association and the General Council and all these bodies for? Eh, laddie? For encouraging the best interests of the profession. Do you suppose they do that by making the population healthy? It's about time we had a mutiny among the general practitioners. If I had the use of half the funds which the Association has, I should spend part of them in drain-blocking, and the rest in the cultivation of disease germs, and the contamination of drinking water.'

—(*From "Conan Doyle" by Hesketh Pearson*).

E. C. Grams: Prints are produced upside down.



Lead I



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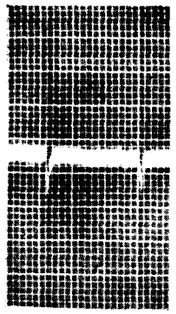
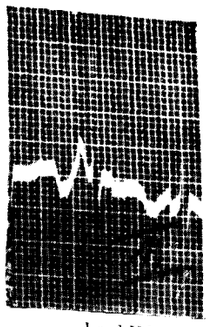
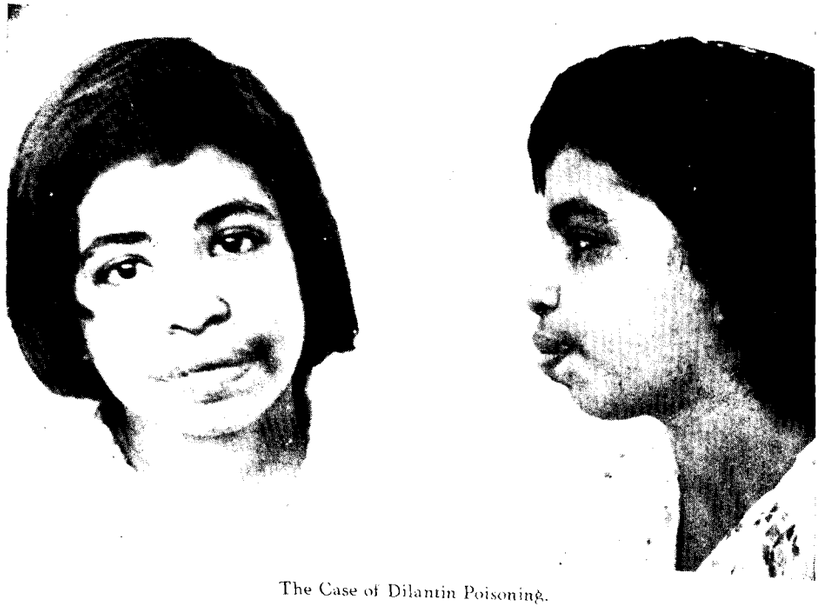


Lead III



Lead IV



The Case of Dilantin Poisoning.

A case of Dilantin Poisoning.

BY

VIRENDRA MOHAN, *3rd year.*

(One who knows how to doubt knows how to get at truth. Virendra doubted this as a case of dilantin poisoning and it came out true on examination.)

—*Editors.*

A girl of thirteen years was admitted for attacks of fits and overgrowth of gums. The attacks came on once or twice every month.

She gave a history of having fits for the last ten years. When her trouble started she was prescribed Luminal which caused considerable imporvement in her condition. Four years ago she was switched on to Dilantin Sodium on a dose of four and a half grains daily divided into three equal doses. (This is the minimum does described in text books) 4 months back her gums started to overgrow her teeth.

The Patient did not look sufficiently grown for her age and bore a dull vacant expression. The face was swollen and the lips thick and protruding. Saliva dribbled out from the angles of the mouth. There was hair growth on the upper lip.

The gums had overgrown the teeth almost obscuring them especially in the region of the incisors. They were firm to touch and on pressure there was no tenderness and no oozing of blood or pus.

She had a spastic gait and her voluntary movements were ataxic. Her speech was slurring and her mental condition backward. She followed and understood commands slowly. Inattentiveness and quarrelsomeness were also present. Pupils were dilated and nystagmus was positive. Abdominal reflex was absent in the upper quadrants and Babinski's sign wasextensor. Stereognosis was impaired.

Her stools were watery and did not contain ova or cysts. Urine was normal and white blood cells were within normal limits.

In arriving at a diagnosis local conditions of the gums like (a) generalised epulis, (b) granulations of the gums, and (c) toxic hyperplasia due to dilantin, mercury and arsenic were considered. But the

with those found in chronic catarrhal Bronchitis were found, and that mottling rarely lasts more than 4 weeks. The classical diffuse mottling is not present in all cases. The extent of lung shadows according to Jhatakia is not proportionate to the severity of symptoms and *vice versa*. Jhatakia reports that the shadows disappeared or became less prominent with treatment. After treatment, the nodular opacity causing the mottling and linear striations disappear. Even in the untreated cases this (mottling) X-ray picture tends to vanish spontaneously. In our series mottling was more or less of the same size in the middle and upper portions of the lung fields, whereas they were slightly coarse in the bases. The mottling in some cases was more marked on one side, either right or left more frequently on the right. A few cases gave a negative picture regarding mottling or bronchial striations in spite of the fact that they had an Eosinophilia above 20%. The hilar shadows were rather prominent in a good number of cases. The duration of illness, its stage, and its severity (as judged by the clinical and haematological findings) have no bearing on the radiographical appearance. Arsenic has a varying effect on the X-ray appearance of lungs, causing the mottling to disappear gradually in some, rapidly in others and completely unaffected in a few cases.

Fluoroscopic examination

Fluoroscopic examination in a few cases revealed a diffuse opacity and ground glass appearance of both lung fields, more prominent in the case which had a high Eosinophilic count.

Pathology:—Visvanathan (1947) has reported the post-mortem appearances in a case of Tropical Eosinophilia that died of Arsenical encephalopathy during the course of treatment. The following are his main findings.

Macroscropic: "Dark reddish-brown areas scattered over both the lungs, more extensively over left upper lobe. Cut surface showed the same multiple dark reddish-brown areas varying in size from that of a split-pea to that of a rupee coin. They appeared to be due to haemorrhage and not consolidation. The affected portions of lungs did not sink in water. Bronchioles contained blood-stained, mucopurulent secretion. The mucous membrane of bronchioles was congested. The brain showed punctate haemorrhages both in white and grey matter. Mesentery showed a few areas of haemorrhage."

Microscopic: The lung showed marked congestion, haemorrhagic areas of bronchopneumonia, and catarrhal changes in the bronchioles. There were several areas of interstitial fibroblastic proliferation. The alveoli were lined with swollen cells and their lumina were partially or completely filled with macrophages and phagocytic monocytes. Some

of these cells contained dark brown anthrocotic pigment, others a small amount of haemosiderin. But most of these cells contained cosinophilic granules grouped in one part of the cytoplasm; these cells were present in large numbers in the interalveolar spaces as well as within the alveoli. In some of the alveoli the mononuclear cells had fused together to form very large giant cells; in each cell the nuclei varied from 15-25 in number, all found gathered together in the centre. In a few cases a characteristic nodule formation could be seen. Section of brain showed congestion of brain tissue with some areas showing perivascular collection of mononuclear cells. Viswanathan is of the opinion that the haemorrhages seen in the brain and lungs were probably due to N. A. B. poisoning. Cellular changes in the lung are suggestive of chronicity.

Meyenberg (1942) has published pathological findings in 5 cases, 4 soldiers killed by accidents and one died of Tetanus. Gross examination revealed only Bronchopneumonia. Microscopic examination revealed exudative eosinophilic inflammations, giant cells with multiple nuclei being a common finding. The veins in the interlobar septa were inflamed. Though there were small thrombophlebitidies, the vessels were never totally occluded.

Course and Prognosis:—The disease runs a benign course. The duration of illness from the available literature is a minimum of 16 days and a maximum of 15 years. In our series the minimum and maximum duration was 15 days and 12 years respectively. Cases have been recorded where a temporary spontaneous relief has occurred. Many of the patients get over the acute stage of illness with or without treatment. If no treatment is given, the condition tends to become chronic. Owing to inadequate treatment Vaidya and Lal have recorded relapses in Eosinophilic Lung cases. In spite of thorough treatment, relapses have also been recorded. In our series 6 cases of relapse have been recorded. The prognosis in this syndrome is very good.

Complications and Sequelae:—The following complications may occur: (1) Increased pressure in Pulmonary circulation causing Artery to be dilated and might lead to cyanosis (2) Emphysema Lungs with secondary right heart failure. (3) May be a predisposing factor to Pulmonary Tuberculosis.

Diagnosis:—The diagnosis of a typical case of Eosinophilic Lung is easy when it exhibits the history, the characteristic cough, asthmatic attacks with wheeze and dyspnoea, constant leucocytosis with high eosinophilia, an increased Erythrocyte Sedimentation Rate, and the mottlings seen in X-ray skiagram of chest. The occurrence of atypical cases should be borne in mind as the clinical features are very variable.

history and finding left no doubt as to the diagnosis of the case being one of Dilantin poisoning. This was further confirmed by the Professor of Pharmacology.

A week after the cessation of the drug, the swelling of the face subsided, the lips diminished in size and the speech became more distinct. The condition of the gums improved. A general improvement in the mental condition of the patient was evident.

Dilantin sodium or Sodium Diphenyl Hydantoinate, a drug closely related to Nirvanol, possesses the greatest anticonvulsant property with the least hypnotic effect. It was introduced in medicine by Merritt and Putnam (1938) as an agent to control convulsive siezures in epileptic patients. It is believed to act by a selective depression of the motor cortex but cases with psychomotor equivalent attacks have also improved.

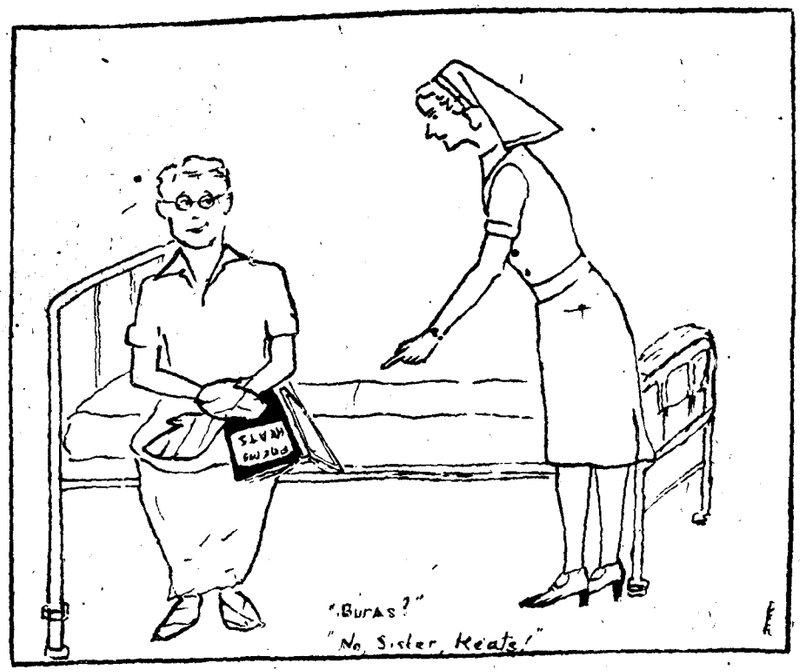
About 15% of cases receiving this drug exhibit toxic reactions, usually of a mild nature. Ataxia, tremors, nystagmus, slurring of speech are a few nervous manifestations. The individual may become confused and irritable. An interesting and peculiar reaction is the hyperplasia of gums, occuring especially in children and young adults. Hirsutism especially in adolescent girls and swelling of the face have also been noted.

(I thank Dr. C. P. V. Menon for having kindly given his permission to publish this case report).

The tireless and energetic physician, John Coakley Lettsom, is commemorated in the following lines, of which many versions exist, well known to many who know naught else of Lettsom, and said to have been written by himself :—

When any sick to me apply,
I physicks, bleeds, and sweats 'em;
If after that they choose to die,
What's that to me, I. Lettsom.

—(*From "A History of Medicine" by Douglas Guthrie, M.D., F.R.C.S.*)



Dr. Abernethy, the famous Scottish Surgeon was a man of few words, but he once met his match in a woman. She called at his office in Edinburgh one day and showed a hand badly inflamed and swollen. The following dialogue, opened by the doctor, took place :—

"Burn?"

"Bruise"

"Poultice"

The next day the woman called again, and the dialogue was as follows :—

"Better?"

"Worse"

"More poultice"

Two days later the woman made another call, and this conversation ensued :—

"Better?"

"Well. Fee?"

"Nothing" exclaimed the doctor, "Most sensible woman I ever met!"

The case of the valiant patient.

To illustrate the importance of maling prescriptions clear to patients, Dr. William Osler used to tell his students this story :—

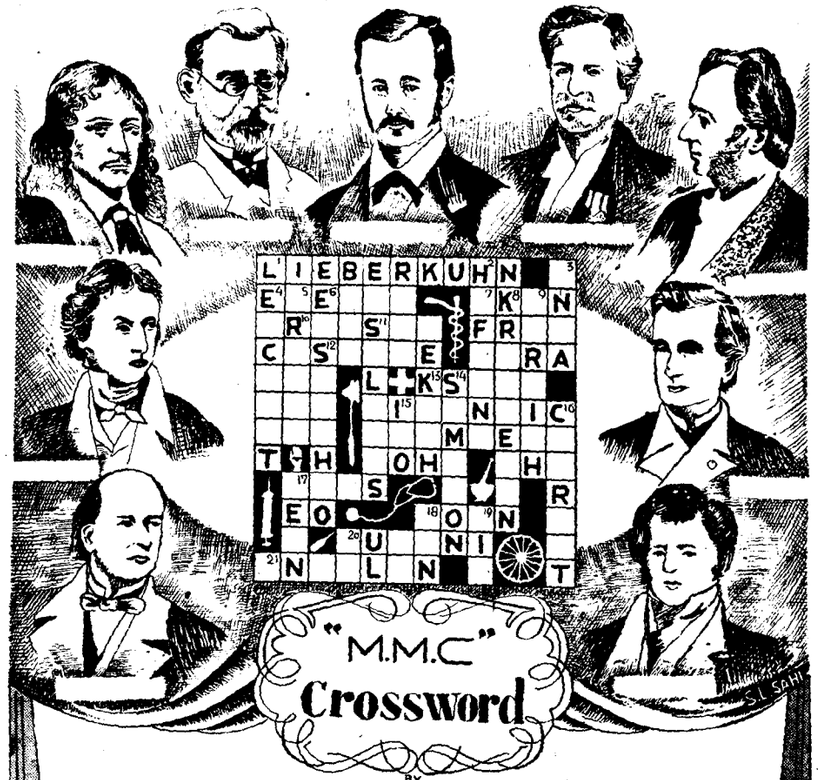
A doctor once told a foreign patient, "The thing for you to do is to drink hot water an hour before breakfast every morning."

After a week the man returned to the doctor's office "How are you feeling?" asked the physician.

"I feel worse if anything"

"Did you follow my directions and drink hot water an hour before breakfast every morning?", asked the doctor.

"I tried my best" replied the patient "but I could not keep it up for more than 15 minutes at a time".



BY
SUNDER LAL SAHI
IV YEAR

Clues Across

1. German anatomist. 's crypts.
4. A pathologist in Halle. 's bacillus.
7. German Physiologist. (1779—1851).
10. A Dutch anatomist. 's membrane, muscle, tube, vein.
12. American Surgeon. 's apparatus, bandage, jacket etc.
17. A Gynecologist (new York). 's position, speculum.
18. 's spores in lung alveoli.
20. Italian Physician (1813—1902). 's disease.
21. Opthalmologist. 's test type, test etc.

Clues Down.

1. Onchocerca volvulus (..., 1893).
2. Coryne bacterium .....i.
3. 's paste.
5. 's disease of Kidney.
6. 's canal, tube, valve.
8. Munich Psychiatrist. 's classification.
9. 's side-chain theory.
11. Aqueduct of.....
13. 's bacillus.
14. A Gynecologist. 's Cyst.
15. Spirochaeta icterohaemorrhagiae Inado and.....1905.
16. 's joint.
17. 's test, 's bone, 's plate.
19. Bundle of .....

The Eosinophilic Lung.

BY

Dr. G. VICTOR, M.B.B.S.

Historical Review.

Many interesting articles have been published on the syndrome 'Eosinophilic lung' the chief contributions coming from :—

Weingarten (1943), True (1943, 44), Owen (1943), Carter, Wedd, D'Abrera (1944), Soysa and Jayavardena (1945), Lal (1945), Bardhan and Nityanand Tyagi (1945), Apley and Grant (1945), Menon (1945), Carter and D'Abrera (1946) Van Der Sar (1946), Jhatakia (1946), Soysa (1947), Viswanathan (1947), and Wilson (1947).

The following have carried out extensive Research Work on this syndrome :—

1940—Frimodt-Moller & Barton	...	India
1943—Weingarten	...	India
Chaudhuri	...	Indian Army
Treu	...	India
Simeons	...	India
1944—Emerson	...	U. S. A.
Parson-Smith	...	Cairo (Egypt)
Carter, Wedd, D'Abrera	...	Ceylon
Ritchie	...	Middle East (Tanganyika natives serving in M.E.F.)
1945—Menon	...	India
Soysa & Jayawardena	...	Ceylon
1946—Stephon	...	Cairo
Hunter	...	U. K. (European recently returned from W. Africa)
1947—Wilson	...	Dar-es-Salam, Tanganyika } E. Africa

The Eosinophil Leucocyte - Cytology and functions.

The Eosinophilic cell measures about 11-13μ and the absolute differential count is approximately 150-400/C. mm. The nuclei are less basophilic than those of the Neutrophils. The cytoplasm is colourless or slightly basophilic. The cell body is closely crowded with large, uniformly rounded, highly refractile granules which (stain a bright red with Wright's stain) exhibit great affinity for acid dyes. According to Domarus (1931) the Eosinophilic count is usually higher in individuals at rising time in the morning than later during the day. There are two diurnal leucocyte

tides due to a variation in the polymorphs and the lymphocytes, the minima are 10 A.M. - 12 Noon and 9 P.M. - 11 P.M.; the maxima 1 P.M. to 5 P.M. and 11 P.M. - 5 A.M. They are independent of meals. The number per cubic millimeter between 9 A.M. and 10 A.M. is 400 maximum and 20 minimum. The above figures correspond to adult men between 20 and 40 years of age. In the fresh state they are spherical cells measuring 9μ in diameter and in dry preparations the flattened cells are about 12μ. Under normal conditions from 2-4% of the leucocytes in human blood are of the Eosinophilic type. The nucleus is usually bilobed and under abnormal conditions the number of nuclear lobes may be increased. Apart from the circulating blood, eosinophils may be found in haemorrhagic pleural effusions, in blood and mucus from cases of Bacillary Dysentery, in Asthmatic Sputum, in Conjunctival smears, and in the Nasal secretion from cases of Vasomotor Rhinitis. Eosinophils are normally found along the entire length of the gastro-intestinal tract especially in the mucosal stroma. They form constituent elements of the bone-marrow, Thymus, Lymph glands, Hemo-lymph nodes, and the Spleen. They occur in abundance in the lactating breast, and occasionally in the lung and the omentum. The granular cells especially Eosinophils of the leucocytic series contain much Histamine. It is thought that Charcot-Leyden crystals are a product of the Eosinophils (McDonald & Shaw, 1922), coagulation product of the Eosinophils (Newmann 1928), or their crystallization products (Leibreich 1921, 1923).

