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THE MADRAS MEDICAL JOURNAL

VOL - III



NO - 12

JAN - 1952

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MADRAS MEDICAL JOURNAL

THE OFFICIAL JOURNAL OF THE MADRAS MEDICAL ASSOCIATION

PUBLISHED QUARTERLY

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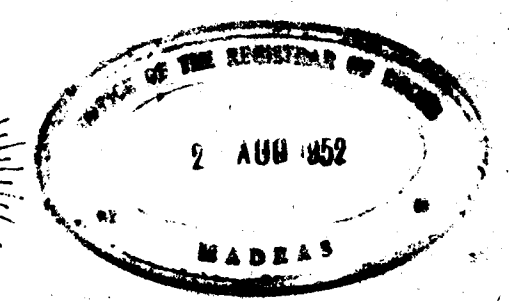
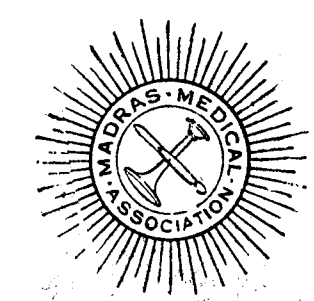
New Series Vol. III	JANUARY 1952	No. 1
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Price: Inland Rs. 6/-

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MADRAS.

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The Madras Medical Journal is issued quarterly, in January, April and October about 26th of the month. All Editorial communications, reports, books for review and exchange should ordinarily reach the Editorial Secretary, The Madras Medical Journal, General Hospital, Madras. Contributors are requested to refer to the special notice appearing in the inside of back cover of this issue.

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Foreign 10 sh., post free. Single copies Rs. 2-8-0.

Rates of Advertisement

	One page	Half page	Quarter page
	Rs.	Rs.	Rs.
Single insertion	50/-	30/-	15/-
Three insertions	100/-	60/-	30/-

For special positions and prolonged periods special rates would be quoted on request.

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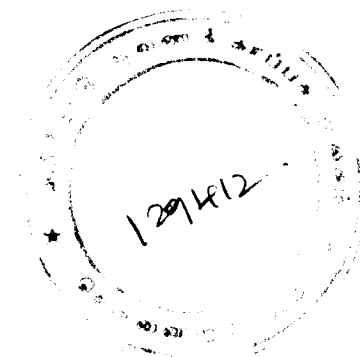
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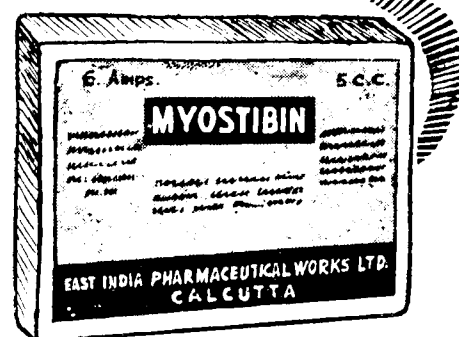
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THE MADRAS MEDICAL JOURNAL

New Series
Vol. III

JANUARY 1952

No. 1

Coronary Insufficiency*

BY

N. VAIDYANATHAN, M.D.,

Professor of Medicine, Stanley Medical College, Madras.

The Title indicates that the physical state of the coronary circulation is inadequate in quality or quantity or both for the metabolic needs of the heart for the time being. Such inadequacy can occur (1) When the coronary arteries are occluded by thrombosis or narrowed by arterial sclerosis. (2) Embolism of the coronary vessel, usually with Acute Bacterial Endocarditis (3) Haemorrhage in the wall of the coronary artery occluding the lumen and (4) as a result of development of mycotic aneurysm.

Such serious insufficiency can also occur even when the lumen of the vessels is not altered, as in (1) severe anaemias or severe heart failure due to diminution of the oxygen carrying capacity (2) when the intra aortic diastolic pressure is much reduced in Aortic stenosis or in Aortic regurgitation, in shock and shock effects (particularly after anaesthesia or operation (3) when the mouths of the coronary vessels are thickened as in syphilis or arterio-sclerotic disorders, (4) when the blood is viscous as in polycythemia, (5) when the minute output of the heart is much reduced at unusually fast or slow heart rates.

Finally the spasm of the coronary arteries can also occur due to nervous stimuli—the result of the disordered emotions, over-loading of the stomach or diseased gall-bladder.

Till recently coronary artery disease was considered synonymous with angina pectoris or coronary thrombosis. These two clinical pictures have now become well impressed on the medical profession but

* (Address delivered at the Tiruchi Branch of the Indian Medical Association at the annual conference held on 18-10-51).

now it looks as if a wide variety of conditions and causes either involving the lumen of the coronary vessels or without it, can produce this condition of insufficiency of blood supply to the heart muscles, either absolute or relative. Hence the conception of coronary insufficiency as the basic condition whose manifestations being wider and more in number than the above two mentioned, has come to stay and it was to emphasize this aspect of it that I chose the title 'coronary insufficiency' for this address.

The normal coronary circulation which is generally sufficient for a very marked increase in the heart's work is being carried on by a system which though anatomically capable of anastomosis and establishing collateral circulation is still physiologically known to be quite inadequate for this purpose and so to all ends and purposes the coronary vessels are end-arteries and what little collateral circulation is possible cannot be relied upon in an emergency to cope with the situation. This has been well brought out by post-mortem studies where though the recent attack may have been attributable to a particular occlusion many such hearts showed evidences of several occlusions and infarctions possibly at various times before with or without clinical history or symptoms to account for them. With narrowing and closure of a coronary vessel occurring gradually, there may be no symptoms, perhaps by developing a well-established collateral circulation in course of time with some other coronary vessel. In acute or sudden cases such mechanism has not this time factor to be brought into play.

Aetiology.—The underlying cause is, in all these cases, arterio-sclerosis of the coronary arteries. The pre-disposing and contributory causes are (1) hypertension with arterio-sclerosis (2) Diabetes with arterio-sclerosis (Hypercholesteremia) and (3) heredity, particularly obesity. Post-mortem of the heart subject to coronary insufficiency of any degree of standing is likely to show (1) varying degrees of fibrosis (2) Infarcts particularly involving the sub-endocardial muscle fibres and papillary muscles (3) varying degrees of dilatation and hypertrophy of the left ventricle.

Clinically the condition manifests in a variety of ways:—

1. Angina Pectoris.
2. Acute coronary occlusion with myocardial infarction.
3. Left sided failure with cardiac asthma.
4. Combined right and left failure.
5. Heart block or other disturbances of conduction or rhythm.
6. Gastro-intestinal or other substitution symptoms.
7. Sudden end, and
8. Finally many cases may be latent or asymptomatic.

The condition can be diagnosed with any or combinations of the under-mentioned features, clinical, or electro-cardiographic evidences of recent or past infarctions, or angina pectoris or even the presence of certain abnormalities in the Electro-cardiographs which I refrain from dealing with or cardiac enlargement and congestive failure, all the above being viewed on the back ground of the aetiological factors mentioned above.

The emphasis therefore lies on the inadequacy of the quality or the quantity of blood supply to the heart. It is the ischaemia or anaemia of the heart muscle which causes symptoms irrespective of the causative factors. In other words it can be described as a fundamental defect of relative disproportion of the available coronary blood supply to the needs of the heart.

Though the different clinical manifestations have been mentioned, I am dealing in detail with three of them, which require close attention, because of their urgency and particularly because the lay public has learnt something of these conditions; and the average person is in dread of them. They are (1) Angina Pectoris (2) Coronary Thrombosis or acute coronary occlusion and (3) Acute coronary insufficiency or coronary failure.

(1) **Angina Pectoris.**—The word angina means strangling. It is a clinical syndrome characterised by paroxysmal attacks of a distinctive pain or pressure, usually retro-sternal, radiating commonly to the precordium and left upper extremity and occasionally to other adjacent areas, and precipitated by an effort and often also by other factors; and relief is by rest and nitrates; and last but not least, frequently ending in sudden death.

Pain.—It is located behind the middle or upper third of the sternum and occasionally in the inter-scapular region in the back primarily. Radiation is common to the neck and lower jaw, upper extremities, precordium, mouth, shoulder and arm, and in severe cases both sides. It may extend to epigastrium or hypogastrium. Sometimes the pain is purely peripheral in distribution.

Character of the pain.—Whatever be the intensity, there is a special characteristic strangling nature variously described as constriction, pressure, boring, vice like grip, tightness etc. It is usually dull and not sharp. It is constant and not throbbing. It may sometimes be burning in nature—in some a sense of oppression and vague undescrivable distress, but it is of an insistent quality compelling rest and quietness and may make him even hold his breath. It may produce a numb feeling of the hand. Hyperalgesia of the affected areas is not uncommon.

This pain is associated in most cases with a sense of impending dissolution which is called Angor Animi. It has nothing to do with fear. It is not a fear of death but it is a sensation as if the end was near. Sir John Ryle has described this in detail in 1928 and he has recently added a post-script in 1949 on his own feelings during anginal attacks and during the final attack of coronary thrombosis.

Duration.—Duration is usually a few minutes, about 2 to 3 minutes, and in other cases 15 minutes particularly when the attack comes on while at rest and due to emotional disturbances. A residual soreness remains for a longer period.

Frequency.—Frequency is very variable, but for the same person they often occur under certain stated conditions and which if avoided may prevent recurrence.

Dyspnoea.—No real dyspnoea is noted except for the presence of belching.

Physical examinations.—May reveal rarely anything except those of the underlying factors. The blood pressure may be normal or often elevated during an attack. The pulse rate is unaffected but the electrocardiograph which is definitely abnormal during the attack returns to normal soon after. This transient abnormality of the electrocardiogram is utilised for confirmation of and detection of patients with coronary insufficiency the tests being conducted under certain standard conditions.