(1) Eosinophil leucocytes act as Phagocytes. (Weinberg and Seguin (1915) Mesnil (1895), Foster (1908) in guinea-pigs). Experimental evidence has proved that the human Eosinophils are distinctly phagocytic towards Staphylococcus Aureus. (McDonald & Shaw 1922) and Staphylococcus Albus and B. Coli (Lawrence & Josey 1932).

(2) According to Schwarz there is a close relationship between eosinophilic leucocytes and the intestinal secretory activity. It is regarded that the hormone of the Eosinophils is important for proper cellular activity.

(3) According to Petry (1908) the eosinophilic granules are concerned in the Iron metabolism.

(4) The eosinophil leucocytes are related to Protein metabolism.

(5) According to Fiessinger (1916) the eosinophil leucocytes play a part in the defensive mechanism against foreign proteins (of war wounds) as a result of destruction of tissue and its infection.

(6) According to Hajos & Mazgon (1929) the Eosinophils are concerned in desensitization.

Eosinophilia and the various conditions in which it occurs.

No eosinophilic count of less than 400 per cubic millimeter has any significance. Eosinophilia is said to exist when the number of Eosinophils in the blood exceeds 4%. Eosinophilia may be a post-infective phenomenon. According to Biggart (1932) the animal organism produces Eosinophils as a protective against a foreign protein. Thus probably post-febrile eosinophilia is the outcome of stimulation of the bone-marrow by protein products liberated during the process of inflammation. Eosinophilia is an expression of a reaction against the toxic products of autogenous or particular foreign protein.

I. **Systemic:**

1. *Alimentary System:*

A. *Diseases due to Metazoa:*

(1) Diseases due to Trematodes:—Schistosomes, Distomes.

(2) Diseases due to Cestodes:—Tape-worms, Hydatid disease of Liver.

(3) Diseases due to Nematodes:—Ankylostomes, Trichiniasis, Dracontiasis, Ascariasis, Filariasis.

(4) Diseases due to Protozoa:—Amoebiasis.

B. Duodenal Ulcer.

C. Intestinal Tuberculosis.

D. Chronic Abdominal Tuberculosis.

E. Chronic Colitis.

F. Icterus gravis.

G. Paratyphoid B.

2. *Respiratory System:*—

Bronchial Asthma, Broncho-Pneumonia, Chronic Pulmonary Tuberculosis, after Pneumonia, and Hydatid disease of Lungs.

3. *Cardio-vascular System:*—

Acute and Chronic Myocarditis, Hydatid disease of heart, Periarteritis Nodosa.

3. *Sex* :—More males are affected than females. (Ratio 4 males 1 female).

4. *Age* :—The extreme limits of age in which the syndrome occurs according to various workers is youngest: 1 year and the oldest: 62 years. (Jhatakia, 1946). Menon puts it as decades below 30 and especially in the group 20-30 years. In our series the age ranged between 6 and 55 years, and the maximum number of cases occured in the third decade.

5. *Parasitic infestation* :—Especially Ascaris Lumbricoides as in Loeffler's Syndrome.

6. *Heredity* :—As seen in Familial Eosinophilia. In our series, history of similar complaint and Eosinophilia occured in 5 families.

7. *Allergy* :—According to Jhatakia & Patel, a history of Allergic diathesis occurs in the family of the patient suffering from Eosinophilic lung, but Weingarten has failed to record similar factor in his collection. Frimodt-Moller & Barton as well as Weingarten postulated an allergic basis mainly because of the most common Asthmatic manifestation.

8. *Mites* :—H. F. Carter, Wedd, and D'Abrera (1944), Soysa and Jayawardena (1945) have done extensive work towards identification of mites in the sputum of patients suffering from 'Eosinophilic Lung' and have claimed that the mites could probably be an important factor in the causation of spasmodic Bronchitis and Asthma associated with hypereosinophilia. The types of mites present in the sputum comprised mainly :

(*a*) Tarsonemidae which included (1) small species of Tarsonemus and (2) species of Pediculoides or allied genus.

(*b*) Tyroglyphidae.

Clinical picture - symptoms and physical signs :—The signs and symptoms of the disease are very variable. The mode of onset is rather gradual and the disease begins with lassitude, a sense of fatigue, loss of appetite, and a low temperature. The fever is very often irregular and intermittent and occasionally shows an evening rise of 100°-102° F. Some have been reported to be afebrile. A little later a dry, hacking, and unproductive cough sets in. It appears in paroxysms being more marked at nights. Gradually the expectoration increases in amount. The cough is neglected, it persists giving rise to a choking sensation in the throat, feeling of suffocation and heaviness in the chest. Lal (1945) observed that chest pain varied from dull pain in the substernal region to a definite sense of constriction and the stitch pain of pleurisy. The cough is susceptible to weather, a drop in temperature or increase in humidity due

to rainfall resulted in an increase in cough. In many cases asthmatic symptoms appear with the typical audible wheeze from a distance. Breathlessness on exertion and expiratory dyspnoea are a common feature. The broncho-spasm is more frequent at nights. Occasionally frank attacks of Bronchial Asthma occur. Haemoptysis occurs in few cases. In the day time patient is comparatively free from cough and dyspnoea. After some time there is some improvement in temperature and loss of weight, but the violent paroxysm of coughing and asthmatic attacks persist at night. Signs of bronchitis occur, hyperresonance of chest, prolonged expiration accompanied by rhonchi and harsh breathing.

In chronic cases basal consolidation with crepitations is observed. Enlargement of spleen is more frequent than that of liver, the spleen is moderately enlarged, is hard, surface is smooth, and is not tender. Enlargement of lymph glands (groin) is reported. Apley and Grant have noticed absence of physical signs in the chest except during exacerbation, and Lal reports cases which showed no physical signs at all in spite of typical X-ray findings and signs appearing for the first time after the institution of treatment.

Laboratory Investigations and other reports.

Urine :—The specific gravity ranges from 1002 to 1030, reaction is acidic in majority of the cases and alkaline in some, albumin and sugar are absent, and deposits include the usual phosphate, oxalate, crystals and occasional Pus cells and epithelial cells.

Motion : Motion of the patients suffering from this syndrome invariably shows parasitic elements as cysts of E. Coli, E. Histolytica, ova of Ankylostomes, Ascaris, and other worms under the microscope. Motion culture in a large number of cases grows the following organisms :— Proteus group, B. Faecalis Alkaligens, Paracolon group, and Asiaticus group.

Sputum :—This is very often scanty, but occasionally copious and mucopurulent, and is glassy. Charcot-Leyden's crystals and Curshman's spirals are a rarity, but clumps of eosinophilic cells are frequently seen in the stained specimens under the microscope. Specimens stained with Leishman stain reveal pus cells, flat squamous cells, cocci, and Eosinophils. Specimens stained with Zeihl-Neelsen stain do not reveal Acid-fast Bacillus but Eosinophil cells are seen in varying proportions. Smears stained with Gram stain show Vincent's Spirochetes, Fusiform bacillus and sputum culture grow the following organisms : Streptococcus, M. Catarrhalis, B. Pyocyanus and Pneumococcus. either separately or in

combination. Carter's technique for identification of mites in sputum carried out in about 30 typical cases in Government General Hospital, Madras, was negative.

Blood:—The severity of the symptoms is not related in any way to the blood count. The percentage of Eosinophils does not increase always proportionately to the increase in the Total W. B. C. Count. Persistently high leucocytosis with massive eosinophilia is an outstanding feature. The absolute numbers of Neutrophils and Lymphocytes remain unchanged. The Eosinophils are on the right side of Arneth's classification. Secondary anaemia is reported occasionally. The blood picture is in some cases the last one to return to normal, sometimes persisting for many years. The total W. B. C. count varies from 5000 to 40,600/c. mm. and the Differential Count of Eosinophil cells from 14 to 90%. Menon had a range of 15,000 to 25,000 Total W. B. C., and 32 to 67.5% Eosinophils in his series, while Soysa and Jayawardena had 10,200 to 37,000 Total W. B. C. and 33 to 81% Eosinophils in their series. Their Highest count recorded in theLiterature is W. B. C. 85,000 and Eosinophils 92%.

Erythrocyte Sedimentation Rate shows a moderate increase and is a valuable guide in determining the progress of treatment. In our series majority of the cases showed a marked increase in the Sedimentation Rate, the maximum and minimum readings for 60 and 120 minutes being 114, 15 mm., and 118, 20 mm. respectively. Menon's record ranges from 25 - 30 mm. at the end of 1 hour in his series, while Jhatakia and Weingarten record a moderate increase in their series.

Wassermann Reaction and Kahn test:—These tests were negative according to Jhatakia. Menon reports 4 out of 7 of his cases with a positive W. R. and a negative Kahn. In none of these 7 cases was available any relevent history of evidence to suggest previous syphilitic infection. Frimodt-Moller & Barton (1940) found positive Kahn reaction in 15 out of 133 cases. Those 15 cases also showed no evidence of syphilis. In our series Kahn test was carried out in 51 cases and W. R. in 5 of these cases in addition. W. R. and Kahn were positive in 2 cases, Kahn doubtful and W. R. negative in 5 cases, and W. R. strong positive and Kahn doubtful in 1 case and the rest were all Kahn negative.

Bone Marrow Appearance:—The sternal marrow shows eosinophilic myeloid reaction. The sternal marrow of the adults and the tibial marrow of the childern in our series show both mature and premature series of Eosinophilic cells in varying proportions the premature series included Premyelocytes, Myelocytes, and Metamyelocytes.

Lymph gland Biopsy:—According to Jhatakia there is subacute lymphadenitis without Eosinophilic infiltration, whereas in our series 3 out of 6 biopsies showed Eosinophilic infiltration.

Positive E. N. T. Findings:—In our series were:—Chronic Suppurative Otitis Media, Chronic Rhinitis, Inferior Turbunate Hypertrophy, Deflected Septum of the Nose, Rhino-Pharyngitis Acute Pharyngitis, Enlarged Tonsils, Septic Tonsils, and hazy Maxillary Antra.

Tonsil Punch: Histological study of sections of Tonsil revealed Eosinophilic infiltration in about 27% of the cases in our series.

Fractional Test Meal:—In our series 32% showed normal levels of total Acidity and Free Hcl. 16% showed low normal, 41% showed low normal Total Acidity and complete Achlorhydria. 1 case showed normal Total Acidity and complete Achlorhydria and 4 cases showed Hyperchlorhydria. Histamine Test Meal was carried out in 5 cases which showed Achlorhydria and Histamine-fast Achlorhydria was recorded in one case, while the rest responded to Histamine.

Cold Agglutination Test: In 90% of the cases of Jhatakia, gave consistently high titre values.

Allergic Tests: These were carried out with two foreign proteins *viz.* Cow's Milk and Koch's Old Tuberculin. With milk out of 53 cases, 5 gave immediate positive and 13 immediate and late positive reactions. With Old Tuberculin, out of 28 cases, 2 gave immediate positive and 3 gave immediate and late positive reactions.

Radiological Findings: Analysis of the radiological findings before treatment show in the majority of cases a combination of mottling of both lung fields, produced by small, discrete, hazy spots and well-marked linear striations. Each of these vary in intensity. Some are mild, others moderate and still others intense. The essential finding in X-ray skiagram of chest is the mottling of the lung fields. Numerous discrete shadows scattered throughout the lungs produce a typical mottling appearance. The size of individual shadows vary from 0.2 to 0.5 cms. in diameter. According to Lal mottling is of a coarse nature than that of Miliary Tuberculosis and could be compared with that of very early Penumokoniosis. These foci are not confluent and according to Weingarten these are more numerous and usually slightly larger in and near hilar regions, commoner in bases than in apices. According to Lal they are always more prominent towards the bases. The combined effect of shadows produced by accentuated finer lung markings and by mottling result in a hazy 'ground-glass' appearance; hence the name 'Snow-storm' appearance, and 'Worm-eaten' appearance. The arrangement of foci and similar distribution of mottling on both lungs seem to follow the branches of the bronchial tree. Jhatakia reports that shadows are more marked in early than in chronic cases; and that no shadows are detected in ambulatory type of cases. According to Weingarten, in chronic cases only prominent bronchial markings identi[redacted]

It is necessary to consider the symptoms, clinical features and the laboratory investigations especially results of blood and X-ray findings together in diagnosing the syndrome; as particular features of this disease simulates certain maladies. Hence it is likely to be diagnosed as Tuberculosis from the clinical, as Atyphical Leukaemia from the haematological, as Syphilitic from the serological, and as Miliary Tuberculosis or Pneumokoniosis from the radiological findings alone. Rapid clinical improvement after Arsenic Therapy is in favour of diagnosing this as Tropical Eosinophilia. Eosinophilic Lung is to be diagnosed from Bronchial Asthma, Parasitic infection, Tuberculosis of Lungs, and other diseases of the skin, blood and allergic origin.

Bronchial Asthma:—is characterised by a more persistent dyspnoea which is more definitely related to the bronchitic attacks, hence common in winter. There usually a leucopenia with eosinophilia (upto 35%). Leucocytosis occurs whenever there is added infection. X-rays of chest show the prominent bronchial striations.

Parasitic Infection:—Loeffler's Syndrome described by Loeffler (1936) is characterised by slight fever, cough, and a high degree of eosinophilia evenreaching 60-70% transient pulmonary infiltration presenting patchy consolidation often confined to one lung. The course is benign and of short duration, clearing up spontaneously in a few days or weeks. It is more common in summer months, is associated with other allergic manifestations, and occurs more frequently in children and also in young abults.

Tuberculosis of Lungs:—Here the clinical features of Bronchial Asthma are absent, sputum shows Acid-fast Bacillus with appropriate staining, haemoptysis is more frequent, and the process of determination is rather rapid.

Eosinophilic Leukaemia:—A very rare disease in which persistent eosinophilia is associated with splenomegaly. Occasionally the liver and lymph nodes are also palpable. Total W.B.C. count varies from 10000 to 25,000/c. mm. and occasionally may be as high as 250,000 C. mm. and the Eosinophil count from 20-80%. Maojority of Eosinophils are mature and only a few Myelocytes are found. Prognosis is moderately good, and death may occur from intercurrent infection. If W.R. is positive, anti-syphilitic treatment gives considerable improvement. Splenectomy aggravates eosinophilia and hence is contra-indicated.

Periarteritis Nodosa:—Is a rare disease characterised by prolonged fever, occurrence of nodular swellings, varying in size upto a pea (in the subcutaneous tissues of abdomen, thorax, and limbs; and in) few cases aneurysm of medium-sized arteries. A muscle biopsy clinches the diagnosis.

Treatment

Symptomatic:—Adrenaline by itself or in combination with Pituitrin is beneficial for asthma like attacks. Ephedrine with Potassium Iodide, Ammonium Chloride, and Codeine are found to be efficient for paroxysms of cough. Antistine, an anti-allergic and anti-spasmodic drug has proved to be a failure. Mist. Asthmatica proves to be unsatisfactory. Anthelmenthic treatment is advised for cases with leucocytosis and low eosinophilia.

Curative: Lal claims success with M & B 693. Treu suggests nonspecific Shock therapy as treatment for this syndrome, but Weingarten has conclusively proved that non-specific protein Shock therapy such as Milk and Autohaemotherapy are useless. In our series too, milk therapy has proved to be a failure.

By mouth:- Carbarsone, Leucarsone, and Stovorsal Tablets (gr.5 of the first, and gr. 4 of second and third) one tablet B.D. for adults and 1/2 tablet B.D. for children below 10 for ten days, repeated after a week's interval if necessary. Liquor Arsenicalis in doses of minims two per ounce of Mist. Heparol given over a prolonged period is helpful in cases a low eosinophilic count. Plain Acid Hydrochlor Dil is supposed to be beneficial, especially in cases of Tropical Eosinophilia with achlorhydria.

By muscle:- Acetylarsan 6-8 injections given every fourth day intramuscularly, the initial dose being 1 cc, then 2 cc, and the rest 3 cc. each for an adult. Maximum dose for children is 2 cc.

By vein:- (1) *Neoarsphenamine*:- (*a*) N.A.B. given intravenously every fourth day in strengths of 0.15 G, 0.3, 0.45 G, repeated twice or thrice in 10% Calcium Gluconate and 2 cc. of Redoxon (200 mgm Ascorbic Acid).

(*b*) In Britain they have given 3 injections of 0.45 G. each intravenously with Ascorbic Acid and Calcium Gluconate at 3 to 4 days interval.

(*c*) In the Indian Army both for the Indian and British patients a graded dose of N.A.B. 0.15 G, 0.15 G. 0.3 G, 0.45 G, the last dose being repeated 3 times, was administered.

(2) *Mapharside*:- Given intoravenously once a week in doses of 0.04 G each.

(3) *Neo-Halarsine*:- Given intravenously once a week in doses of 0.04 G each.

Combination treatment:—A combination of Carbarsone and Neoarsphenamine has been tried by Ceylon workers. (a) It consists of a 10-12 day course of Acetarsal or Carbarsone followed by weekly intravenous injections of Neoarsphenamine, after an interval. (b) A high dose of N. A. B. has been given by Wilson in East Africa. He considers the most effective method of treatment to be a 10 day course of Carbarsone, followed after a few days by 4 weekly injections of Neoarsphenamine 0.6 - 0.75 G each.

In the light of the results obtained from the treatment of cases in our series, the following recommendation in the use of Arsenical drugs is made :—In conditions of Eosinophilic Lung with an Eosinophilia of 70% and above N. A. B is preferable, 50 - 0% Mapharside, 20 - 50% Carbarsone, Leucarsone, or Stovorsal ; 10-20% Acetylarsan, and 5-10% Liquor Arsenicalis. In cases with very high eosinophilic percentage the best line of treatment recommended is, (1) Deworming (if parasitic ova are present in motion), (2) Carbarsone for 10 days, (3) rest for a week, (4) a course of N. A. B or Mapharside consisting of 4-6 injections intravenously once a week or every 4th day, using Calcium Gluconate 10% 10 c.c. and injectable Vitamin C.

Effect of Arsenic on clinical, haematological, and radiographic picture.

The modren consensus of opinion is, that Arsenic is the drug of choice in the treatment of Eosinophilic Lung syndrome. Though the exact role of Arsenic is not understood, it seems to reduce the degree of sensitiveness of the patient and so proportionately the Eosinophilia. In general, response to Arsenic is uniformly good. Several patients have exacerbation of symptoms between 2nd and 6th day of Arsenic treatment- a flare up after the lst or the 2nd injections - consisting of aggravated symptoms (fever, lung signs), a rise in Total W. B. C and Differential Eosinophilic Counts. This Jarisch-Herxheimer's type of reaction lasts for few days and then gradually subside with or without any furthur treatment. It has been observed that the rate of return of blood count to normal varies much, irrespective of the drug used, and this period varies from 6 to 10 weeks. Symptomatic response occurs towards the end of the course, within a fortnight of cessation of treatment, or the eosinophils may even fall more gradually and continue so to fall for several weeks. According to Soysa and Jayawardena "the criterion of cure is not the control of the clinical condition (which is gradually effected in 7-10 days), but the reduction of the Eosinophil count to a satisfactory level and Arsenic therapy is continued accordingly. Thus the blood picture and not the lung symptoms should be the factor to determine the duration of treatment." Even with Arsenic treatment the X-ray changes and the blood counts are the last to come to normal.

Toxic effects of Arsenic and their treatment.

Toxic effects of Arsphenamine preparations are grouped under two headings.

(1) *Local* :—(a) Intravenous injections of any Arsphenamine preparation may cause thrombosis of the injected vein, (b) Intense pain, swelling and infiltration of the tissues which may lead to sloughing if the solution escapes around the vein.

(2) *General* :—Damage to Capillary endothelium. Patients who have died as a result of Arsphenamine injections have shown the following lesions : -blockage of cerebral capillaries with small haemorrhages around, haemorrhagic nephritis, haemorrhage into lung alveoli, submucous petechiae, ecchymoses in the stomach and bowel, and in a few cases degeneration of liver cells.

Clinically, toxic effects are manifested by one or more of the symptoms mentioned below :—

(*a*) During or immediately after the injection - (1) Vasomotor distrubances, also called "Anaphylactoid symptoms" or Nitritoid crises, (2) Urticaria, (3) Syncope, and (4) Pain in gums and teeth.

(*b*) Following the injections usually in a few hours and occuring generally on the same day - (1) Rigor, rise of temperature, and headache. (2) Vomiting, diarrhoea, pain in the back and cramp in the legs (3) Herpes Labialis or Herpes Zoster.

(*c*) At various times from a day or two, to a month or longer after a single injection or a course of injections :—(1) Albuminuria, (2) Stomatitis, (3) Chronic Headache, Lassitude, loss of appetite, weight, and sleep ; (4) Erythema and Dermatitis, (5) Jaundice, (6) severe cerebral symptoms, (7) various blood dyscrasias, (8) Polyneuritis, (9) Jarisch-Herxheimer reaction, (10) Chaudhuri and Chaudhuri have reported Agranulocytic Angina after treatment with Acetylarsan.

For escape of the solution around the vein, the treatment is to infiltrate the local tissue at once with a few c. cs. of sterile 0.85% Saline. Application of ice is soothing, but hot fomentation is harmful and contra-indicated. For the general toxic symptoms administration of alkalies by mouth and bowel, and saline per rectum are advised. The following prescriptions may be useful :—

R		R	
Pot. Citras	3i	Vitamin B_1	9 mgm
Pot. Bicarb	3i	Vitamin C	150 mgm
Liq. Amn. Aromaticus	3iss	Cal. Lactas	5i
Syrup	3i		
Aqua ad	3iii		

one ounce three times a day. F. P. 3.....One powder three times a day.

Arsenic is temporarily suspended and the patient put on a salt-free diet. Glucose, milk, and fruit juices should be given freely. A week later the urine is examined for albumin, and if clear Arsenic, is continued. Dextrose and Calcium Lactate may be given a few hours prior to administration of Arsphenamine compounds, so as to prevent liver damage.

Post-Script:—The investigations were carried out in Lt. Col. C. K. Prasad Rao's Unit, Government General Hospital, Madras, in the year 1947-1948. The cases were not followed up, since the study of the subject was not continued in the same Unit.

Acknowledgement:—My grateful thanks are due to Lt. Col. C. K. Prasada Rao, M.D. and Dr. R. Subramaniam, B.Sc., M.D., M.R.C.P. for their courtesy, guidance and co-operation extended towards compiling this article. I am also indebted to the Barnard Institute of Radiology for their kind photographic reports.

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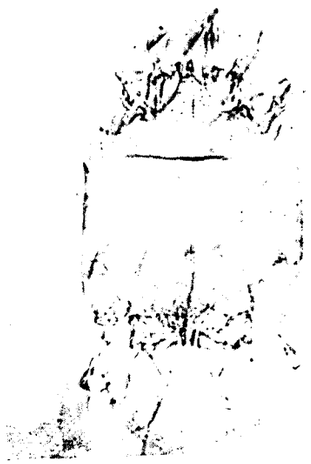
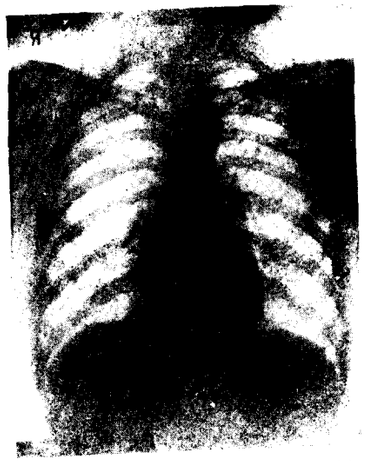
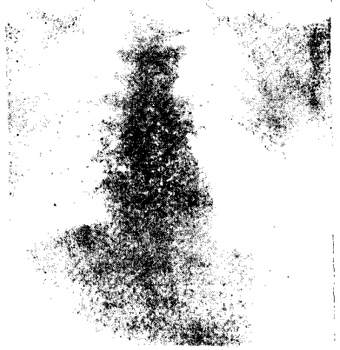


Mite From Sputum

Mite From Sputum.



X-ray skiagram of chest showing diffuse mottling of both lung fields before treatment in a case of Eosinophilic Lung



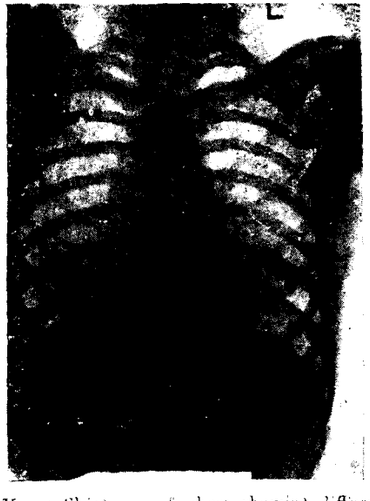
X-ray Skiagram of chest of the same patient showing complete disappearance of mottling after treatment with napharside.

Why think? Why not try the experiment?

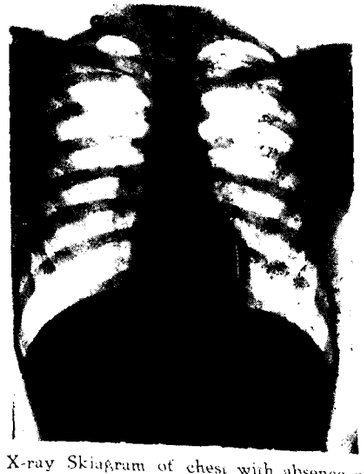
In 1748, John Hunter (1728-93), youngest of the family of eleven children, set out on horseback from his home at Long Calderwood, near Glasgow, to join his brother William in London, and reached his destination in about a fortnight. John had no inclination for scholarship but had an insatiable curiosity regarding "birds and bees and grasses" and all the works of Nature. William, ten years his senior, set him to dissect the upper limb, and the exellence of his work as an anatomist was immediately apparent. John also commenced the study of surgery under the two great surgeons, Cheselden and Pott. The life story of John Hunter has so often been narrated by numerous 'Hunterian Orators' that it need only be breifly sketched. Threatened by tuberculosis, he was advised to seek rest in a warmer climate, and this advice he followed by enlisting in the army and serving as a staff surgeon in Belle Isle and Portugal for four years. During John's absence on military service, his brother William was assisted by William Hewson (1739-74), a brilliant young man who demonstrated the existence and function of the lymph vessels in animals, and established the fact that the coagulation of the blood was due, not to a solidification of the corpuscels, but to a substance in the plasma which he called "coagulable lymph" later known as "fibrinogen". Hewson died from septicaemia following a dissection wound at the the age of thirty-six.

When John Hunter returned from Portugal he commenced those vast researches in comparative anatomy and physiology to which the remainder of his life was to be devoted. He taught anatomy, although he was never a good lecturer, and on one occasion he asked the porter to bring in the skeleton so that he might preface his remarks with the word "Gentlemen". Later in his career he lectured on "the whole circle of the sciences around surgery" and hé certainly raised surgery from the level of a technical accomplishment to that of a definite science. John Hunter was the founder of surgical pathology.

—(*From "A History of Medicine" by Douglas Guthrie, M.D., F.R.C.S.*)



X-ray Skiagram of chest showing diffuse moulting and bronchial striations in a case of Eosinophilic Lung.



X-ray Skiagram of chest with absence of motdling in a case of Eosinophilic Lung with high leucocytosis and high Eosinophilia.

Hostel Olympics.

J. S. Sathyadas.

Royal Family at the Olympiad.
(Organised by Willie.)

J. S. Sathyadas.

Arrival of the Olympic Torch.
(Organised by Willie.)

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Osler's keen interest in pathology is illustrated by the oft quoted tale of the old and seedy individual who begged for alms on the street. He gave the man a coin, with the remark "There is only one thing of value about you, and that is your 'hobnailed liver,'" referring to the appearance of the alcholic liver, familiar to pathologists. Then, handing the beggar his overcoat, he added, "You may drink yourself to death, but I cannot allow you to freeze to death." The man inquired the name of his benefactor, and the reply came, "Dr. William Osler, and don't forget the liver." When the old fellow died a fortnight later it was found that he had made a will, leaving "to my friend Dr. William, Osler, his overcoat and my hobnailed liver."

(From "A History of Medicine" by Douglas Guthrie, M.D., F.R.C.S.)

Osler could never have undertaken his vast programme had he not worked to a time-table in which each duty had its allotted hour. Life was to be lived in "day-light compartments," for "when the day's activities are properly directed and rightly balanced, work is not work, but pleasure." "Banish the future; live only for the hour and its alloted work."

(From "A History of Medicine" by Douglas Guthrie, M.D., F.R.C.S.)

first few years of the school, during the interval of 8 years between 1837 and 1845, only 10 private students were admitted, all Europeans or Indo-British. Later, even when the Hindus began to enter the school all of them were Sudras. D. Seshaish was the first Brahmin pupil of the Madras Medical College.* The appearance of a brahmin student among the Medical College was looked upon as a sign of growing popularity of the Medical School, and of western medical education. The favourable atmosphere to his admission and his progress dnring the first two sessions gave a promise of a brilliant school career. But, unfortunately he resigned his scholarship in the 3rd year, probably on account of the opposition and prejudices of his relatives regarding dissections. For many years after-wards, the profession was boycotted by the brahmins. As late as 1878, the principal of the medical college in his convocation address referred to this question and refuted the religious objections advanced by the brahmins against dissections, by citing quotations from various ancient Hindu authors. He specially drew attention to the third book of Shushruta, which teaches Anatomy and added :

> "I learn from it that your personal prejudice against dissections had no existence in those good old times when kings and sages were doctors".

He even said that he was preparing a paper on the subject for submission to the Government recommending that brahmins wishing to study medicine might be excused the study of practical Anatomy, as he felt that this was the insuperable bar to the study of Western system of medicine by good caste Hindus.

Failure and difficulties of native students, due to English as the Medium of Instruction.

From the early days, the language problem was always very troublesome. The authorities in Calcutta suggested teaching of the classics to the native people, in the vernacular instead of in English. But, the proposals were not accepted.

In Madras, also, there were frequent complaints. One of the professors felt that most of the pupils do not generally profit either by lectures or by examinations.

*Pandit Madusudana Gupta was the first high class Hindu who boldly broke the traditions and began to dissect a human body in Calcutta on 10-1-1836. His bust is kept in the Calcutta Medical College.

The first year of study was devoted to preparatory education. The student was directed to acquire the facility of writing to dictation in English and of expressing himself in English. By hearing lessons and lectures to the other students, the students also became acquainted to the technical terms. This was a good preparation and an advantage for his real medical studies, during his second year at school.

By 1850-51, a preparatory class was arranged, during the first initiatory year of study. The students were, attached under the denomination of "Preparatory Students" to the different hospitals and dispensaries in the Presidency, in the same manner and with the same duties to perform, as the students of the first or junior class. They attended the classes of instructions in Anatomy and Chemistry, but were not to be examined in these subjects. They were examined for one hour daily at the Medical School—2 days of the week being devoted to improving them in the use of the English language generally—one day to writing and dictation—one day to arithmetic, especially the Rule of Three "Practice" and Fractions one day to writing "Technical" and "Scientific" terms with their meaning in a book with the view of comitting them to memory, and one day to examinations by the Superintendent on all the above subjects together with their hospital duties. Each student was required to provide himself with an "English Dictionary" but "was allowed from the school the use of a slate with slate pencils."

Staff and Students.

Though the regular list of successive professors of Anatomy and Physiology from 1847 to 1867(when the two subjects were entrusted to different officers) is still a matter for historical research, one interesting though short, passage from the report of Principal Keess, submitted to the Golden Jubilee of the Medical College (in 1835) gives a clue. It refers to "Professor Chipperfield, who, for his great attainments, while still young in service, was selected to fill the chair of Anatomy and Physiology". Surgeon W. N. Chipperfield joined as Professor of Anatomy and Physiology on 16th September 1859. He was subsequently Professor of Medicine also. According to Principal Keess, Doctor Chipperfield died on 22nd May, 1873 while holding the appointment of Professor of Ophthalmology and Physiology. The Chipperfield medal founded in 1881 perpetuates his memory. He is said to have been a man of large experience and extensive study. He may be the first occupant of the chair of Physiology after the bifurcation of Anatomy and Physiology Departments.

One may here add a few words on the career and long service of Brigade Surgeon Dr. Lt. Col. E. F. Drake-Brockman F. R. C. S. He joined the staff of the College in July 1870 as professor of Pathology and Materi[illegible]

Medica (A curious combination) and a few years later, was appointed to the Chair of Physiology, and Ophthalmology. (Probably in succession to another distinguished predecessor, Dr. Chipperfield) From 1873, Drake-Brockman was the Professor for 2 decades of Physiology, except for a short period while he went on furlough in 1884-85. During his leave, Dr. Sibthorpe who was in the Department of Anatomy took over the Professorship of Physiology. It is recorded that Drake-Brockman was a man of ability and energy and that he won the reputation of being among the foremost ophthalmologists of his time. He retired from service on April 4th 1894.

Among the winners of the prizes, medals and certificates in the year 1885, the names of those proficient in Anatomy and Physiology are given below. Some of those prize winners later became distinguished medical men in Madras.

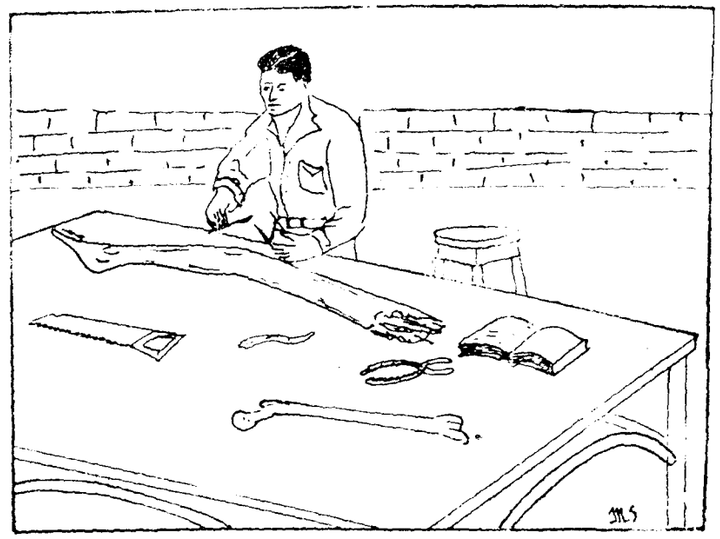
Prize for practical Anatomy.	*Prize of Anatomy*	*Prize for Physiology.*
Miss. D' Abreu	D. Gnanam,	P. G. Mahoney,
W. Karney,	A. Masilamoney,	W. Dal,
C. Moonesawmy.	*G. Rama Rao,*	*M. C. Koman,*
	J. Morrison.	A. F. Matthias.

Doctor G. Rama Rao had the unique distinction of being the first Indian Professor of the Madras Medical College.

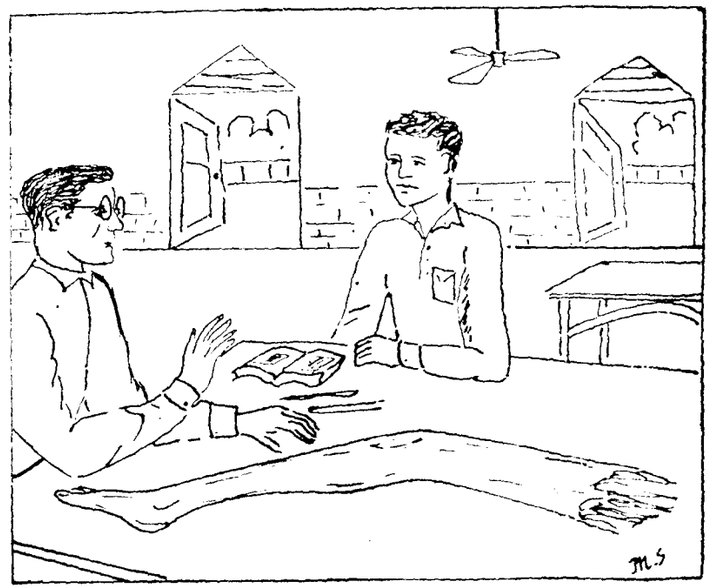
"Osler drew his inspiration, not only from an extensive clinical and pathological experience, but from a wide knowledge of classical medical literature. When the textbook was criticised for a lack of detail regarding treatment, he replied that already there was far too much treatment, and that he had little faith in drugs. Time, in divided doses was a favourite prescription with Osler. He often told his class that Oliver Wendell Holmes learned three things in Paris—"not to take authority when he could take facts, not to guess when he could know, and not to think that a man must take physic because he is sick."

—(*From "A History of Medicine" by Douglas Guthrie, M.D., F.R.C.S.*)

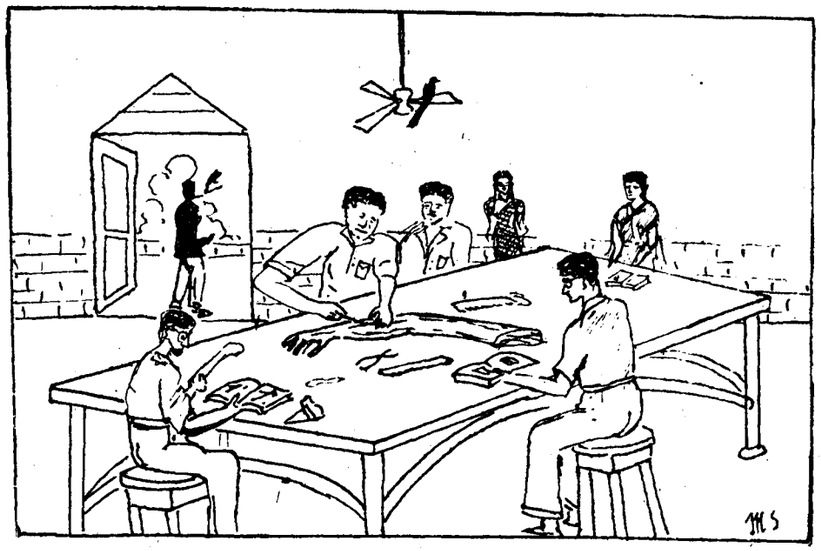
Shape of Things to Come ?