It is well-known that the precipitating factors are (1) bodily exertion (2) meals and indigestion (3) cold (4) emotion; (5) Tachycardia and lastly (6) Hyper-insulinism a condition to be borne in mind in coronary failure with diabetes—the usual dosage of Insulin being likely to cause anginal attacks. The contributory factors are diabetes, hypertension and biliary and digestive disorders. Males suffer more than females. Intellectual professions and business executives are more prone—the medical profession particularly so, and among them perhaps Physicians. Heredity, constitution and temperament have also some influence on the incidence of coronary heart failure after anginal attacks. The pain has to be diagnosed from all other causes of pain in the chest.

Prognosis.—Prognosis depends on the underlying causative disorders. The average duration of life is about 8 years. It also depends upon the heredity factor. The danger of sudden death is unpredictable but is inherent in the disease and has to be borne in mind, and a cautious prognosis given. Recurrent attacks, frequent and severe, are unfavourable factors.

Treatment.—Drugs, Nitrites, Amyl nitrite capsules (acts within 10 to 15 seconds)—Trinitrin tab. 1/100 gr. to 1/200 gr. one or more tablets *chewed and kept under the tongue* are quite effective within a few minutes. These tablets contrary to popular belief can be repeated without any ill-effects—the relief for the patient being the prime and only consideration. The other longer acting nitrites are not quite so useful.

Xanthine group drugs have a mixed reception among the profession. Some view it as dangerous—sudden death having occurred which may be attributed to the intravenous administration of this group.

Rest of the treatment between the attacks is the treatment for the underlying disorders:

(1) Treatment and elimination of the contributory factors like anaemias, gastro-intestinal and biliary disorders etc.

(2) Precipitating factors such as exertion, cold, excitement, strain, avoidance of tobacco, exercising caution in the administration of Insulin or Adrenalin.

(3) Finally the general management or regimen must be on sound common sense lines, on a purely individual and personal assessment basis, on the various questions like work, rest, activities, vacation, diet, etc. Undue restrictions are to be avoided and moderation enjoined in all respects. Sedatives may have a place in the excitable group of patients:—Khellin, alkaloid of Ammis Visnaga in 100 mgm. doses I.M. or orally t.d.s. are highly rated by some as a preventive of anginal attacks. The Canadian School have expressed a very high opinion on large doses of vitamin E, 150 to 300 International units by mouth daily and claimed that in many cases anginal attacks have been stopped successfully over long periods. Testosterone injections have also been tried with success by some. I am not referring to the surgical aspect of treatment of coronary insufficiency.

Acute Coronary Occlusion and Infarction.—This term indicates the closure of a coronary blood vessel. Thrombosis is only one among the causes of such occlusion. The cardiac infarction is the result and need not necessarily follow all cases of occlusion.

There has been noticed a rather rapid increase in the incidence of coronary thrombosis. Such increase may be real or only apparent. This is probably due to the greater attention paid by the members of the medical profession and because also of the frequent discussion of the subject. The general consensus of opinion seems to be that the increase has been to some extent real.

Previous history of bacterial endocarditis is common in some of these cases. Aetiology is the same as for Angina Pectoris. The majority of cases occur while the patient is at rest, most often perhaps while sleeping. A few cases have been described in relation to actual physical exertion. The possible relationship of emotional strain or sudden mental shock to a sudden large infarction has been mentioned. Trauma as a precipitating factor has also been pointed out in a few cases. I would like to emphasize here that it is likely to occur shortly after surgical operations while the patient is still in a state of shock and as such the signs or symptoms may completely be lost sight of or masked, only to be recognised later on when cardiac symptoms become manifest and persistent, after the shock has passed off, and even then only if such a contingency is borne in mind by the Physician. This hazard in the post-operative phase has to be constantly kept in mind in susceptible subjects, both by the Surgeon and by the Physician.

In this condition, the infarction occurs in a part of the cardiac muscle which has been cut off from its blood supply. The extent of the area involved will naturally vary in each case and it has to be borne in mind that such an infarcted area may possibly run through and through, from the pericardial to the endocardial surface. The area undergoes ischaemic or coagulative necrosis and it may become soft and yield giving rise to an aneurysmal dilatation which may rupture at this site subsequently or it may be replaced by fibrous tissue which may not be strong enough to withstand the pressure and it may again become aneurysmal. The organisation of this area is generally complete in about 4 to 6 weeks and this period is very important indeed in the matter of enforcing rest to the patient to prevent some of the above complications.

The extension of the infarcted area to the pericardial surface results in a fibrinous pericarditis, manifesting itself clinically by a pericardial rub, if it is on the front of the heart. This rub is characteristically transient, and may appear a few hours after the infarction, and may disappear within 3 or 4 hrs. or it may persist even for over a week. The presence of the pericardial rub in such cases is confirmatory and positive evidence of the occurrence of an infarction.

Similar extension of the process to the endocardial surface gives rise to the changes in the endocardium and formation of clots and fibrin thrombi. These constitute a real source of danger to the patient. They may get detached and produce embolic phenomena in various parts of the body from time to time. They may cause irreparable damage to other organs though the patient may ultimately recover from the coronary infarction.

The heart generally enlarges after a coronary thrombosis.