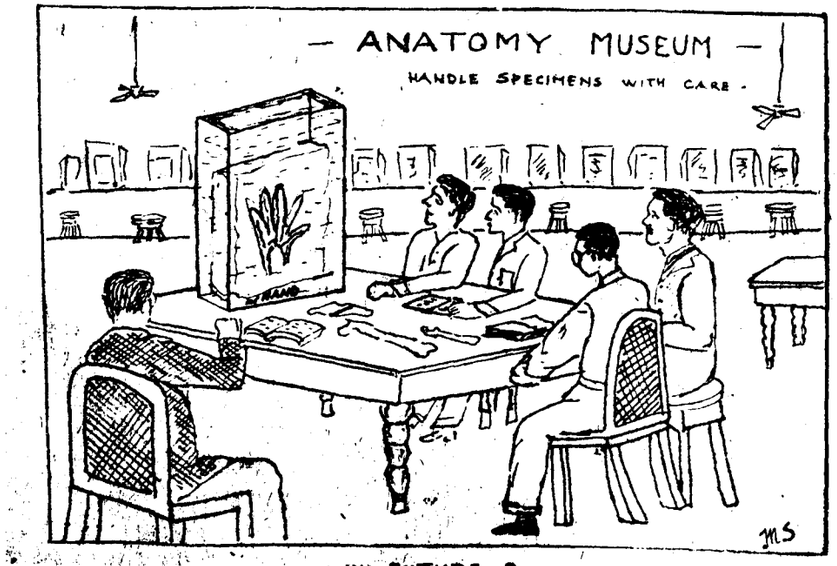
YEARS AGO



A FEW YEARS BACK



AT PRESENT



IN FUTURE ?

Whither this prate of Equality ?

BY

"MARK TWAIN"

(A frank opinion from a student who has seen facts as they stand to-day. As this is a controversial subject, Editors invite opinions from the readers).

—*Editors.*

With the end of war, we hear many progressive women's organisations arguing for parity of representation for members of their sex with men in the differnt walks of life. It is a bit disturbing to note that even the armed fighting forces have not been spared of this onslaught. Unless we pause and think what all this noise means, this boom may soon drift into a deadlock in society.

It has always been the fashion to praise women to the skies by attributing to them many qualities and paying them at times undeserved complements. There are many who think that equality and freedom are the legitimate dues of the feminine gentry and those conservatives who do not contribute to this school of thought are likely to be dumped as out of date specimens of humanity. Clever people easily win the trust and endearment of women through a generous use of flattery and praise but an impartial weighing of the pros and cons on the claims of equality does not permit here the employment of such a technique.

Certain facts have to be admitted to be beyond argument. The male and the female of the species have to be present if extinction of humanity is to be averted. It is an indisputable fact that in spite of all scientific progress, child bearing has to be carried out by women and she cannot change places with man however much she may quarrel over it. It has so far been her privilege and has always been a matter of convenience to be treated in a spirit of chivalry by man. With this background let us examine the achievements of both parties in the light of their physical strength, intellectual attainments, hold in arts and mental powers before passing any verdict on equality.

Enthusiasts argue that given equal facilities women will easily compete with men in the field of might. This argument cannot hold water, for apart from aesthetic considerations the anatomical and physiological drawbacks of women do not qualify them for any appreciale physical strain and their sex has been aptly titled the weaker sex.

And what has been the experience of those exceptions who succeeded to attain equality in strength? Imagine a prototype of Gama among women and consider how many there will be to cast covetous glances, to give winning smiles, to make scintillating remarks or to strike up lilting music as she passes by!!

Even the most noisy fighter of this equality longs in her heart of hearts for the strength of a he-man to prop her up in this world. How does a woman react when her name is coupled with a milk-sop in any amorous affair? Doesn't she struggle hard to stifle all such talk even in the bud? But if the person happens to be bigger, better and wiser, what smiles of gratification giving a tinge of realism meet insinuations of imaginary amorous escapades? With what stealth she points him out to her inquisitive friends and with what cunning and pride she transfers all the infatuation over to his head though all this goody goody talk may ultimately find the unguarded fellow in hot water?

In intellectual attainments of the material world, man has always been at the fore front. It may be said that any impediments due to society have always retarded woman's progress. It is true that many of the personalities at the top-most rung in the ladder of politics industry, commerce, science etc. started from the very bottom surrounded by difficulties which must have looked unsurmountable in the beginning. If so much could be achieved with handicaps, it follows that many well placed women could have achieved equally honourable deeds, if their intellectual abilities were similar. The fact that their attainments have been small so far, indicate that their intellectual faculties are not tuned to deal with the intricacies of the external world.

Both men and women have done much to improve art, but who has done most towards improvement? In a galaxy of names like Tagore, Rosini, Handel, Schubert, Schuman, Mozart, Beethoven and Wagner can be paraded as benefactors, how many are there among women? The same is true in literature, poetry, painting and dancing. Conceptions always came from man and woman carried out their execution with a fineness which is her heritage. Will it be arrogance to point out that wherever woman usurped man's vocations she usually proved to be nothing more than of nuisance value?

Yet "the Taj was built for a woman, Troy was destroyed for a woman, a Mark Antony destroyed himself for a woman and monarchical Rome turned Republic through a woman. Cupid capitulated to Psyche, Eros to Agape; Zeus to Europa; Bacchus to Venus; Hercules to Omphale; Socrates to Zanthippe; Plato to Brouno; Dante to Beatrice; Shakespeare to Hathaway; Goethe to Anna Katharina; Keats to Fanny Browne; Comte to Clotilde; Johnson to 'Tetty'; Gibbon to Susan Curehod; Nepoleon to

Josephine; the Duke of Windsor to Mrs Simpson and so on". Adam was the first to show this weakness. If he had not yielded to Eve and eaten the forbidden fruit the ground would not have been cursed to bring forth thorns and thistles.

Shouldn't there be something fascinating to make her the author of so much mischief and confusion? In spite of her follies, fashions, flirtations, fickleness, rivalries and peacock temperament, the peculiar mechanism of her mind strengthened by sacrifice, endurance and love has something pretty about it. "She is by the very fact of her motherly sex the senior partner in the process of creation, the first nurse and protection of the human race, the prime reservoir of human affection and love and it is only through a long and strenuous process of coquetry and charm exercised with the native intelligence of her race that she has been able to bring her physically strong and more aggressive partner under her control and harness his wild energies to the benefit and protection of herself and her progeny."

From what has been said, it is clear that both man and woman are put in totally different footings. How can there be any comparison when the same measure cannot be used to gauge abilities of both? How can there be equality when no comparison is possible? From time immemorial in the face of all taboos, there has always been the boy-girl trouble leading on to man-woman relationship and thereafter he doing all the strenuous work and she the lighter ones. There was contentment, and no spirit of rivalry raised its head. To-day when we hear much talk on the fight for equality it will be fitting to sound a note of warning to the champion of this fight. The home has always been the sanctum of peace and harmony. No one wants it to be a brewery of rivalry and those who labour to ape man are only striving to run men's affairs as well as their own and are bound to fail at both. Sooner these turbulent paths are abandoned the better for all concerned.

As long as a woman can look ten years younger than her daughter she is perfectly satisfied.

Oscar wilde.

The difference between prejudice and conviction is that you can explain a conviction before getting mad.

MY INDIA

1. My India ! I love because you are mine,
   For me all my pleasure henceforth is to shine,
   My country, your glory and honour I'll guard,
   Till death, serve you faithfully, " Help me O God ! "

2. I love you because of all that is past,
   More glorious to make you I'll strive till the last,
   And hand on the " torch of freedom " That's won,
   That those who come after, complete what's undone !

3. I'll love all our leaders, great Ghandiji most,
   His " Gospel of love " shall be all my boast
   Till love burns in action, selfless I'll see
   One India, one world, growing to be !

—VICTOR CONRAN.

Jumboo Wears Spex.

BY

P. NARENDRAN, *5th year.*

(To some wearing spex is an ornament - no doubt some faces look better wih this. But how Jumboo became crazy to get it is really thrilling to know)

—*Editors.*

Jumboo, the medico, was not a man who would have turned a monkey by the mere look of women and climb trees to pluck nuts for them. He was a young fop, a determined popinjay who would, if wanted, sell sweaters to Polar bears and tooth brushes to crocodiles. He was one of the latest models of the streamlined medicoes. But he felt something terribly lacking in his magnetic personality as a superfortress aircraft would have felt when it found its tail missing in mid air and that was a pair of spectacles. He was heard to neigh often thus :—

" Every cloud has a silver lining,
And every medico must have a spex shining. "

It was quite within the meaning of the act as the lawyers would say. But what riled him was that he was not endowed with any defect of the eye by the merciful providence !

He was not so easily put off. He was a medico who ' willed ' and not ' wished ' his way through this world. So one holy day, overwhelmed with his ' burning ' desire took an oath, as he was very well tuned up at the College in the matter of taking oaths.

" I, a two legged being, belonging, to a race often called by the name of mankind, son of my father and mother, both of them of the same race, who named me as Jumboo, but often called me a ' bottle of mischief ', on this fifth day of the eighth month of the year ninteen hundred and fortyeight A. D., take this solemn oath before the sacred earth and steth, that I will or shall spoil my eyes by hook or crook and that to the best of my ability and judgement will faithfully keep this oath and obligation."

From that day onwards he metamorphosed into a silverfish for the thousands of books kept in the public libraries including our College library. There is one thing congenitally aboriginal with all these libraries and that is the air and look of antiquity especially with the remnants of fossils preserved there, called the books. If you happened to ask for the

latest edition of a book, the Librarian there, will produce the then latest edition when the scalp of your dad was not the skating rink for the mosquitos. That edition was, of course, artfully decorated by the various marks of affection left over by the members of the Blattidae family. Jumboo could not procure any book which dealt with 'How to spoil the eyes' from these libraries; but he was rewarded with some books on 'How to improve our eyesight'. He was happy in a way because he did exactly contrary to what was written in them. For instance, if the books said, 'Do not read in poor light' he purposely strained his eyes in places dimly lit, and went a further step by doing the same for a number of hours at a stretch. It was a sight for the Gods to watch him wipe off the streaming tears and continuing with a vehemence often attributed to him alone. If the books advised to curtail movies he did see a couple of shows daily. Thus with undaunted spirit, the modern Robert Bruce underwent his 'course' of spoiling the eyes.

After a month, to his dismay he found eyes as sound as ever. So he lost faith in such books and discarded them as nothing but a lot of junk and rubbish stuffed into the form of books, only fit for the Corporation dust-bins.

So when my room mate and I met him one morning in the students' common hall, no wonder the chewing gum in my mouth stuck to my uvula. He looked seedy and completely bunkered. His eyebrows had acquired a permanent lift, his cheeks had sagged and his usually Brylcreamed hair was like the bristles of a dried up tar brush.

"Hallo, goat!!" we greeted him with the attitude of a modern medico approaching his chum.

Jumboo looked at me as if across a chasm, twisting his drooping lips.

"Oh! hallo" he grunted back spiritlessly.

"You look mashed up. What is the trouble" I queried with sympathy. He inserted himself into a chair opposite to us.

"Where fore this grumpy air" my room-mate asked him.

"This life", he wailed, "is a rotten show. The blasted existence is a nightmare. I am giving up the fight".

"Never say die", I encouraged, "Tell us all".

"You know my lad" he began and told us his story till the end of dust-bins.

After giving a patient hearing to his tale of woe my room-mate said, "Jumboo, look. I have a wonderful idea," and stamping me lightly on the foot added "Why not try Ogling at girls at each and every opportunity. I am sure this will help you to spoil your vision". He said he will try that, even though he didn't have much confidence in that.

One pretty evening, while he was ogling at some one in the OTHER terrace, from our Hostel terrace, an original idea struck him as a bolt from the blue, an idea which he was sure would elicit universal applause and cheers.

With a full blown pigeon chest added to a peacock gait he stepped in to the Ophthalmic Hospital next morning with hopes soaring high. Straight he beetled into the room of the Surgeon there.

"Good morning" greeted Jumboo.

The Doctor nodded.

"Doctor I have short sight and I can't see distant objects distinctly". The doctor pointed him to a chair facing a board containing some printed matter in different sizes. To begin with, he gave him a thick lens to wear and asked him whether he could see the letter G on the board. He said 'No'. Then he told him to try another. Again the same reply. Thus he was asked to try eleven lenses and every time he could not see the letter G distinctly. Finally the doctor looked at him straight and asked, "Look here, can you see the letter now without any glasses?". Impulsively or not the word 'Yes' slipped out of his lips! (quite evidently our Jumboo had been malingering). But immediately he tried to counteract the effect by giving a loud yell, "No, no, I can' t see".

Poor doctor was fed with him. But he was a doctor with some real grey stuff in him. He took another lens and asked, "Try and say whether you see the letter G clearly now". The next moment Jumboo shot up from his seat and actually yapped out, "Vow!, I can see very well! I can see quite distinctly every nook and corner of G. Atlast I am going to have a spex!, a spex of my 'sweet' own".

The doc paused for a moment, put on a bewitching smile and calmly voiced thus, "My foot; it is only a plane glass!".

Dear reader, now you shouldn't Ogle at his face, Please!

P. S. Facts are stranger than fiction.

The Secret of life is not to do what you like, but to like what you do.

—*A World Treasury of Proverbs.*

ADIEU PRE-REG.

BY

ASGHAR ALI (*1st year*).

I'll-fated pre-Reg ! I bid thee adieu ;
Now I tread on a path, odd and new.
Ah ! But how can I forget our friendship old,
Never to be seen again by the eyes of the world.
My shadow wert thou, in my nine months-stay,
To haunt me, to startle, to puzzle and to waylay ;
As Rahu to the moon is an eternal foe,
So wert thou to me nine month's ago.
Yet shall we part as comrades sweet,
Since in Future, we never shall meet.

Stone-hearted pre-Reg ! In our struggle and fight,
Thy weapons so mighty, dazzled very bright ;
The experiments of practical held so powerful a sway,
They were agents of Fate, who knew their play
From Earthworms to Frogs thy power was stretched,
From Magnets and Colloids thy arms thou fetched,
But alas ! though thy warriors were so perfectly armed,
Against a determined foe, they vanquished and calmed.
Chemistry with Biology and Physics could not for long
Hold thy Fortress, though mighty and strong.

Woe - stricken Pre-Reg ! Death has knocked at thy door,
The sufferings thou caused are now things of Yore.
Time, the unconquered king has showed his hand
To bring thy end, with a powerful wand
Like a mortal thou lived and suddenly went
Fretting for a while thine hour in my tent
But the days thou lived, thou work'd with Napoleon hands
To wreck and to shatter the young medico's plans
With this credit alone, thy heart to boast
Thou shalt perish, with Death as thy host.

A broadcast talk on the International Radio.

BY

S. S. PALANISAMY, *4th year*.

(In these days of international organisations why not we have an international committee to introduce the best dishes in every man's food ?)

—*Editors.*

Friends of the world and country men, now I am here to talk to you, about Idli Campaign. I have come to praise idli, not to decry chappathi. Those days when rations were very limited, idli was not served in hostel messes so often as it is to-day. It was a thing of luxury. The situation became so acute that a member of our hostel dreamt of Mr. Idli and Mrs. Sambar only the other day. At least in dream he enjoyed its sweetness. But why is it, idli, the natural article of food discarded like this? According to the latest census only 15% of the people of South India are taking idlies. It is a matter for consideration for the leaders of India who are interested in the welfare of the people of this country.

Now I shall give the pleasures in idli. Look at the shape, both sides convex (Morphology). A thing of beauty is joy for ever. So any man with a sense of appreciation of beauty cannot but enjoy, not only its shape but also the taste. Supposing a newly married girl serves her husband *nice* idlies accompanied by sambar, the fellow cannot imagine a better pleasure. That is all from the view-point of a man in the street.

Physiologically also idli is superb. It produces varied effects in the body. The exact nature of its action is not known. So to explain the action various theories have been put forward by various workers. According to Idlicantha Sastry, the Professor of Idli Chemistry in the University of Amanjikarai, "Idli is the best tonic that man has ever produced. The pity is, the humanity has not appreciated its full merits". Secondly Dr. T. K. Pillay, who has written not less than seventy eight volumes on sex in ninety six novels, says that Idli is directly concerned with acceleration of production of sex harmones in the body. This is experimentally proved in Pigmies and Eskimos. Still another theory is propounded by Professor Singh who has produced a wonderful book 'How to live 100 years'. It says that Idli, in the long run, is responsible for the longevity of life itself. But the modern and approved view is that when man is living under unfavourable conditions, for example in an hostel, tiresomeness is produced and idli gives complete relief from this.

This is the well-known theory of Vengaya Iyer. This is all the literature available about Idli and its physiology till 1943. After that due to war conditions and later amidst the talk of the Third Great War, the literature is not available; Rations being scarce research was not pursued.

It is a matter of common experience that it produces intelligence and clear vision. Why do we have Rajaji as the Governor-General of India to-day? Why is he 'one of the five superman of Hindustan?' That is because he never forgets idli even if he goes to the north or east. How is it that many Madrasis become eminent doctors, advocates and judges? How is it that Sir S. Varadachari became judge of the Federal Court? What about Sir C. V. Raman? How did he become one of the great scientists of the world? All because of idli, though some people hold diverse opinions, to cite an example, a learned professor says that a dip in the Cauvery gives the South Indian (particularly the Tamilian) the intelligence which was admitted by no less a celebrity than Mahathma Gandhi. Still another view is, the curd which the Madrasis take, is the fountain source of his intelligence.

Now I want to give some concrete suggestions for the popularisation of idli in the world. An Idli expansion Board should be set up immediately. A delegation consisting of Mr. Blackgram Iyengar and Mr. Chutney Rao should be sent to visit America and other civilised parts of the world and lecture on "making idli an international article of food". They will recommend the approval of adding fifth freedom, that is freedom to eat anything, to the so-called Four Freedoms of late Mr. Roosevelt.

An All-India Idli Front should be launched forthwith and propaganda should be made throughout the length and breadth of this sub-continent. Newspapers should spare some space for this matter, when they can afford to waste columns on the divorce of a Hollywood Star or headache of a popular cricketeer. There should be weekly Idli programmes in the All-India Radio. The Radio cannot serve better than for this noble cause. What about Information Films of India? They can write stories, take some films and exhibit all over the globe. Poets who can write poems on 'railway train' and 'a hairy leg' can certainly write about the virtues of idli. If the poet thinks about it, poetry will flow out like blood from a bleeding artery.

The Government should appoint a committee consisting of idli specialists to advice the Government a post-war scheme. Any post-war scheme without reference to idli, I am sure, will be a fatal failure. We hope the National Government will not include any anti-Indians or our Comrades in the committee for obvious reasons. The latter would like to introduce some article of food from the country of their ideal to be our national dietwho knows? Those who serve best in that committee will be awarded 'Idli Sahib' medal. They will get so high titles as Sir Idli Ayyasamy Iyer. The wife of Sir Idli Ayyasamy Iyer will become Lady Ayyasamy Iyer for no sin of her own.

The next step in this direction is to start a Research Institute. They will do research on different varieties of idlies and find the best suitable side-dish for Idli. Then they will advise the formation of "My Idli Bar" where idlies of different colours and taste will be served. Thus only by this scientific outlook on life, man can improve his lot.

But one thing I want to tell you. There is no need for an idli controller. Let every man eat as much as he wants. This idli movement is a revolution; a movement for rejuvenation of mankind. The motto and watch word of the front rank politician should have been "Eat idli and get Swaraj". That is the slogan that every patriotic Indian should have adopted. By this movement we are not demanding any 'Idlistan'.

The same attitude should be taken by all our hostelers and they should encourage idli production and eating. Then only we will have more gluttons. They can eat even 100 idlies because of the peculiar anatomical nature of their digestive system. It has been said and rightly so, that for them the stomach begins even at the neck.

Thus idli is fine philosophically, economically, politically, socially, anatomically, physiologically, embryologically, histologically and in short artistically and scientifically. Now we can look forward towards a world order where men will be idli-minded.

IDLI ZINDABAD. SAMBAR ZINDABAD.

One of the least lovely sights that most of us can imagine is the obese human being, male or female, demonstrating redundant jiggles and swirls while under motion, their often spurious good humor, and their ever present hazards whether by virtue of the excess burden upon their own supportive and locomotor systems or upon one's antique furniture.

—*An American Journal.*

Lay Clinicians.

(By Courtesy of "Post Graduate Medical Journal", London).

Often when reading a book or play one comes across an excellent description of some disease, which though written by a layman, is probably more happily phrased than in any textbook of medicine.

1. 'Mrs. Amorest was gone, and in the silence that followed her departure, there came a new sound that May had never heard in that house before. It was the dripping of a tap. It must be out there on the landing. How clearly it came through the closed door. Like someone counting time. One, two, three, four-then a pause-then several drips together. Like an old man querulously complaining, and then in the steady drip, drip again something stern and remorseless. Some one counting as though he said, "Now when I've reached thirty."

'May began to count. She counted to ten, and after that so many came together that she could count no longer. She would never sleep with that horrible thing at the door. The fantastic idea came to her-and one's ideas are fantastic when one is sick and has been lying in bed with so many idle thoughts hovering about one-that that horrible woman had started the noise. It would be like her. There would be other noises also in the house that would be of her agency. Oh! I must escape from this! I must; I will go into Mrs. Amorest's room and never mind if she thinks me a fool. I will tell her that I must stay with her, that I won't be alone.....

'She moved, got half out of bed; but her head was swimming. The room danced round and round her. Pip climbed off the bed, gave her one beseeching look, and crawled away out of sight.

'She sank back upon the pillows again, and weakly cried, "Pip! Pip! Come back. Come here. Good dog!," But Pip did not reappear.

'A curious lethargy slipped upon her. It was as though something had seized her limbs and that she would never be able to move again. She was almost asleep and fancied through her half closed eyes that figures moved dimly about the room. She was in her childhood once more; all the family were round her with their noise and their selfishness and their jokes, in which, for some reason, she was never able to share.....She lay, the sweat on her forehead, her body trembling, her heart running and jumping and missing, and missing and jumping and running. She could see quite clearly. There were no longer any shadows in the room. She

heard, so plainly that it seemed that it must be with her now beside her bed, the running tap. One, two, three, four....She lay, trying to remember Mrs. Amorest's prayer. "Lord Jesus, Lord Jesus, Lord Jesus" she repeated.

"She closed her eyes, but a sound forced her to open them again. She cried, "Who's there?" The handle of the door was turning. Very quietly and carefully, closing the door behind her, Agatha Payne came in.

"May neither answered nor moved. A long silence followed, and for May it was filled with an agonising determination not to show her fear. She would not move; she would not speak. She was biting her lips, her hands were fiercely clenched, one holding tightly the red amber. That woman might kill her but she would not move. Then her heart ceased to beat. It ceased absolutely. She began to suffocate.'

This extract from 'The old Ladies' by Hugh Walpole describes most vividly the patient's impressions f extra-systoles in a failing heart. 'May's' cardiac failure terminated fatally the same night after a shock.

No. 2.

'Besides the natural desire to get home, we had another reason for urging the ship on. The scurvy had begun to show itself on board. One man had it so badly as to be disabled and off duty, and the English lad, Ben, was in a dreadful state, and was daily growing worse. His legs swelled and pained him so that he could not walk, his flesh lost its elasticity, so that if it were pressed in, it would not return to its shape, and his gums swelled until he could not open his mouth. His breath, too, became very offensive; he lost all strength and spirit, could eat nothing; grew worse every day, and, in fact, unless something was done for him, would be a dead man in a week, at the rate at which he was sinking. The medicines were all, or nearly all, gone, and if we had chestful, they would have been of no use, for nothing but fresh provisions and terra firma has any effect upon the scurvy. This disease is not so common now as formerly, and is attributed generally to salt provisions, want of cleanliness, the free use of grease and fat (which is the reason of its prevalence among whalemen) and, last of all, laziness. It never could have been from the last cause on board our ship, nor from the second, for we were a very cleanly crew, kept our forecastle in neat order, and were more particular about washing and changing clothes than many better-dressed people on shore. It was probably from having none but salt provisions, and possibly from our having run very rapidly into hot weather, after having been so long in the extremist cold.

'Depending upon the westerly winds, which prevail off the coast in the autumn, the captain stood well to the westward to run inside of the Bermudas and in hope of falling in with some vessel bound to the West Indies or the Southern States. The scurvy had spread no farther among the crew, but there was danger it might; and these cases were bad ones.

'Sunday, Sept. 11th.— Lat. 30 deg. 4 min. N., long. 63 deg. 23 min. W., the Bermudas bearing north—north-west, distant 150 miles. The next morning, about 10 O'clock, "Sail ho!" was cried on deck, and all hands turned up to see the stranger. As she drew nearer, she proved to be an ordinarylooking herma-phrodite brig, standing south-south east, and probably bound out from the Northern States to the West Indies; and was just the thing we wished to see. She hove to for us, seeing that we wished to speak to her, and we ran down to her boomed-ended our studdingsails, backed our main topsail, and hailed her - "Brig, ahoy!" "Haloo!" "Where are you from, pray?" "From New York, bound to Curacao." "Have you any fresh provisions to spare?" "Ay, ay! plenty of them!" We lowered away the quarter-boat instantly, and the captain and four hands sprang in and were soon dancing over the water and alongside the brig. In about half an hour they returned with half a boatload of potatoes and onions, and each vessel filled away and kept on her course. She proved to be the brig Solon, of Plymouth, from the Connecticut River, and last from New York, bound to the Spanish Main, with a cargo of fresh provisions, mules, tin bake-pans, and other motions. The onions were genuine and fresh, and the mate of the brig told the men in the boat as he passed the bunches over the side, that the girls had stung them on purpose for us the day he sailed.

'It was just dinner time when we filled away, and the steward, taking a few bunches of onions for the cabin, gave the rest to us, with a bottle of vinegar. We carried them forward, stowed them away in the forecastle, refusing to have them cooked, and ate them raw with our beef and bread. And a glorious treat they were. The freshness and crispness of the raw onion, with the earthy taste, give it a great relish to one who has been a long time on salt provisions. We were perfectly ravenous after them. It was like scent of blood to a hound. We ate them at every meal, by the dozen, and filled our pockets with them, to eat in our watches on deck, and the bunches, rising in the form of a cone from the largest at the bottom to the smallest, no larger than a strawberry at the top, soon disappeared. The chief use, however, of the fresh provisions, was for the men with the scurvy. One of them was able to eat, and he soon brought himself to by gnawing upon raw potatoes, but the other, by this time, was hardly able to open his mouth, and the cook took the potatoes raw, pounded them in a mortar, and gave him the juice to drink. This he swallowed by the teaspoonful at a time, and rinsed it about his gums and throat. The strong, earthy taste and smell of this extract of the raw

potato at first produced a shuddering through his whole frame and, after drinking it, an acute pain, which ran through all parts of his body, but knowing by this time it was taking strong hold, he persevered, drinking a spoonful every hour or so, and holding it a long time in his mouth until, by the effcet of this drink and of his own restored hope (for he had nearly given up in despair) he became so well as to be able to move about, and open his mouth enough to eat the raw potatoes and onions pounded into a soft pulp. This course soon restored his appetite and strength; and ten days after we spoke to the Solon, so rapid was his recovery, that from lying helpless and almost hopeless in his berth, he was at the masthead, furling a royal.'

This masterly account of scurvy is taken from 'Two years Before the Mast' written in 1840. The author, R. H. Dana, was born in 1815 and graduated in law at Harvard in 1837. He suffered from some affection of his eyes and on this account broke his college career to make the voyage which is described in this book.

HOMAGE.

BY

C. V. NARASIMHAN, B.Sc., B.Sc. (Pharmacy) Final.

O! Mother of our sacred land,
Thy fetters are shattered and bondage broke.
Slavery ceases and Freedom begins-
Thou emerge from the foreign yoke,
A remnant of the past with a vigour lost;
And still thy beauty clings and charm persists.
Thy face brightens and eyes enlighten,
And eyelids moisten with tears of reunion
Lo! Thy face clouds and smile disappears,
And clouds of sorrow cover thy looks
At the thought of heroes lost and divisions cast
On this land of glorious past.
O! Ye, Queen of Eastern lands;
We salute Thee on the ides of August,
When Thou attain Independance
And Thy flag flies without disturbance.

BATTU DHANAKOTI.

Dhanakoti - don't you know him? Better go on a pilgrimage to the Pathology Department. As you climb up the first flight of stairs to the Library, you will find the 'Preparation Room' with an old board, 'NO ADMISSION' nailed on the door. Don't hesitate, enter - that laboratory is no more a forbidden field! There you find the great Karma Yogi, the religious emblem boldly painted in white and red on the transversely furrowed forehead, a pair of spectacles (lenses secure in the rims!) sitting snugly on the tip of the nose and very busily engaged with the microtome - that unruly instrument over which he has swayed age-long mastery.

As students we know very little of him, unless and until we are out to take examination, and that too, seriously. The junior attender has his own designs on you, on the box of slides, never comes to serve you. It is then, that this 'Benefactor' appears and you are face to face with this great man; Every doctor and every anxious relative waiting for a biopsy report knows Dhanakoti. You know how busily he shoots from the paraffin bath to the microtome, from the microtome to the staining cup-board, and to the laboratory. And all that with the lofty ideal of satisfying his conscience and that of the anxious soul outside.

It is 9 A. M. and he is there every morning, wet or dry, with a lusty "Good morning, Sir." Motor-cars, buses or electric trains or the like have no place in his programme of life! he believes that automobile transport aggravates his Osteoarthritis! he must walk, thus nourish the tissues. His junior colleagues come at 10; at times, wait for the Diesel Engine Omnibus to miss it, and then turn up leisurely any time before 10-30 and yet look tired and exhausted and anxious to stop work the moment you turn your back. Poor Dhanakoti works and he does the work of all the rest.

He is methodical, he is quick and he is a master-craftsman. The speed is there and is perfection there too. The soothing panoramic staining, the thinness of the sections unfolding the cellular mysteries and the elegant labelling, will all betray the artist in him and the technician he is. No wonder every day the Professor is lost in the technical nicety and exclaims in despair that when Dhanakoti retires who would serve Science so well!

Why should he work? Is it the unconscious but unperverted, organismal urge which makes one work? We know very well that mightier creatures like Megatherium and Leviathan have perished perhaps for want of work. The Gospel of Gita was preached in this land and it is no wonder we have people like Dhanakoti to uphold the doctrine of work - Work for its own sake - Virtue for its own reward. It is when the doctrine reaches the acme of perfection throuh universal practice that such sparks of wisdom as Gita come into existence in their full stature.

Here he is absolutely oblivious of his immediate or remote personal gratification. He personifies the essentials of self-abnegation; he is for the cause of the suffering. Whether rich or poor, whether he is paid or not, he is ready to do all he can.

His comments on the laboratory techniques are wonderful. He has his own modifications and that too with strong arguments in their favour. His memory is prodigious and he is the only man who knows all the apparatus, big or small, some purchased the day before or a 100 years ago when the college was opened, their use, their history and a very sagacious remark.

It was in 1908 as a youngster of 18, he entered service as an attender. He was to join the Government Press as a compositor but Aesculapius was not too late to commandeer his services. Two of his grandfathers were working as Senior Attenders and he was brought to this college changing the vocation overnight. He would have been one with the machine, eternally facing and setting the unimpressive and unimpressionable types and feeding the machine with paper. He would have never had the opportunity to view with delight - amounting to ecstacy at times - the pleasing pictures in varying shades under microscope. Only those who had worked in this laboratory would understand with what romantic delight he rushes to the microscope with a section in hand to have the first glimpse before he hands over the slides to you.

His pay was Rs. 7/- for managing so many departments - Midwifery Surgery, Medicine, Jurisprudence, etc. He looks at the present day youngsters with absolute scorn at their laziness when in spite of their numbers in each department, the work is left undone. Then, the work was strenuous, he stood the strain but he says he could not stand the sight of cadavers in the Operative Surgery Classes. So he decided to leave the college in case a transfer to another department should be refused. Recognition of the meritorious services of his elders came - in a humble way; he was appointed in the Pathology Department to be in charge of the Museum on a sum of Rs. 12/- per mensem.

Movie-minded modern student knows little about the thrill of grandparents telling stories but to them I say, "Listen to Dhanakoti; you

won't like to go for pictures." How sweetly he narrates, wonderfully chronicles, the events of the past four decades with a Homeric diction in grandeur - all with the same regard for truth and perfection.

For 3 years he was Junior Attender and then he was promoted as Senior Attender. Sir Mudaliar and Dr. Tirumurthy were students. The professors had multifarious activities - they had the clinical and non-clinical subjects to deal with; they had to look after patients in the wards and teach students in the various pre-clinical subjects. And they suffered frequent transfers - interdepartmental mostly - not that they were versatile geniuses but they had indefatigable energy to master any situation. Dhanakoti talks about Donovon; look at the beam in his eyes as he portrays the gigantic stature and the number of hours of work he used to put in!

Then students were limited in number, the space was inadequate; the practical class in Pathology and Physiology were held in the same hall. He need not tell us that it was a great strain to carry microscopes and materials to the practical hall and in addition, the staining materials, for in those days the students had to stain and mount their own slides for the study of histo-pathology. The greatness of this child of Karma is that he has nothing bad to say about anybody. He is a cheery optimist—a Browning with a veracity and practical mindedness - "Every-body is good to him." This is a great philosophy, "If you are good, the world is good to you."

All his masters were kind to him and everyone of them had a great regard for him. All the testimonials presented to him on the eve of their departure bespeak of the same unfaltering excellence of his work. Major Russel testifies, "He is an excellent man at his job, cuts sections, prepares specimens in a first class manner and is altogether indispensable as regards the running of the labarotary. He is a very skilled worker and is always, in addition very willing and obliging." Major Leonard Forsyth, I.M.S., writes - "He is exceedingly well up in every branch of his work, his sections are of a very high order. I have found him very punctitious in detail, I am much beholden to him for the excellence of his work. I have not met with a better Assistant in India of his class."

He was offered very attractive terms at home when these English Professors retired. Dhanakoti had his attachment to this college where his ancestors had toiled and he preferred to devil for a paltry sum. It is heard-rending to go through the recommendations for an increase in his wages and the response of the various governments in power was the same - no increment. To quote Forsyth, "His pay compares very badly indeed with that of attendants in other colleges and he is worth at least double his present emoluments. Blood cannot however, be drawn from a stone - and Dhanakoti's wages must continue to be small."

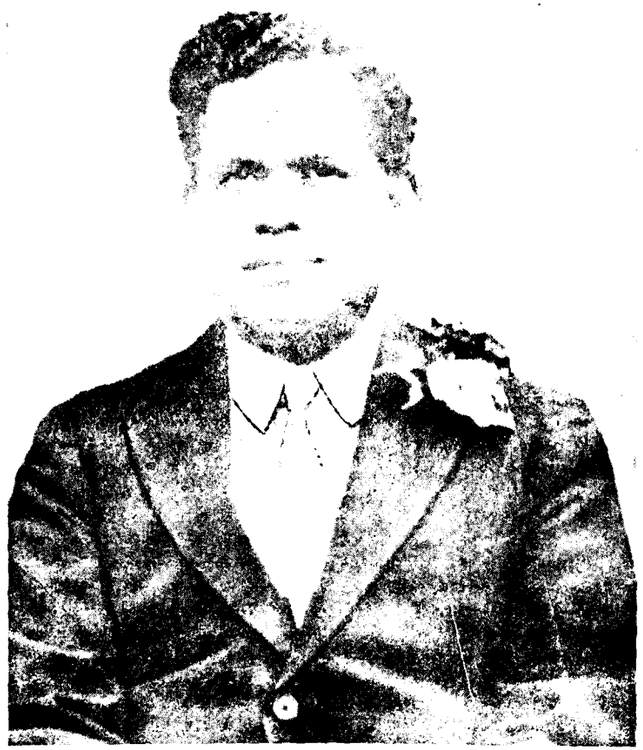
After a long and continued struggle he has risen to be a technician and as characteristic of every "paper - promotion", it was on the paper with no appreciable monetary betterment in his life. Dhanakoti entered service in his teens, sacrificed the best in him in the cause of science, devilled for 40 long years to achieve the summit of Rs. 40/- per mensem. The Bible glorifies 40, but a mortal cannot rest content.

(Permit me, Editor, Sir to appeal to your readers for a liberal contribution towards a pre - Retirement Purse Fund which may give him the thrill of having a purse worth its name - (Not 40 chips - A thrill which he had never experienced all these 40 years).

'There are one or two elementary rules to be observed in the way of handling patients, remarked Budd, sitting on the table and swinging his legs. The obvious is that you must never let them see that you want them. It should be pure condescension on your part seeing them at all; and the more difficulties you throw in the way of it, the more they think of it. Break you patients in early, and keep them well to heal. Never make the fatal mistake of being polite to them. Many foolish young men fall into this habit, and are ruined in consequence. Now this is my form'. He rushed to the door and bellowed downstairs. 'Stop your confounded jabbering down there! I might as well be living about a poultry show!' Dead silence ensued. There, you see! They will think ever so much more of me for that'.

(*From "Conan Doyle" By Hesketh Pearson.*)

IN MEMORIUM.



Dr. E. ACHUTHA MENON.

Dr. E. Achutha Menon, M.R.C.O.G., F.R.C.S. (Edin.) entered service in 1913 as Civil Assistant Surgeon and served Government Hospital for Women and Children, Madras and moffusil stations like Chowghat, Erode, Madura etc. He was popular in all these stations and had a lucrative practice. In 1927 he went overseas and took F.R.C.S. (Edin.) with Obstetrics and Gynaecology as special subjects. On return he was posted back to Government Hospital for Women and Children where he served as lecturer in Obstetrical Clinics and Superintendent of the hospital. He was then transfered to Andhra Medical College, Vizag as Professor of Obstetrics and Gynaecology from which post he retired five years ago. He was just 60 when he died suddenly of "Coronary thrombosis" at Ernakulam where he was staying with his son - in - law.

IN MEMORIUM.

Dr. T. BHASKARA MENON.

Dr. T. Bhaskara Menon, M.S., F.R.C.P. (Lond.), D.Sc. (Edin.) was Principal and Professor of Pathology, Andhra Medical College. He was sent on deputation by Government of India for three months to study post-graduate medical education and research in U. K. and U.S.A. He served the Pathology Department, Madras Medical College and was lecturer in Stanley Medical School and later Professor Stanley Medical College before he was transferred to Vizag as Professor of Pathology. He has published several papers on Pathological Subjects and a textbook on Tropical Pathology. He was a reputed Pathologist of a very high order.