In dealing with the symptoms I would like to mention them in order of urgency and also in order of importance from the point of view of diagnosing this condition with more certainty from among the various causes of a severe chest pain. The pain is often more severe and increasing than in angina. Even the patient who has had angina before, often recognises this pain as distinct, new and of a different type. Nitrites give no relief but the pain is aggravated. It is more crushing in intensity and it is intolerable because of its prolonged duration. The location is similar but the abdominal type is often mistaken for acute abdomen. The pain persists for many hours. It is not relieved even by Morphia and when it subsides it may be replaced by a real anginal pain probably tending to recur often.

I would like to emphasize here that sufficient number of cases have been recorded without pain, atypical, silent and manifesting only by cardiac signs, and failure, and abnormal rhythms or rates. Some others manifest themselves by sudden weakness, dyspnoea vertigo, syncope, sweating or vomiting, as substitution symptoms. I have had opportunities of seeing some of these types of cases also.

Next comes *Shock* evidenced by prostration, collapse, slumping in the chair, loss of consciousness, etc. Sometimes followed by death. Milder cases are seen with cold sweats, dyspnoea, etc. and with marked *Angor Animi*. Pulse becomes rapid, weak, thready with cold clammy extremities, pallor or greyishness of the face, low blood pressure and pulse pressure, bradycardia or tachycardia. Respirations rapid and shallow may also be present.

Signs and symptoms of *cardiac failure* are usually pronounced.

Restlessness is an important symptom and a constant feature in most of these attacks. In some cases the attending restlessness was the only clue on which the diagnosis was based and confirmed later, by the subsequent progress of the case. This restlessness may not be apparent or may be masked in cases in which shock is very pronounced.

Dyspnoea.—It is another feature which I may say is constant in all attacks however atypical they may appear to be otherwise, and has to be borne in mind as an important point of differentiation from angina pectoris.

In some cases the condition may present itself soon after the attack (when probably first seen by the medical attendant) as an acute left ventricular failure with pulmonary oedema or as arrhythmias or with symptoms of embolic phenomena in some organ or other. I have already mentioned about the abdominal type of pain and I may again say

that this type is not at all uncommon and they may present themselves with symptoms referable to upper abdomen or other gastro-intestinal disturbances.

Physical signs of examination of the heart are surprisingly little. Distant, muffled and faint heart sounds, tic-tac rhythm, with a soft systolic murmur are very strongly indicative of the recent infarction. Gallop rhythm appears in a day or two and may disappear gradually and such disappearance is a sign of improvement of the cardiac condition in such cases.

I have mentioned already about the *pericardial rub*, as a positive evidence of the presence of the infarcted area reaching upto the pericardium. I shall again emphasize that it is very transient in most cases. Other positive evidences of such infarction are the presence of (1) *fever* varying from a moderate rise within 12 to 24 hrs. to even high temperature which may continue for nearly a week. (This temperature must be carefully looked for in suspected cases, if necessary by second hourly taking of temperatures and preferably rectal temperature—as the mouth and surface temperatures may be subnormal in cases attended with shock). (2) *Leucocytosis* sometimes going upto 18, 20, 25 thousands with marked polymorph increase; and (3) *Increased erythrocyte sedimentation rate*.

Other features are the tendency to tachycardia, occasionally bradycardia, onset of abnormal rhythms such as premature beats, auricular fibrillation, flutter or paroxysmal tachycardia. Heart block of various grades in all these cases, varies from time to time, and appears in the course of illness.

Blood pressure.—Usually there is a rapid fall immediately after the attack to very low figures. This is attributable and is proportional to the degree of shock. This fall of Blood Pressure may continue to be progressive over a period extending to 2 to 48 hrs. or more and then having recovered from the shock, the pressure may show a tendency to rise slowly but never to the original high levels. It is note-worthy that in about half the cases of the coronary thrombosis in people with hypertension the final stabilised blood pressure is often in the region of normal figures; an apparent blessing in disguise and an example of the saying 'out of evil cometh good'. It will really be a matter for congratulation for all concerned if this state of affairs was likely to continue; but unfortunately the type of patient temperamentally and otherwise is such that the necessary placidity is not there and the advantage so unexpectedly gained is not retained and they lose ground sooner or later.

I am not referring to the X-ray or E. C. G. changes; though they may be, to a certain degree, of value in confirming the diagnosis. In most cases the diagnosis is really one to be made on the typical history and

clinical grounds essentially. The chances of error are not so high that one has got to resort to X-ray or E. C. G. for the purpose. Incidentally I should like to emphasize the possible adverse repercussions on the patient's condition by any such attempts to get graphs out of him, from a sense of diagnostic enthusiasm.

Certain complications are likely to occur among which shock cardiac failures and rupture of the heart have been mentioned.

I have only to mention the liability to sudden death, particularly within the first fortnight after the attack which may be due to a massive pulmonary embolism or rupture of the heart internally or externally or a cardiac standstill due to the onset of ventricular fibrillation.

Bronchopneumonia may occur. It has been my experience that in one case, what looked like successive attacks of bronchopneumonia repeated at intervals of a week or a fortnight, subsequently turned out, in retrospect, to be recurrent attacks of coronary thrombosis with lower blood pressure after every such attack. The clinical picture was indistinguishable from recurrent attacks of bronchopneumonia at very short intervals.