Death of a Distinguished old Student of our College.

Dr. Yellapragada Subba Rao (1895-1948).
Noted Indian Physiologist, and Medical Scientist.

(by Courtesy of Grimalkin)

Studied in the Madras Medical College, and graduated in 1920. Lecturer and Vice-Principal, Madras Ayurvedic College 1921-1923. Post-graduate studies in London and U.S.A. 1923. Joined Harvard University School of Medicine.

University fellowship (1923-1928).
Rockefeller Fellowship (1928-1930).
Received the Doctorate of Philosophy in Biochemistry.
Teaching Fellowship in Biochemistry at Harvard (1930-1936).
Associate Professor of Biochemistry & Biological chemistry—1938.

Joined Lederle Laboratories in 1940, as Associate Director and became Research Director in 1942.

Died in Pearl River, New York, 9-8-1948.

PART OF THE PROCEEDINGS

OF THE

GENERAL HOSPITAL CLINICAL SOCIETY.

10th January 1948.

Dr. R. V. Rajam's unit:

A case of Secondary yaws with a persistent primary yaw.

Patient N, 7 years old, admitted for warty lesion left ankle of 3 months duration with skin lesions of one month's standing.

Previous history:—No history of contact with a similar case. No history of previous illness of any kind.

Family history:—Parents alive and healthy, his elder brother and younger sister healthy. No history of similar complaint in the family.

Present illness:—The present complaint started with a papule-like lesion in the region of the left lateral malleolus 3 months ago. This was not preceded or accompanied by any constitutional symptoms like headache, fever, digestive disturbances, arthralgia, etc. The papule gradually increased in size, ulcerated and then became crusted. The patient had a course of deep X-ray exposures—26 in number—for the same complaint. One month later he developed patches of desquamation in the right elbow region anteriorly which later developed into crusted dome-shaped lesions. The left elbow region and forearm showed the same lesions after some time. The legs, trunk and face were next affected in the order mentioned. There is no constitutional disturbances of any kind now. The skin lesions are not itchy or painful. No evidence of mucous membrane of mouth or nose involvement.

Condition on admission:—A fairly nourished boy of about 7 years, not anaemic.

The submandibular, submental, posterior-superficial cervical, inguinal, epitrochlear lymph glands on both sides enlarged, firm, discrete, not tender, freely movable.

An oval crusted granulomatous vericose lesion about 2½ inches by 1 inch immediately below the left lateral malleolus, raised above the surface, with a healthy irregular floor with no induration at the base, no tenderness.

Diffuse symmetrically-distributed small oval or circular patches of desquamation over the lower extremities with vesical formation over some areas and ulceration in some others. A few circinate lesions in both the

buttocks with an ulcer in the natal cleft; no penile lesion; diffusely scattered fine maculo-papillar eruptions over the front of chest and abdomen; diffuse uniformly scattered patches of desquamation over the back and face and also in both the upper extremities; a crusted oval dome-shaped lesion in the region of the bend of the right elbow and similar lesions in the left forearm, two of which are very much raised above the surface with perfectly regular margin and a darkish brown crust over the top. A few scattered lesions over the palms. None of these lesions are tender or show any active evidence of inflammation. No lesions on the soles of the feet. No bone or joint lesions evident.

Cardio-vascular system and respiratory system and C. N. S. Nil abnormal. Liver and spleen not palpable. No masses felt in the abdomen.

Investigations:—Dark ground illumination preparation from one of these crusted ulcerations shows triponema pallidum like spirochaetes.

Diagnosis: Secondary yaws with a primary yaw on the strength of

(*i*) the typical primary and secondary lesions, the time interval that elapsed in between.

(*ii*) age of the patient.

(*iii*) site of the lesion.

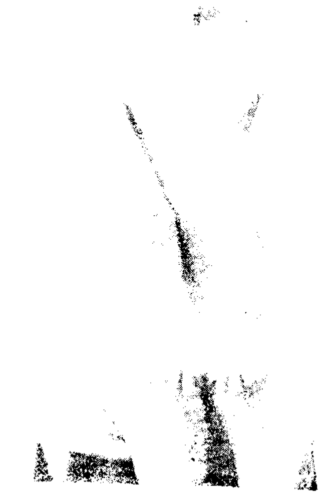
(*iv*) coming from endemic area.

(*v*) Dark ground examination.

Endemic areas in the Presidency are South Arcot Dist., Travancore, Cochin, some areas of Malabar, a village near vizag-4 miles - Lawson's Bay.

A few interesting skiagrams showing bone changes and clinical photographs showing crab yaws, gangosa, and soft tissue destruction were also shown.

Primary yaw



Raised Button like nodule (Secondary yaws)

A pea sized secondary yaw nodule with furfuraceous patches of desquamation on the face.

10th January 1948.

Lt. Col. C. K. Prasada Rao's unit:

Jaundice complicating untreated case of Kala-azar.

This case is presented to show the rare complication which sometimes occurs in cases of Kala-azar untreated for long periods and which further misleads us from the correct diagnosis prolonging the course of the disease with eventual termination from one of the agranulocytic complications: Broncho-pneumonia, Cancrum Oris.

This patient was admitted with a history of long continued fever of 6 months duration resembling malaria having been treated outside with anti - malarial drugs:

Quinine—1 month

Mapacrine—60 tablets.

On admission patient had

(1) Deep icterus with yellowish coloration of the skin,

(2) Spleen was enlarged up to umbilicus—firm and tender.

(3) Liver was just palpable.

(4) Patient had colicky pain in epigastrium resembling biliary colic.

(5) Urine contained bile salts and bile pigments. There was no acholuria thus ruling out haemolytic type of jaundice, malarial and acholuric jaundice.

(6) Stools were coloured yellow showing the patency of biliary passages.

(7) Van den Bergh was Biphasic; Icteric index—42 units.

(8) Blood W. R. negative.

(9) Total leucocyte count 3000 per cmm.

The above clinical features and laboratory findings are in favour of hepato-toxic type of jaundice, and in view of the fact that no extraneous hepato-toxic substances were administered Hanots type of hypertrophic biliary cirrhosis was thought of, and the patient was put on Hexamine mixture, glucose and calcium gluconate. Magsulph. early in the morning. The patient was put on the D. I. list and a bad prognosis was pronounced.

As a last resort serum reaction of kala-azar was done which was found to be positive and later a sternal puncture revealed the Leishman-Donavan bodies. The patient was immediately put on stibamin 10 c. c. I. V. for 10 days and Pentose-nucleotide to raise the Leucocyte count which was progressively falling. There was gradual subsidence of temperature, fall of Icteric index, marked amelioration of general condition. At present, one month after treatment, icteric index is 10 units.

The case is presented to show how easily the presence of jaundice with the other features of kala-azar completely changes the clinical pictures leading us to an erroneous diagnosis in spite of the fact that Kala-azar is one of the most widely prevalent of tropical diseases thus altering the treatment and thereby the prognosis.

Discussion :—

Dr. Saxenna :—Why cannot this be Infective Hepatitis in the course of Kala-azar?

Lt. Col. C. K. Prasada Rao, M.D.—Long duration of jaundice. Response of jaundice to specific treatment.

Dr. R. Subramaniam. M.D., M.R.C.P.—In infective hepatitis, motion is usually free from bile. In this case motion is bile stained.

Dr. Thangavelu : Explanation for jaundice :—The extreme degree of fatty degeneration noticed in the liver cells (secondary to blocking of the reticulo-endothelial cells as a result of parasitization) may account for the jaundice—the diseased liver cells failing to excrete the bile pigments into the biliary apparatus.

Dr. J. A. S. Masilamany's unit :

A Case of? Meningo—Vascular Syphilis.

(Presented by Capt. Z. A. Ahmed, M.B.B.S.)

Mr. R, age 30 years, admitted on 19-7-47.

Complaint :—Paralysis of the left side of the face and paresis of the left upper and lower extremities. Duration 2½ years.

History :—8 years ago, he had sore on the penis for which he took indigenous medicines. Ulcer healed. 2½ years ago patient took an oil bath one day and drank arrack the same evening, and was sleeping on the pial at night in the open air. He woke up in the middle of the night to pass urine, when he found to his surprise that he could neither move his left leg nor the left arm. He called out for help and was taken inside the house and was treated for four or five days with indigenous medicines. Subsequently he was admitted into Cuddalore Hospital, where his blood was taken for serological tests. After it was proved to be positive he was given 6 weekly injections of N. A. B. After the first injection he says he realized he could not close his left eye completely and that saliva dribbled from his left angle of mouth.

After about 4 or 5 injections of N. A. B., he recovered the use of his upper and lower extremities but the face remained the same. He discontinued treatment after 6 injections of N. A. B. Ever since then he used to get almost every month bouts of fever, headache, rhinitis and pains in the muscles and joints which last for about 10 days. Of late, headache has increased in severity and is only relieved by analgesic drugs.

Family history :—Married 6 years ago, wife had abortion in the 8th month of her pregnancy for the 1st conception second died at the age of 6 months. 3rd and 4th children are alive and healthy.

Habits :—Takes toddy occasionally, smokes beedies, non-vegetarian.

General condition :—A fairly well-nourished individual of about 28 years. Has inability to close the eyelid on the left side. Cannot wrinkle the left side of his forehead or below his left cheek. Epitrochlear glands palpable on both sides. Tenderness over the left stylomastoid region.

Central nervous system :—

(1) *Psychical functions* :—Intelligence, attentiveness and memory normal. Orientation normal. Emotional reactions normal. Phobias nil. Hallucinations and delusions—nil. Sleep normal. Speech : Slight amount of dysarthria. Patient is right-handed.

(2) *Cranial nerves* :—I nerve normal; II normal; visual acuity normal. Fields of vision and fundii normal both eyes. III, IV and VI nerves - pupils equal, reacting to light and accommodation. Ocular movements normal. V nerve - Sensory : left half of the face and scalp.. Touch and temperature sensations lost. Pain slightly diminished. Right side of the face sensation is normal. Motor : Normal. VII nerve :—complete paralysis of the left side of the face. Taste sensation of the left half of the tongue lost. VIII nerve normal. IX nerve :—sensory : Taste sensation lost over the posterior 1/3rd of the left side of the tongue. Motor : Pharyngeal reflex lost. X nerve :—palatal reflex present. XI nerve :- Paresis of the left trapezius muscle on shrugging the shoulder. XII nerve normal.

Motor and sensory functions are all normal.

Reflexes : Deep :—Biceps, triceps, knee and ankle all exaggerated on the left side. Normal on the right. Superficial : abdominal present in all 4 quadrants. Plantar extensor on left, flexor on the right. Other systems nil abnormal.

Investigations :—

(1) C.S.F.—Fluid clear, not under tension, no cells. Total proteins 50 mgms% globulin plus chlorides 650 mgms% ; sugar 69% mgms. W.R. doubtful on 2 occasions. Lange's test negative.

(2) Blood for Kahn negative.

From the Department of Pathology :

A case of Splenic Anaemia.

Splenectomy done by Lt. Col. C. R. Krishnaswamy.
Clinical history and operation notes presented by Capt. Pakiam, M.B.B.S.
Specimen presented by Dr. Thangavelu, M.B.B.S.

Clinical notes :—

A male, aged 22 was admitted to the medical ward with oedema of the legs and abdomen. The symptoms dated one year. A year back he had an attack of fever with rigor (Patient hails from a malarial district, Gundalpet, Mysore Dist).

Condition on admission :—

Anaemic, ill-nourished, face puffy, chronic sores on both legs.

Clinical findings :—

Spleen enlarged 3" below the umbilicus.
Liver enlarged 2" below right costal margin.

Laboratory investigations :—

Blood : R. B. C. 2. 11 millions per c.m.m.
Hb : 50%
W. B. C. 1,800 per c.m.m.
Differential count—P-57 ; L 32 ; M-11 ; E 0 ;
Smear : No malarial parasites.
Plate cells :—2,20,000
Van den Berg ;—Negative.
Icteric index—5 units.
Bleeding time—2 ' 40 ".
Coagulation time—4 '
Serum : Albumin 3.239%
Globulin : 4.075%.
Gel & Chopra :—Negative.
Sternal puncture :—No L-D bodies in the marrow. Normal erythropoesis. Hypoplasia of the leucopoietic system.
Spleen puncture : No L.D. bodies seen.
Faeces : No ova or cysts.

Patient received Ferrum reductum, Cal. gluconate, Vitamin C and liver extract with no clinical improvement. By a process of elimination a diagnosis of splinic anaemia was arrived at and he was subjected to splenectomy.

Under spinal anaesthesia :—Through a left paramedian incision the spleen was delivered out of the abdominal cavity breaking down a few flimsy filmy adhesions. The splenic artery was tied and the spleen was seen contracting down in size. After 5 minutes the pedicle was ligatured and spleen was removed.

Abdomen contained a few ounces of straw coloured fluid. The liver was enlarged and pale yellow—showed fatty degeneration.

Post-operative treatment : and progress :—Patient had 350 c.c. of citrated blood I. V. Two days later he developed signs of post-operative pneumonia and he was put on penicillin and sulphathiazole. The later period was uneventful.

Pathology of the spleen removed :—The spleen weighed 3500 gms. the capsule was thickened, opaque in areas and there was on evidence of any adhesions on the diaphragmatic or posterior surface. The splenic artery was small and paeraceous, the vein was very much dilated and it contained no thrombus. The vessels showed no occlusions, no atheromatous changes, etc.

Microscopic appearance :—The capsule was very much thickened. The pulp showed uniform congestion with dilatation of the sinusoids. Reticulum stain revealed reticular hyperplasia when the slide was stained for haemosiderin it gave a positive reaction. But the amount of pigment was not much. There was commencing fibrosis round the small arterioles but no classical siderotic nodules.

Discussion :—

Dr. Thangavelu, M.B.B.S. :—Splenic anaemia is a disease of unknown etiology. Two distinct phases in the pathological processes should be understood irrespective of the pathogen (it may be toxin). The irritative phenomenon of the toxin in doses small to cause death of tissue associated with any tissue response results in proliferation of defence mechanism. In this case, the histological picture is one of a reticulo-endothelial proliferation and interpreted in relation to the fatty change in the liver noticed on the table, the march of the pathological process is not progressed to the extent of causing necrosis of the parenchyma and replacement fibrosis. Based on the work of McNee and Barcroft, who have proved experimentally the reservoir function of the spleen, we could assume an anaemia of splenic origin as a reservoir of toxins with a potential danger of releasing [illegible] massive doses thus bringing about a

slow devitalisation of the liver or an acute hepatic crisis. This explains the need for splenectomy in cases of splenic anaemia where an early diagnosis could be made as in this case.

Dr. Bhaskara Menon, working in Edinburgh University, conducted a series of experiments to prove that portal stasis, as such, do not result in splenomegaly with histo-pathological picture identical with that of Banti's. With chronic intoxication induced in animals by manganese chloride and by an alkaloid senectonine he suggested that lesions comparable with those of splenic anaemia could be produced in spleen—both proliferative and fibrotic reaction. Cameron and De Srama marsupialised the spleen and showed that the proliferative change, that is, hyperplasia of the splenic pulp is independent of portal obstruction and they provided support for the fact that cirrhotic splenomegaly is the result of pulp hyperplasia and portal obstruction.

Regarding the associated anaemia, Professor Reddi and Dr. Raja Rao's contribution from Madras was the earliest. They came to the conclusion that reparative fibrotic changes similar to those seen in liver and spleen were not found in the bone marrow of rabbits though they noticed necrotic changes in the bone morrow due to the same toxin.

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Intra Cranial Tumour.

Mrs. K. Female 25 years, Lt. Col. C. K. P. Rao

Clinical Diagnosis :—Intracranial tumour.

Headache, vomiting and fits. Duration - one month.

Previous illness :—2½ years back she had fever with rigor during her 3rd pregnancy in the 5th month. She was treated. Since then she is not able to hear properly. 2 years back glands in the submaxillary region were swollen.

Habits :—Non-Vegetarian.

Family History :—Married, 4 children. All alive, normal deliveries.

Present illness :—Since 1 month she is having severe headache (not confined to one side or one particular region). It is continuous. No fever. Sleep not disturbed. Appetite is good, but she vomits everything about ½ hour or 1 hour after taking food (preceded by nausea). Since 1 month output of urine is increased. No pain in the abdomen. Since 1 month she is having fits - 5 times each lasting for 15 minutes, when patient is unconscious brings out froth in the mouth and lying stiff. Now she is having temperature.

Condition on admission :—Moderately nourished. Not anaemic. Not jaundiced or cyanosed. Tongue coated and dry. Teeth dirty. Lips - cracked. No oedema of feet. Submaxillary glands palpable, slightly tender. There is tenderness over the frontal sinus and the forehead.

Respiratory system :—Nil abnormal.

C. N. S. :—Pupils contracted, reacting to light. No rigidity of neck. Kernig's sign - negative. All cranial nerves excepting 8th normal. VIII N - Bone conduction better than air conduction in the left ear. Motor power and tone of muscles good.

Reflexes—Biceps, triceps and supinator - Present.

Knee jerks - sluggish, ankle jerks - brisk. Plantar - flexor, abdominals present in all four quadrants.

Sensation - Normal. Orientation - stereognosis no 1ma

Alimentary system :—Liver and spleen not palpable.

C. V. S. :—Nil abnormal.

Laboratory investigations :—

Urine —Alkaline, phosphates. No albumin ; no sugar ; no pus cells.
Blood —W. B. C. 6800/C.mm. P_{74} L_{20} E_3 M_3 . No . P.
C. S. F. —L. P. Fluid clear, under very high tension. 118. drops/min. Queckenstedt's positive.
Protein - 80 mgms%. Globulin positive.
Chlorides - 750 mgm% Sugar - 59 mgm%.
Lange's curve - 0033100000
X-ray skull —Right antrum hazy.
Blood W. R. postive.
E. N. T. —Throat - nil particular.
Sinuses - clear.
Nose - chronic Rhinitis.

Ophthalmic examination : Pupilloedema present in both eyes. More marked on the left. - 2.0 D thickness. No characteristics changes to locate lesion.

Treatment :—Mist. specific.
Bismuth injection 1 cc. I. M.
Glucose 50% 25 cc. I. V.
Phenobarbitone etc.

Venereal Dept. report (4-12-47 :—Clinical examination negative for any evidence of syphilis. If the patient has shown clinical improvement with bismuth, the same may be continued. She can have large doses of Iodides by mouth.

L - P - relieved headache. Patient slept well.

Autopsy Notes :—

Cranial cavity :—The dural vessels were congested and more so in the left side. There was slight increase in the amount of C. S. F., the cortical vessels were congested especially on the left side. The brain was removed with the pituitary gland. The Sella was enlarged and found to be eroded. The pituitary gland was slightly larger than normal. The cortex felt firm in places - imparted a nodular feel to the fingers and white, opaque, masses about 2 cms. in diameter with irregular margin were seen on the surface. Just behind the optic chiasma an oval defect was noticed in the cortex, margin of the opening regular and showed greyish material. The brain was preserved in strong formalin.