The last but not the least complication is *embolisation*. It should indeed be tragic to get the patient recovered from a coronary attack only to have him disabled by loss of power over limb or limbs or loss of vision or to lose him due to a massive pulmonary embolism. Recent trends have been to anticipate such embolisation phenomena and as far as possible to prevent them by increasing the coagulation time of the blood—by the use of anti-coagulants over a period of time till he can be considered safe. This has not been much in vogue in this country due to the inherent difficulties in having to keep a constant watch over the blood clotting time frequently during such anti-coagulant therapy. I have no doubt that it will become more prevalent in our practice within a short time.

Differential diagnosis.—Among the conditions from which coronary thrombosis has to be differentiated are (1) angina pectoris, (2) pulmonary embolism—this will show signs of tachypnea, (3) pain of acute pericarditis, (4) spontaneous pneumothorax, (5) dissecting aneurysm, a rare condition, nevertheless to be borne in mind, (6) spontaneous interstitial emphysema of the lung and finally, (7) acute abdominal conditions—surgical and medical particularly with reference to the upper abdomen.

Prognosis.—Much change has occurred in our outlook on the prognosis of the acute attack. The diagnosis of coronary thrombosis is no longer signing a death warrant as it was considered a few years ago.

A good number of these patients have been now observed after the attack and they live for periods ranging from 2 to 10 years. The longer they live after five years, the better their chances of their living to their full term. Therefore, I should like to say that excessive pessimism is not necessary provided other conditions appear favourable.

Factors affecting the prognosis are (1) age—people under 40 and over 60—poor (2) previous attacks—worse, (3) severity and duration of the pain and no relief from morphia—poor (4) degree of shock and low blood pressure figures 80/20—poor, (5) heart failure is an added load. (6) High degree of fever, leucocytes and a persistent rise of Erythrocyte sedimentation rates are unfavourable factors (7) Embolisations naturally are undesirable, (8) Considerable cardiac enlargement before and after is unfavourable.

Treatment.—Much depends on the patient's co-operation and the way his morale is kept up and on this is based the essential principles of treatment of this condition. Treatment is designed (1) to reduce the work of the heart till the infarct heals firmly and that will be about 6 to 8 weeks (2) to alleviate the immediate pain and other discomfort and (3) to overcome shock, failure, and rhythm complications.

For the first, *rest in bed* is very essential. As far as possible the patient is to be helped in his movements for the first two weeks and relaxation permitted in the light of his progress and condition later if necessary; and further rest, if enforced, was considered likely to be deleterious to the patient's general morale. Natural evacuation of the bowels should be encouraged however delayed. The inclination to give enemas should be strongly resisted.

Pain morphia, Phenobarbitone soluble as injections or Pethidine or Physeptone in suitable doses, to relieve the pain to the maximum extent possible is necessary.

Oxygen in a tent or through a B.L.B. mask at fairly rapid rates is likely to be of great help in reducing the pain and also in reducing the cyanosis.

Shock has to be treated on appropriate lines. Nursing care and low diet for the first few days are recommended.

Anti-coagulants—Heparin, Dicoumarol and now Tromexan are available. They have to be used with care and their use must be pushed almost to the border line of safety, below which apparently they are without effect. This requires the availability of facilities for frequent check up of the coagulation time.

Digitalis group of drugs is indicated for cardiac failure but with care.

III. Acute coronary insufficiency or coronary failure.—This is the third condition and in this the duration and severity of the ischaemia are apparently intermediate between angina pectoris on the one hand and acute coronary occlusion on the other. The pain may come on at rest or with effort. It tends to persist longer some times for a few hours. It is not relieved by Amyl Nitrites or other nitrites. It is associated with evidences of disturbances in the cardiac function like pallor, sweating, transient drop of blood pressure and more persistent and constant electrocardiographic changes. However with the subsidence of the attack recovery is complete, and permits the electrocardiograph returning to normal. There are no positive evidences of actual infarction of the heart muscle, like pericardial rub, fever, leucocytosis or raised sedimentation rate. This is a new conception of the clinical state of acute coronary insufficiency which may be put in a category by itself.

I have endeavoured though at length to give an idea of the newer conception in regard to coronary circulatory disorders and incidentally I have attempted to emphasize such aspects of the clinical conditions of the more urgent and dramatic forms which could be of help to the general practitioner in his day to day work, as I feel that any doctor may have the opportunity of seeing such cases and that this might help him.

Congenital Absence of Both Upper Limbs in Human Siblings

BY

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In the Exhibition that was held at Bangalore last April, I happened to visit a stall where three children, two sisters and a brother, were on show, displaying their ability inspite of absence of upper limbs to do various items of work like winnowing, sieving, grinding, combing, drawing, writing, etc. These were interesting enough but to a geneticist the congenital absence of both upper limbs in siblings was a matter deserving of more attention. I made a request to be permitted to examine the children and was allowed to do so.