Thoracic cavity :—The thorax was opened through a lateral thoracotomy incision along the eighth intercostal space. The lung was slightly adherent near the base which was easily separated. The lung felt nodular and it was removed. The diaphragm showed small greyish white nodules on the pleural surface - a portion of the diaphragm was removed.

Abdominal cavity :—The abdominal viscerae were inspected through the defect in the diaphragm and the following organs were removed :

Both kidneys, spleen, uterus with the tubes and the left lung, liver and a portion of the large intestine.

Left lung :—Pale grey in appearnce. Nodules could be felt firm Section - Reddish grey in appearance. Miliary nodules were seen throughout the section.

Investigations :—

6/3. L. P. blood stained fluid, did not settle down on standing.

10/3. Coagulation time 4 min. 15 sec.
Bleeding time 16 sec.

11/3. Coagulation time 3 min. 16 sec.
Bleeding time 15 sec.

14/3. Platelet count: 156,000 per c.mm.

5/3. Urine nil abnormal.

16/3. Urine alkaline, no albumin, sugar trace, deposit:—4 pus cells per field high power. Phosphate crystals present, R. B. C. present.

9/3. Ophthalmoscopic examination:—

Right eye and left eye congested disc.
No subhyloid haemorrhage.

B. P. arm 85/55.
leg 90/65.

12/3. X-rays skull normal.

Progress :—

6/3. Back - arched patient screems occasionally.

7/3. Patient unconscious with intervals of consciousness.
Pupils dilated but reactive.

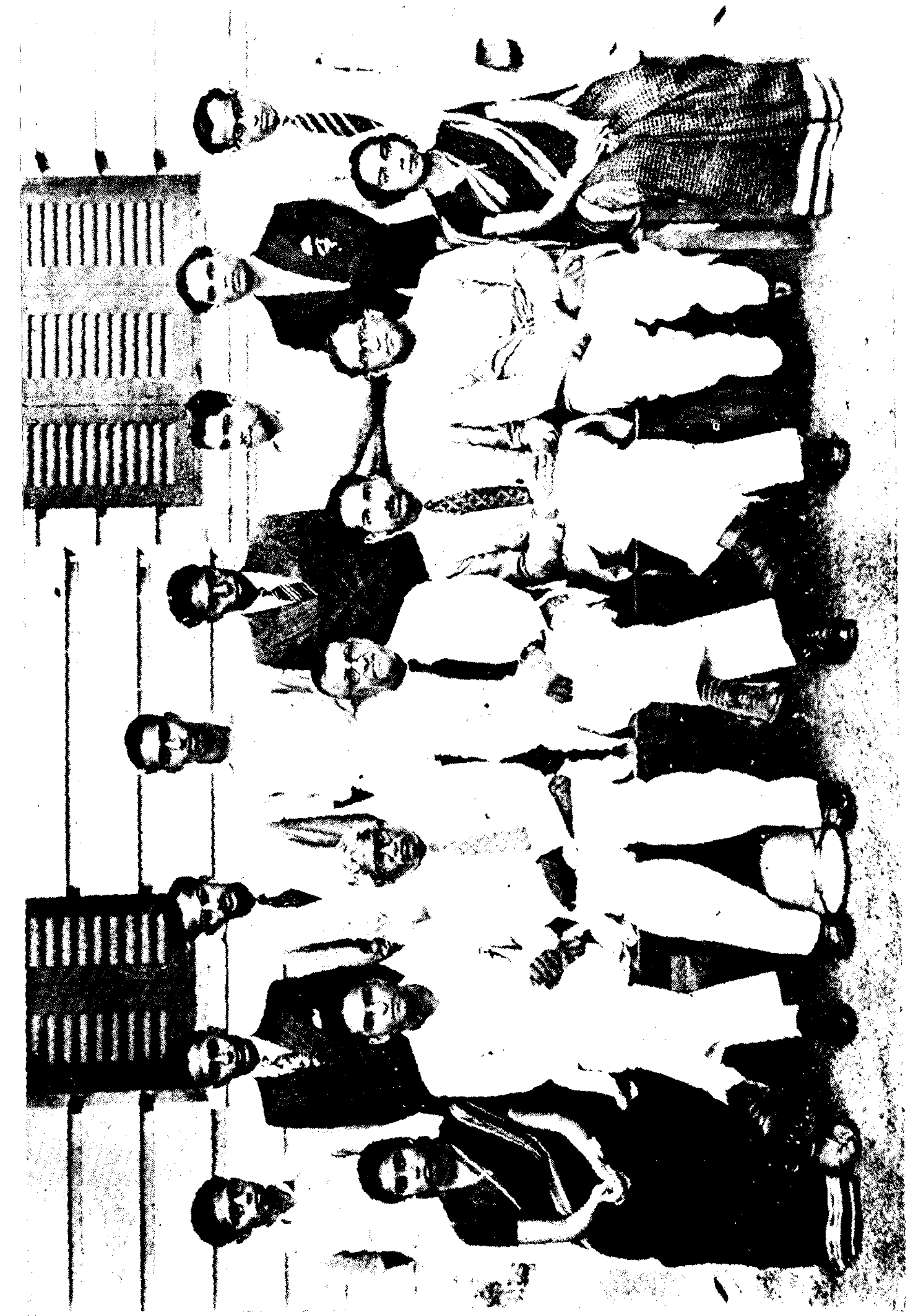
9/3. Bilateral facial paralysis developed.

6th nerve palsy on left side. Babinski positive knee and ankle jerks absent, pulse regular, pupils equal and reacting.

17/3. Slight puffiness of face.

Final conclusion:—Intra cranial haemorrhage subarachnoid or heaving aneurysm beating with cranial nerve palsies, cause of haemorrhage not known.

The Executive Committee 1948-'49.



Sitting (Left to Right): Irene Pinto Lady Rep., C Gopalan Nair (Gen. Sec.), Dr Sivasubramania Mudaliar Vice-Principal, Dr. R V Rajam Principal, C M David Student President, Dr T Janardanan Treasurer, Sarojini Vedamanickam Student Vice-President.

Standing (Left to Right): Abdul Kuduz Fine Arts Secy., Verghese Chacko I Year Rep., K G Sreedharan Nair III Year Rep., C S Ebenezer Rep B.Sc. Pharmacy, A B Ramachandra Reddy Sports Secy., K Gopalakrishnan V Year Rep., V M Bhaskar Rao Asst Secy., Muthu Aloysius IV Year Rep.

Absent: J S Satya Das II Year Rep., N Kailasam Pre-reg. Rep.

Dr. K. N. Krishnan, B.A., M.B.B.S., M.Sc.,
Retired Professor of Physiology.

(As we go to the press we got this photo, and we are extremely happy to publish this)

He was a Student of this College. After taking the degree, he served in the army during 1st World War. On demobilisation, he returned to civil service—served for sometime in moffussil stations as assistant surgeon. Then he was lecturer in Physiology in Tanjore Medical School. He joined the Physiology department of this College in 1933 as assistant Professor. Here he did research and took M.Sc. He became Professor in 1945. He went on leave preparatory to retirement in June 1948.

He was the Honorary Treasurer of the Madras Medical College Association. He was a Professor loved and respected by one and all. We wish him the best of everything in his retired life.

REPORTS.

Men's Hostel Report.

1947—'48.

The year ending report is submitted by every General Secretary and I am sure each one of them would have had the same mixed feeling I am having now. Joy at the completion of a strenuous secretaryship but feeling bad at the thought of not having done many things which I planned and dreamt of doing.

It is the same beginnig every year. So also 1947 - '48 started without much noise but for that due to the returning of students It is the election of office bearers which brings some life, and people start bustling about with activity. Sri S. Muthuvairu was elected General Secretary as also Sri Shanmugasundaram for sports. S. Ramanathan was elected as the Bus Secretary and Sri V. R. Palaniswamy in charge of the Garden, Sri Narendran for the Radio and T. I. Williams for the reading room.

There were early signs of welcome changes in the hostel, when the age long barabarous way of initiation of the freshers to our fraternity was abandoned. It is well known that there were few all these years who were of opinion that the 'Ragging' was a very cheap way of imitating the West and imbibing only the bad in them. But this time majority of the seniors felt the need and so, successfully, saw to it that the 'Ragging' was not carried out. I am pretty certain by this approach we have cultivated better friendship with the freshers and they in their turn feel quite homely in our midst.

The months rolled on. August made its August appearance - a month of importance to the hostel as well as to the nation. It brought back to our memory in a rush all the thoughts about the days in the hostel soon after August 1942. For reasons obvious there was a triumphant air about each hosteler this time. The much awaited day of India dawned on the 15th and as the clocks chimed the hour of 12, a thrill passedthrough the frame of all. The hostel celebrated the glorious day in a fitting manner. In what way would it have celebrated in a more fitting manner than by calling the hero of 1942 Dr. Syed Ahmed Kabir to perform the flag hoisting ? It was he who was the beacon light to us and guided us through those days and it was by his and a few others' efforts that the whole lot of hostelers moved out as one man when the honour of the very same flag was threatened. Kabir started calmly as his usual self but he would not keep the restraint for long. He let loose a soul stirring and thought-provoking speech and he reached his climax when he felt sad that, that english-man who asked the flag to be removed was not there to pay his

homage to the same flag and hoist it. To the singing of the national anthem, the national flag slowly and gracefully reached the top of the mast and fluttered in the air. To the fortunate few who were here in '42 it was a matter of unparalleled pride and joy. Dr. P. V. Cherian presided. It was evident that when the whole of India changed, it never allowed anyone to lag behind time. He subscribed to the opinion of the house and assured that under Indian governonce the state of affairs of the Country are bound to change for the better. It is difficult to draw a pen picture of the grandeur of the flood lit hostel that day, and when the music and dance had to come to a close with the approach of dawn, everyone felt sad that even such a memorable day was no exception to 24 hours a day rule.

As there is calm after a storm, so also the hostel switched on to normal routine without any activity for some time. Time rolled on and people started focussing their attention on the on-coming February - the month full of festivity for our College and Hostel. Each was offering suggestion as to how best to celebrate the first hostel day in Independent India. At one time, it appeared as though the whole thing would turn out to be a chaos as people started asserting their freedom to speak, sing and dance. But whoever thougt what was awaiting us? God felt that too much jubilation was not congenial to our new born Free State. With the usual thamasha that is attendant on winning an Inter Collegiate match. we returned after the foot-ball finals on the 30th January only to hear the shocking news which shook the nation to its very foundation. The person who out of dust made us into men was to be no more with us. When the whole nation was shrouded with grief, it does not behove of us to dwell at length how miserable and helpless we felt on that fateful day. Amidst sobs and tears we conducted a meeting and paid silently our humble homage to the Father of the Nation. We pledged to preserve his creed, and all that he stood for. The whole day we fasted as also on the 12th. That day we arranged for poor feeding for over two thousand - the dharidhra-narayana, for whom he lived and died.

Time is the best healer. but not all wounds heal without leaving a trace behind. The month of February practically became a month of mourning and out of deference to the passing away of the nation's idol the hostel day was cancelled.

The whole world may change but our examnations won't. So with the on-coming examination the hostelers were busy. As I am reaching the end I would be failing in my duty, if I do not thank my colleagues on the committee who lent such a helping hand during my tenure of office. I am sure that others would not resent my special mention of S. Ramanathan's name. The very fact that he was the bus secretary who showed a net profit of Rs. 900 speaks volumes about his efficiency.

Now a bit of bitter reading for those in authority - but please sirs, do not swallow the pill as usual. We need a better hostel. If you go round the hostel once, you will be convinced that it is a perfect negation of hygiene. The sanitary fittings under modern conditions would have been quickly removed to the nearest museum lest the people should miss something of pre-historic value. Drainage has been so thorough that there is a cess pool formed near the kitchen spoiling the flavour of food if any. The beautiful chairs with the broken legs remind us of Venus - setting our minds to think how much more beautiful would it have been if the figure were complete. Yes Sir, we have a library - an apology for the same. These complaints you would have so often read that you would know them by heart. It is not difficult for you - the persons who know 1,2,3 etc. points of differential diagnosis or all the relations from lateral to medial side. I am sure that when you read the first line of this paragraph, you would have known the last one and the the ones in between two. Let us not cry like babes in the wood - let this not, pray, be a cry in the wilderness. I request you to act immediately and make a home out of this house for human beings to dwell as at times we wonder what we are when three or four are dumped in a room.

As every tale has an end, my report should touch the finish. When I look back even as I said in the beginning, it is a mixed feeling that I get. But there is one consolation, in this year of supposed to be not too many activities, one, that we shared the joy with the nation and the sorrow as well.

JAI HIND.

S. Muthuvairu.

(June to September. 1948.)

Though the Hostel was full enough to suffocation, there was a sense of incompleteness about it when we gathered back from our various summer resorts. Many of the stalwarts those well-known faces that had become almost chronic in the Hostel, were missing from our midst. Well, we couldn't expect them to be wedded to the Hostel for ever; permanence is the bane of most weddings. And so 'Bon Voyage' to them in the great journey of Life and hope they remember the Hostel that harboured them for so long. Instead of these seasoned nuts, there was an influx of a band of "batchas", all looking at sea, creeping about with a peculiar apologetic look about their faces, as if begging your pardon for their very existence. Due to rather disturbed atmospherics, we could not apply to them the only corrective that can cure them of this effeminate diffidence, that is at once purgation and absolution, that at the same time humbles them to the level of freshers and elevates them to the level of happy hardy Medico Hostellers - I mean that institution of fraternisation impiously called Ragging. I am certain that the juniors feel themselves the losers by this.

By the time the Hostel settled down to anything like tranquillity, the Independence Day was upon us—India had respired in freedom for a year. While the flag of our nation rose slowly to the head of the mast, in tune to the strains of our National Anthem, we stood still and a brief year of National history, its calamities, achievements and glory, all passed in confused array before our mind's eye. In purificatory mood, we daubed each other with the saffron colour of our flag—and zealous as we always are to do unto others as we would to ourselves, we largeheartedly included some of our neighbours also in this sacramental bath. Later, in the evening, Mrs. Radhabai Subbaroyan unveiled a portrait of Gandhiji. We thought it fitting that on the first anniversary of our hard won Independence, when a nation undermined, emasculated, affronted and degraded by centuries of subjugation had, at the inspiration of one noble soul become vital, strong and living again in the joy of Freedom and was celebrating its first year of freedom, (we thought it fitting) that we should pay some small tribute to Him that moulded it with His own life. Dr. Cherian, the students' principal as he should be known in token of his unique identification with their every real need, sprang a delightful surprise on us by presenting to us the portrait that had been unveiled. Mrs. Subbaroyan spoke to us in her lovely voice, simply, words of wisdom and words of hope and faith in Youth that would inspire anyone to braver deeds and nobler ambitions. She spoke with a touching sincerity that did not ask for unattainable Utopias but merely recommended to us the practice that cardinal feature of Gandhiji's life, his profound humanity. On this moving note the meeting closed—and left the field thus open to the fair neighbours of ours who were terribly and loudly hungry.

On Independence Day, for the first time in the annals of our Hostel, we held a Hostel Olympiad, admirably organised by Lord Burleigh Willie. His Majesty King Patel I declared the Olympiad open. He was accompanied by Queen Lalitha Elizabeth and his two daughters Princesses Leela Elizabeth and Margaret Blossom—all lent from our neighbouring Hostel. A colourful march-past followed, each flat in its own National uniform and with its own emblems. The Ladies' Hostel was represented by a few mighty athletes who were hard to match in their speciality of Show March. Miss Jayakannan ran the graceful first lap with the Olympic Torch, lit in the Ladies' Hostel kitchen. John Madhavan, whose identity was a matter of mystery till the very last moment, lighted the Olympic flame. A dove was released in token of peace and goodwill....we had intended employing the more universal symbol of the crow for this purpose but they were pervesely enough, not accomodating to let themselves be caught. And then followed the mighty contest between the flats. The Goats' flat led by their historic symbol of a live Goat, triumphed. And so ended a day of breathless pageantry, high endeavour and great sportsmanship.

The next event of importance was our Reception to the Graduates. The Honourable Sri A. B. Shetty, Minister for Health presided and the Mayor of Madras, Dr. U. Krishna Rao, was the speaker of the day. After the tea, the General Secretary welcomed the graduates and Dr. Thangarajan replied suitably, though it was tinctured with what he himself termed " the release phenomena ". Then we listened to a very comprehensive speech by the Mayor which contained many valuable suggestions and interesting criticisms of prevailing policies. Sri A. B. Shetty made spirited rejonider to some of the Mayor's points. He however threw cold water on our fond hopes for a new Hostel, long overdue, but he put the blame squarely on the shoulders of the Central Govt. which has ordered stoppage of all new building projects. He promised however to lend an attentive ear to all our complaints and what is more, try to help us make conditions more livable in the Hostel than at present. Well, we live in the greatest hopes that his promises will bear fruit.

The other activities of the Hostel are proceeding apace. Our Bus has undergone a rejuvenation course and we optimistically hope that this year, it will make more trips to the College than to Simpsons. The Garden Secretary is very busy trying to make our precincts a veritiable Garden of Eden and if he does not succeed it can only be attributed to the fact that only serpents and no Eves are about in this garden. The extent of the members' interest can be guaged from the fact that the Reading Room Secretary has not satisfied himself with recaning the Common Hall chairs but has replanked them. It must be supposed that the Messes are keeping up to form for the statistics do not reveal any increase in the mortality rate—only a few sundry cases of gastro-enteritis at most. The Sports activities are such that they have started overflowing into the neighbouring Hostel grounds also. The Radio was working overtime on Test days and an observer could have witnessed the whole gamut of human emotions expressed on the faces of eager listeners.

And so we go on in the old old way, singing " Ra Ra Medicoes, Medicoes never die "—

V. V. V. MENON,
General Secretary.

U. O. T. C.

Annual Report for the year 1947-'48.

We started with a strength of 159 after the usual discharges and fresh recruitment. Amongst the discharges I would like to mention U/O Raman for his uniformly mertorious service throughout his stay. This year in particular was a year of feverish activity, and usual engagements for the U. O. T. C. From July 1947 the usual training was carried on, mainly due to the valiant efforts of our own Under - Officers and N. C. O's.

Then came the memorable August 15th 1947 when we played an impressive part in both the Colleges in connection with the Independence Day Celebrations. We presented a Guard of Honour with Salutation of our Tri - Colour. This was very much appreciated by everybody. At Stanley Medical College and Madras Medical College, the Guard was commanded by Lt. Sarathy, the second in Command being U/O Venkataraman and U/O Sundaram respectively. On the same evening members of our Company took part in the Independence Day March Past at the Munro Statue. After this we also took part in the Guard of Honour in connection with the University Convocation.

In September 1947, the U. O. T. C. Batallion was represented by the Medicals only in the Sub-Area Sports held at St. Thomas Mount, where we came off with flying colours.

Long Jump	1st Cdt—Krupa Rao	2nd Cdt—Shanmugasundaram.
Hop Step & Jump	1st Cdt—Krupa Rao	2nd Cdt—Madhavan.
Pole Vault	1st L/Cpl —Ramalingam	2nd Cdt—Krupa Rao.
400 yards Hurdles.	1st Cpl—Balram	
110 Metrs Hurdles.	1st Cdt—Shanmugasundaram.	
100 yards Dash	—	2nd Cdt Shanmugasundaram.
Shot Put	—	2nd Ramalingam.

Subsequently due to the fine performance in the Sub-Area Sports, many of our men were selected for the Area Sport held at Saidapet, Y. M. C. A. where we did our part very creditably. It is a matter of great pride for all of us that we are the Area Champions in Basket-Ball. Our team was represented by L/Cpl. Parasuram, Cdt. Dhandha, Cdt. Gurupatham, Cdt. Sivasankaran, Kandasamy. Then about this time we took part in the March Past held in the Corporation Stadium in connection with the Silver Jubilee Celebrations of the Madras Corporation.

In December 1947, during the Holidays there was an S. O. S. from the Headquarters that we should take part in the Military Sports day of the Park Fair. It was a Herculean task for me to collect the men as it was during the vacation. I could hardly get four of my men to represent the Batallion. Anyway due to the splendid efforts of only three of my men Cdts. Shanmugasundaram, Krupa Rao and Goulding, we shared points equally with the winners.

During the December vacation few of our men attended the Special Cadre held in connection with the War Certificate Examinations. In the certificate examinations held subsequently L/Cpl. Gopalachari, L/Cpl. Alexander Mathew and Cdt Gangadhara Rao appeared for A, and all three passed. Incidentally I would like to mention that we Medicals do not get an atom of benefit from these certificates as compared to other Arts Colleges, but we did go in her these just in a sporting spirit.

Then came a period of pressing activity for the preparation in connection with the Silver Jubilee Celebrations of the 1st (M) Bn. U. O. T. C. Cdt. Adjutant Velu and Cdt. Quarter Master Venkataraman of 'A' Coy. were in the Ex-Cadets' Committee and Cdt. R. S. M. Hashmi of 'A' Company was in charge of the Regimental Police. But alas! then came the rude shock of the unexpected assasination of the Father of our Nation, Mahatma Gandhi, when the activities had to be post poned.

A unique feature of this year was the institution of the Interplatoon Rolling Shield for the first time in the history of this Company. This was entirely due to the ready and willing benevolence of our two Principals Dr. Cherian and Dr. Kutumbiah after whom it has been named. This year four items were fixed for the competition. (1) Arms Drill (2) Route March (3) Bayonet Training and (4) Attendance. We started training for these competitions, which evoked keen interest amongst the men. The real spirit of competition started only from then on. Fortunately we had the assistance of C. H. M. Ayya Pillai to help us. After the training the items for the competition were gone through and the 1st Platoon emerged victoriously as All-round winners for the Inter-Platoon Shield. This platoon was commanded by U/O Sundaram, the platoon Seargent being Sgt. Paul Doraiswamy.

Again we were blessed with another Rolling Shield which was donated by an Ex. Under - Officer in honour of Rao Sahib Capt. Dr. Sivasubramania Mudaliar for the best platoon in Bayonet Training. In this competition, the 2nd Platoon emeraged victoriously. This platoon was commanded by U/O Hari Rao, the Platoon Seargent being Sgt. Augustus. I wish that very soon we will have more and more Rolling Trophies due to the benevolence of our well wishers in both the Colleges.

I feel that there trophies and Prizes defenitely evoke more interest, and a Competitive Spirit in the men.

Just few days ago with hardly a fortnight before our University Examinations in April, we were asked to take part in the Military Tournaments conducted by the Sub-Area. Our players found it very difficult to carry out these engagements due to the nearness of the University Examinations, but with all that they responded well. We are proud to present that our Company was mainly responsible in winning that covetous Foot-Ball Trophy. Nine of the eleven belong to 'A' Company Medicals. They are L/Cpl. Ramalingam, Cdt. Madhavan, Ramachandra Reddy, Viswanthan, Sivasankaran, Shanmugasundaram, K. N. Subramaniam, Delip and Janardhanan. I wish that at any cost we must retain this Trophy and the Basket-Ball Area Championship for many more years to come and at the same time win more and more laurels, in whichever field it may be.

We hope that rapid changes will be taking place very soon and as mentioned in an announcement about a Medical Corps in the Army group of the Senior Section, we will be getting our long awaited Medical Unit.

The day will not be far off when our U. O. T. C. men will be rewarded with a Medical Unit and called for more useful work and service.

Now I wish to thank our two Principals and Vice-Prinipals for their kind Co-operation and help given to me in the management of the Company. Our Commandant Lt. Col. Rao Bahadur S. Paul and Adjutant Capt. G. K. S. Pathy have been very sympathetic and kind to us all through. Incidentally I should not forget the Staff of the Battalion Headquarters particularly the Quarter Master and the Head-Clerk for their help and co-operation. But of course the success in the activities of the Company is entirely due to the untiring efforts of the U/O's, N. C. O.'s and Cadets of the Company who did Yeomen Service all thorugh at a great personal sacrifice.

Unfortnately it was my lot to shoulder the responsiblity of this Company single-handed for the past two years. It has been really taxing and I spent a lot of time and energy for this. I have done my best. I hope that at least in the near future, I will have some assistance. *I feel that the Commanding Officer of the Company should have some executive authority over the men, at least in the matter of their attendance certificates, since this is a voluntary organisation. Otherwise we cannot expect top-notch efficiency.*

I take this opportunity of respectfully congratulating our new Principal Dr. R. V. Rajam on behalf of the 'A' Coy. and wish him the best of everything. We are particularly proud and happy that our Ex. Officer Commanding of the 'A' Coy. Rao Sahib Capt. D. Sivasubramania Mudaliar has been made the Vice-Principal of the Madras Medical College. On behalf of 'A' Coy., I offer my congratulations to him.

We have done good work for the year and we hope to do more and more hereafter and bring glory and honour to our Country.

JAI HIND.

K. P. SARATHY,

2/Lt. O. C., 'A' Coy (Medicals) 1st (M) Bn. U. O. T. C.

Interplatoon Competition Winners 1st platoon 1947-48

Sports Section U. O. T. C. Winners of Area
Foot Ball Championship and Area
Basket Ball Championship.

A Company Medicals, First (M) Battalion.

Inter Collegiate League Champions.
M. M. C. Basket Ball Team 1947-'48.

Athletic Club activities.

BY

P. BHASKAR REDDY,

(*Sports Secretary 1947—48*).

The M. M. C. Athletic Club.

President:—Dr. P. V. Cherian M.B.E. *Secretary*:—P. Bhaskar Reddy.

Vice President:—Lt. Col. Sanghamlal I.M.S. *Staff Representatives*:—

Hony-Treasurer:—Manjunath Rai. Dr. C. Venkataramiah.

Physical Director:—Mr. M. Swaminathan, B. Sc. Dr. Sarathy.

Lady Rep:—Miss. C. Tapsall.

Captains.

Hockey:—	D'Ashe.	*Basket-Ball*:—	Palaniappan.
Foot-Ball:—	Thomas Mathew.	*Volley-Ball*:—	Krupa Rao.
Cricket:—	S. Adyanthaya.	*Athletics*:—	Shanmugasundaram.
Tennis:—	Rangamannar.	*Boxing*:—	Goulding.
Badminton:—	Poornan.	*Table Tennis*:—	Thaiman.

Our College athletic club had a successful season. Though our record for the year may not reveal glittering triumphs, yet we put up a good show. We always endeavoured to live up to the best sporting traditions realizing that the game is ever greater than the prize.

Cricket:—Though the performance of our team this year is disappointing, yet we can look for a brighter future as this year's team is the youngest ever represented this College. Many stalwarts like Balakrishna Shetty, Narayana Rai, Venkat Rao and Bhaskar Rao have passed out. Good luck and do not forget us.

Hockey:—It really pains me to confess that our team has fared a bit too bad this year in spite of the fact that it has the maximum number of one-time University players. New blood should take up reins and lead up to the standards of Dr. Cullen the All India player's days!

Foot-Ball:—As usual we had the strongest side in the league and still we lost to our sister institution in the league and avenged the defeat in May and Baker's Tournament conducted by us by a comfortable margin and came out as winners of the trophy for the fourth year in succession.

Basket-Ball:—This is the only team which brought the College laurels in the inter-collegiate league. Success is mainly due to the keen interest and regular practice they have and let me congratulate the captain and his men: Gurubatham and Dandha played uniformly well.

Volley Ball:—We are runners up in the league in spite of the fact that we lost only one match and made good the loss by winning the Bertram Memorial Shield conducted by Loyola College: Krupa Rao is to be congratulated for both the plucky play and able captaincy.

Tennis:—Our representatives did not have a good season which is due to lack of practice.

Badminton:—For the first time we competed, we won the shield in the Loyola College tournament open for all Colleges. That is really grand!

Athletics:—We had a quite successful season and came second in the inter-collegiate on test through untiring efforts of our star athletics, Shanmugasundaram our champ, Krupa Rao and Desmond.

Boxing:—We are too good in the ring and yet to be conquered outside the ring too, I mean either on the roads or on the fields!

Swimming:—Desmond proved a good swimmer by winning some prizes in the I. C. contest.

Ladies Section:—It looks as though our tennis stars are a bigger surprise to other Colleges than the American Ladies on the international courts and in this connection let me congratulate Miss. L. Loganathan and Miss. I. Sambasivan: And that is not all:—Our ladies are champions in the throw ball. There is yet another game for the other Colleges to win over us and that is Tennikoit: Miss. P. Thomas and Saroja Uthaya played their part in that game too well. So congrats Miss. C. Tapsall! After all we have to learn from you. Wake up boys, they are too ahead of us!

Sports Day:—This is the last and the most glorious functions of the College noted for its fun and fancy all over our province. May I be allowed to quote our chief guests words " This is the most glorious function I have witnessed in these recent years " spoke Dr. C. R. Reddy, Vice-Chancellor, Andhra University. Yet another notable event of the day

was the presence of a galaxy of great personalities for a single function of any college, like Dr. C. R. Reddy, Maharani Saheba of Vizayanagaram, Hon'ble Mr. A. B. Shetty and Mrs. Shetty, Sir A. L. Mudaliar and Dr. Kutumbiah. Added to all this was the march past of our athletics all in black and white, a novel inception by us which was greatly appreciated.

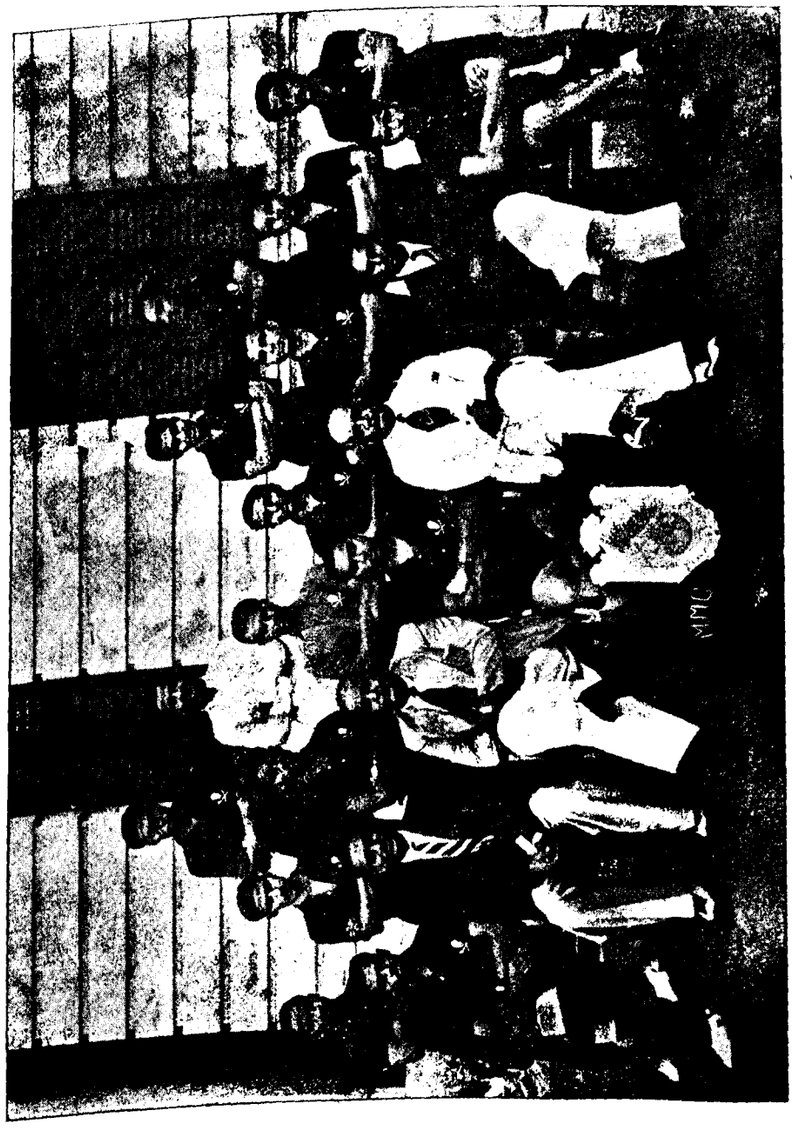
Lastly let me thank all the members of the executive committee who took keen interest in the activities of the club. On behalf of our club let me wish Dr. and Mrs. Cherian a long and happy retired life. In our new President Col. Sangham Lal my successor will find a great asset for the club and an easy time for himself with the silent, strong man in Mr. M. Swaminathan our physical director.

My last advice to the members of the club is:—"Play up to the standards of our great College, the premier institution of the east and keep the flag flying"

JAI HIND!

The Catholic Medical Students' Guild of Madras.

Under the auspices of this guild a small but well equipped dispensary is doing a great service to the public of Madras in George Town. Nearly fifty patients attend the dispensary every day. Medical Students under the direction of a doctor help in dispensing and distributing medicines. This is a free dispensary for the poor. The guild deserves all praise and every possible help for making the clinic work better. The guild runs an official organ "The Medical Guild". All those interested can refer to the Secretary, C. M. S. Guild of Madras, 2. Armenian St., G. T. Madras.



Winners of May & Baker's Shield.
M. M. C Foot Ball Team 1947-'48.

Winners of Bertram Memorial Shield.
M. C. Volley - Ball Team 1947-'48

Medical Hostel (Women's Section) June to September 1948.

We must first put on record our appreciation of the services rendered to us by our ex-warden, Dr. (Mrs.) Sarah J Souri and also offer a hearty welcome to her successor Dr. (Miss.) Achamma Thomas.

This time the functions have been very few in our hostel. The only hostel function we had this term has been the Independence day celebrations. Mrs. Parijatham Naidu kindly consented to preside over our morning function on August 15th and unveiled Gandhiji's portrait. At night we had an open air dinner followed by a short but I hope sweet entertainment! We thank the rain for having kept away that day. We took the opportunity of welcoming our new graduates on the same occassion. We congratulate them one and all and assure them that we miss them though they may not be missing the congenial hostel atmosphere.

I would fail in my duty if I omit to echo the hostel cry for a bus. Entreaties for a new bus have borne no fruit and now it seems that even our old one has forsaken us. Labouring under such difficulties it is nothing surprising that we find absolutely no time for any extra activities. So I do not think I could end this report in a better note than by appealing to the authorities to help the damsels in distress.

P. Chandravalli.

Report of M. M. C. Association 1947-'48.

It was the year of joy and it was the year of sorrow. It was the year we were liberated and it was the year the liberator was assasinated. This was the feeling of our land and it was the feeling of the world. So were the feelings of our association.

The Activities started with a very pleasant function when on 11th of March '47 Dr. P. V Cherian was presented with a congratulatory address in a silver casket, on his being appointed as the Surgeon General with the Government of Madras.

Elections were conducted on the 15th of July. Mrs. P. Chenthamarakshi, Mr. P. Gopinath, and Miss Lily P. Thomas were elected Vice-President, Asst. Secretary, and Lady Rep. respectively.

Meetings:—The first general body meeting was held on the 22nd July '47. On 12th Aug. Dr. A. L. Mudaliar delivered the inaugural address.

Sri Sarath Chandra Bose addressed a large gathering of students for an hour.

Under the auspicies of the P. M. S. A. Dr. Kutumbiah spoke on "Evolution of Medicine". Dr. Jivaraj Mehta addressed the students on the 29th Jan. '48. On 13th Feb '48 the Indo-British Mission addressed the students, and were taken round the College.

On 24th Feb. '48 the portrait of late Sri K. T. Bashyam, who was intimately connected with the association was unveiled. Dr. Venkat Rao Chemical Examiner spoke on the occasion.

On 5th March '48 Dr. R. Subramania Iyer delivered the valedictory address.

Independance Day:—15th Aug. '47. The hostellers dressed in white came in a procession to the College. The flag was hoisted in the grounds with a record gathering of people. 21 guns were fired as the members of U. O. T. C. saluted the flag. Ceremony and Solemnity were marked features of this function. Then came on the light refreshments. Lt. Col. Sangham Lal, Dr. Mannadi Nair, Dr. P. V. Cherian spoke at the meeting. There was jubilation all over. Coloured water was liberally sprayed on all.

Graduate's Reception:—9th Oct. 47. No less than 118 Graduates responded, to the invitation. Refreshments and a variety entertainment were provided in the traditional style.

Condolence Meetings:—Were held to bemoan the loss of Dr. Miss Abida Latiff, Col. Mahadevan, Dr. Habibulla and two students Mr. Joseph Lawrence Kamalam, and Mr. K. T. Bashyam.

On 3rd Feb. a meeting was held to pay respects to the departed soul of the Mahathma. On 12th wreaths were placed on behalf of the association at the Inter - Collegiate Memorial held in the Rajaji Hall.

Debates:—In the inter collegiate debate at Y. M. I. A. Mr. Gopala chari was awarded the 2nd Prize.

At a College debate held on the 30th Jan. to select two candidates for the inter-collegiate debate the judges Lt. Col. Sangham Lal, Dr. Kanakasabesan, and Dr. A. Srinivasan, selected Mr. Surendranath Baga, and Mr. Gopala chari from amongst keen contestants.

In the inter-collegiate debate our college shared the Dr. P. V. Cherian Rolling Shield with the Law College. Mr. Surendranath Baga was awarded the individual prize. The judges were Mrs. P. V. Cherian, Justice Govinda Menon, and Barrister Pattabiraman.

At the annual elections conducted, Mr. Ranjan David and Mr. C. Gopalan Nair were elected as President and Secretary respectively.

Music:—Miss. T. N. Vijayalakshmi and Miss. [illegible] have won us the shield again at the inter-collegiate Music contest conducted by the Vivekananda College.

Demonstrations:—There was a physical culture demonstration by Prof. Y. Suri which was very much appreciated.

Representations:—The Surgeon General and the Health Minister were approached for reduction of the enhanced Fees. Nothing came out of it. The principal was requested to resume publication of the college calender. The Principal was contacting the concerned authorities to provide a telephone for the use of the students.

The Magazine:—Due to the financial reasons more than one issue could not be brought out. Under the able guidance of Dr. D. Sivasubramania Mudaliar, the finances of this section has immensely improved and with the enthusiasm of Mr. N. Krishna Moorthy, I am sure that in the ensuring year the normal four issues will be brought out.

I finally thank Dr. P. V. Cherian and Dr. Y. S. Narayana Rao for the kind help they have given me, and the executive and members of the association for their co-operation.

K. M. REDDY,
(General Secretary).

O.

27.2.97

24.5.97.