The youngest showing the deformity is Chinna Narayanappa aged 5 years. He is a small but intelligent child, not at all peevish and apparently interested in being examined. There was absolutely no trace of the appendicular part of the upper limb on either side (Fig. 1, 2). The clavicle and scapula could be palpated. The glenoid cavity appeared to be narrow. The next, Narasamma, was an elder sister aged 11. The left upper limb was totally absent; but the right side showed a small vestige of an appendage with a single terminal digit. The third case, Mallamma, was another sister aged 14. I could not possibly make a thorough examination of this girl in the stall but her condition was seen to be similar to that of her younger brother, i.e. both the limbs were absent.

The Family.—These three children hailed from a village Kanagamagalapalli in Kolar district about 66 miles from Bangalore city. Their parents are peasants and have no apparent defect whatsoever. The father, Chinnamallappa, is about 50 years old and the mother, Lingamma, is 45. They were married 30 years back and have had nine children. The first child, a son, aged 25, normal and healthy, married since last five years, has no issues till now. The second child, a daughter, died 5 days after birth. According to the mother's statement this child was normal. The third child, a daughter, normal, married, has had no issues so far. The fourth child, a daughter, Mallamma, aged 14, has defect, both upper limbs being absent. She attained puberty a year ago i.e. at 13 years. The fifth child, daughter, Narayanamma, is aged 11. She has a vestige of the right limb present with a single digit. The left upper limb is absent. The sixth child, a son, aged 9 is a normal healthy boy. The seventh



Fig. 1

Fig. 1.
Boy aged 5 showing deformity, absence of both upper limbs.



Fig. 2

Fig. 2.
Boy aged 5 (side view) showing deformity. To the right is his sister aged 14 also showing the deformity. Behind the boy, is the mother (normal) carrying the youngest child normal.

Thus there is a gap in information regarding the siblings of three out of the four grand parents. Hence it may be reasonable to assume that the defect is caused by a recessive gene and that the recessive gene is carried by both father and mother.

I am thankful to Shri G. Prabhakar, B.Sc., Medical student, Mysore, for valuable assistance to get the family history and to take the photographs.

SUMMARY

The deformity of congenital absence of both upper limbs occurred in three children in a peasant family in a village, Kanagamagalapalli, in Mysore State. The parents are apparently normal and six other children, siblings, are also apparently normal. The children showing the deformity are (1) a boy aged 5 showing total absence of both upper limbs; (2) a girl aged 11 showing complete absence of upper limb on the left side but showing a small vestigial appendage with a single digit on the right side; and (3) a girl of 14 showing complete absence of both upper limbs.

The family tree of the father and mother of the siblings has been traced. There is a gap in our knowledge of the ancestry of three of the four grand-parents of the defective children.

The condition is explained as probably caused by a recessive gene carried by both father and mother.

REFERENCES

Gates, R. R. Human Genetics, New York, 1936 (consulted for references cited.)

Cow's Milk as dilutor for artificial insemination of Cattle

BY

Dr. R. VEERAMONEY IYER, G.M.V.C.

Veterinary Surgeon, Artificial Insemination section, Madras Veterinary College, Madras.

(Communicated by Dr. A. A. Ayer.)

The prompting idea to seek an alternative to the yolk buffer now used as a diluent for insemination work was that the yolk of egg is a medium prepared by Nature for preservation and nutrition of the ovum and the early embryo, need not necessarily be the best medium for the preservation of a positively charged uni-cellular organism like a spermatozoon. The one medium which any organism, young or old, sick or healthy, would tolerate without discrimination is milk. The idea of replacing egg yolk with cow's milk was tried.

Raw milk was first tried. Though the effect was as good as egg yolk raw milk was too thick for microscopical examination. Hence, diluting milk with sodium citrate solution M/10, M/15 and M/20 were tried to afford a change of the pH of the medium to suit the collected semen whose pH varied.

The milk was boiled and cooled to eliminate any extraneous bacteria and was diluted with suitable sodium citrate solution.

The fat globules being excessive, the idea of eliminating some fat which is not essential for the effective preservation and viability of the sperm was undertaken. Skimmed milk would remove almost all the fat and skimmed milk was not found suitable. Hence the milk was boiled in a flat vessel, allowed to cool gradually to form the top layer cream which was removed. The resultant fluid was diluted with suitable sodium citrate solution as aforesaid and used to dilute and preserve samples of semen. This gives as good results if not better than that of egg yolk dilutor.

Observations on viability are attached in table I.

It is also observed that no sedimentation took place on preserving for over a week; that examination under the microscope was conveniently easy, and that milk was available at all times and the quantity required was small.

TABLE I.

Serial No.	Date of Collection	Breed bull No. of donor.	Motility of Sperms in yolk medium days.				Motility of Sperms in milk medium days.				Remarks.
			1	2	3	4	1	2	3	4	
1	17-10-50	Ongole 196	5	5	4	4	5	5	4	4	
2	17-10-50	Sindhi 448	5	4	4	4	5	5	4	4	
3	25-10-50	Buff 96	5	4	4	4	5	5	4	4	
4	10-11-50	Ongole 289	5	4	4	4	5	5	4	4	
5	10-11-50	H. F.	5	4	4	4	5	5	4	4	
6	13-11-50	Ongole 196	5	4	4	4	5	5	4	4	
7	14-11-50	H. F.	5	4	4	4	5	5	4	4	
8	14-11-50	Sindhi 448	5	4	4	4	5	4	4	4	
9	17-11-50	Buff 96	—	—	—	—	—	—	—	—	Bad Sample.
10	18-11-50	H. F.	5	4	4	4	5	5	4	4	
11	19-11-50	Sindhi 448	5	5	4	4	5	5	4	4	
12	22-11-50	Ongole 196	5	5	4	4	5	5	4	4	
13	23-11-50	Buff 96	5	4	4	4	5	5	4	4	
14	23-11-50	Buff 62	3	1	—	—	3	3	1	—	
15	26-11-50	Sindhi 448	5	4	4	4	5	5	4	4	
16	29-11-50	Ongole 289	5	4	4	4	5	4	4	4	
17	30-11-50	H. F.	5	4	4	4	5	5	4	4	
18	2-12-50	Ongole 196	5	5	4	4	5	5	4	4	
19	8-12-50	Ongole 196	5	5	4	4	5	5	4	4	
20	8-12-50	Sindhi 448	5	5	4	4	5	5	4	4	

TABLE I.—(contd.)

Serial No.	Date of Collection	Breed bull No. of donor.	Motility of Sperms in yolk medium days.				Motility of Sperms in milk medium days.				Remarks.
			1	2	3	4	1	2	3	4	
21	11-12-50	H. F.	5	4	4	4	5	5	4	4	
22	12-12-50	Ongole 289	5	5	4	4	5	5	4	4	
23	12-12-50	Buff 96	5	4	4	4	5	5	4	4	
24	14-12-50	Sindhi 448	5	5	4	4	5	5	4	4	
25	17-12-50	H. F.	5	4	4	2	5	5	4	4	
26	18-12-50	Sindhi 448	5	5	4	4	5	5	4	4	
27	20-12-50	Buff 62	5	4	4	4	5	5	4	4	
28	22-12-50	H. F.	5	4	4	4	5	5	4	4	
29	24-12-50	H. F.	5	4	4	4	5	5	4	4	
30	26-12-50	H. F.	5	5	4	4	5	5	4	4	
31	28-12-50	Ongole 196	5	5	4	4	5	5	4	4	
32	28-12-50	Buff 96	5	4	4	4	5	5	4	4	
33	31-12-50	Sindhi 448	5	5	4	4	5	4	4	4	
34	3-1-51	Ongole 196	5	5	4	4	5	5	4	4	
35	6-1-51	Ongole 289	5	4	4	4	5	4	4	4	
36	9-1-51	H. F.	5	4	4	4	5	4	4	4	
37	10-1-51	Buff 62	4	3	—	—	4	—	—	—	Bad Sample.
38	12-1-51	Sindhi 448	5	5	4	4	5	5	4	4	
39	19-1-51	H. F.	5	4	4	4	5	4	4	4	
40	23-1-51	H. F.	4	—	—	—	5	4	—	—	



"Reminiscences"

BY

Dr. J. C. DAVID.

Annual Oration of the Madras Medical Association, Dec. 26, 1951.

I stand before you this evening as a member of the Madras Medical Service Association—a senior member of the Association and one who has during the course of the year laid down the shackles of office. I appreciated the invitation extended to me to speak to you to-night, and I even to a greater extent value the confidence expressed in me unanimously by the Executive Committee. I tender my whole-hearted thanks for this token of your regard for me.

I am no orator and it is a misnomer to refer to what I am saying now as an oration. This idea, I think we owe, to Dr. Prasada Rao; and we were very lucky in having Dr. R. V. Rajam as our first orator. It was a learned oration and could not be equalled by any of his successors. Last year, we had Sir A. Lakshmanaswami Mudaliar whose gift in this respect is well-known throughout this country and in even other countries. The former had made an international reputation in his speciality and the latter, in addition, in other ways also. We are proud of them and of the feeling of possession in that they are members of this body. While not labouring under an inferiority complex, I do not for a moment place myself on a par with them. What I propose to do is just to think aloud with you on certain matters of interest to us in the service.

On the 28th of April 1919, *i.e.* by a curious yet happy coincidence on my 23rd birthday, I got the results of the final examination and within one month, I was appointed a temporary Assistant Surgeon. Since that date till the 28th April 1951, I have been a member of the Service and for many years a member of the Association. I am not certain in my mind when the Association had its beginning. I believe, we have been given some glimpses into the past, now and then, but there is no written record. I wish that one of our men with a flair for historical studies—like Dr. Subba Reddy—would take this up and write up the history of our Service and our association.

Not till I came over to the City on the staff of the College had I any intimate connection with the Association. In 1926, I remember contributing an article to the magazine edited then by Dr. Srinivasamurthy, while I was in Calcutta. We used to have great difficulties in finding a quorum for our annual meetings. I remember Dr. Kesava Pai coming

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over to the College on the evening of the annual meeting and with personal pleadings collect sufficient members for the quorum. Even the nominations for the office bearers could be got signed only then. Still, in those days there was a feeling of oneness among the members of the Service—quite understandable to those who knew the history of the Service.

In my student days, the Service had little status. The members were known as the "Assistant Surgeons' Class" who joined and mostly retired as Assistant Surgeons. The duty of the Assistant Surgeon in the General Hospital was to carry the prescription book or to dress cases and put up cases for operation. I believe even a hypodermic injection could not be given by them. I think Sir A. Lakshmanaswami Mudaliar gave us some ideas of the position then existing.

There were about 4 Civil Surgeons given as "BAKSHEESH" to the Assistant Surgeons—but no administrative district appointment.

I remember the jubilations which occurred when the first permanent Indian Professor of Anatomy, Dr. G. Rama Rao was appointed. Later, when I was in the 4th year—I think, Dr. Tirumurthi was appointed Professor of Pathology. I remember standing with a crowd of senior students near the big tree to the South of this hall and cheering him as he went to take his first lecture class as Professor.

The emoluments of the Service too were meagre. There were 2 classes—the lower, originally known as Dressers, later Hospital Assistants and then as Sub-Assistant Surgeons. I remember hearing about a speech by Col. Giffard comparing the salary of his motor driver favourably with that of the Sub-Assistant Surgeon. The upper grade—The Assistant Surgeon started on Rs. 100/-. Even the time-scale came later. It was—I think—about 1920 or so that by one stroke of the pen, a Civilian with sympathy and vision—Sir Alexander Cardew, I believe it was—who doubled the starting salary and granted a time-scale which was modified in 1931 and later further modified during the first Congress Ministry.

After the 1st World War, some of the districts and a few more of the Professorial appointments fell to our lot. The fight to wrest our legitimate share from the powerful I.M.S. was quite a strenuous one and this required union and solidarity. In our efforts, I must say that a few of the Indian members of the I.M.S. showed their sympathy for us and even worked for us. We also had one of the greatest Statesmen of South India—The Raja of Panagal also to fight our cause. So our success became more and more spectacular until in March 1950 the Service got as its head for the first time as a regular appointee, one of its own members. I, who have had the proud privilege—so to say of blazing the trail, of our Service

as the first Provincial Surgeon-General have all along felt that I was still a member of the Service and its Association in the same way as I was ever before and have tried to feel and also bring home to all members of the Service, senior or junior, the oneness of the Service.

I have loved the Service and its Association passionately. Some of the most fruitful and happiest years in my service were those in which I served the Association as Joint Secretary and Editor along with the late Dr. S. K. Sundaram whose devotion to the cause of our Association was well-known and because of which, among other reasons, his loss has been greatly deplored. It has been said of one of the Queens of England that "Calais" was writ on her heart. It might well be said of Dr. S. K. Sundaram that Madras Medical Service was writ on his heart. And I might even say that my love for the Service Association has been so great that the same may well be said of me too!

Our Service has become a hereditary successor to the civil branch of the I. M. S. The I. M. S. has had a great past. It has had its shortcomings; but there is no gainsaying that members of the Service had done great service to this country and have also enriched Medicine in its many aspects

A few weeks ago I was reading a Review of a book "*History of the I.M.S.*"—I think written by Sir Rikard Christophers, who was in the Medical Research Department. I was wondering in my mind if, ever, a History of our own Service would come to be written, and if so, what achievements could be credited, to our Service. I fell to comparing the I.M.S. with the Madras Medical Service. In doing so naturally one has to open a credit and a debit column. What were the special features in the I.M.S. which helped to make it proud of its own achievements?

A feeling of comradeship or oneness.—If one is a member of a Service there must be a common ground on which he can meet his fellow members. The junior-most member of the I.C.S. naturally looks up with great respect to his seniors in the Service; and I know, in some cases, he might even, be mortally afraid, of his chief. But this is only in official matters. He is socially, not considered inferior, to any of his seniors. It has been so in the I.M.S. too. The junior-most member of the Service received the same courtesy from the Surgeon-General as the senior-most and he was never made to feel that he was an inferior. The Madras Medical Service has two main categories—The Civil Surgeon and Civil Assistant Surgeon. The former consists of those promoted from the latter grade. Both are of gazetted rank and therefore the relationship between the two is not comparable, to that, existing, between the grade of Tahsildar and members of the Executive Service, or Inspector of Police

and Deputy Superintendents of Police. Therefore, a junior Assistant Surgeon is entitled to demand courtesy and consideration from his District Officer. This comradeship, which is fortunately not non-existent, has to be promoted still further. The greatness of the I.M.S. has been built on such comradeship.

I have heard of a District Medical Officer expressing the opinion, that, as while he was an Assistant Surgeon, he was not treated courteously or offered a seat by the European I.M.S. Officer, his Assistants could not expect better treatment from him! In another district, talking informally to the junior Medical Officers who were all my students, one of them blurted out "Sir, you treat us just like friends—but our District Medical Officer, treats us like peons or ward boys." I must say that by the time the District Medical Officer left the district, the atmosphere changed considerably and by example, and by giving hints, the behaviour of the D.M.O. to his assistants greatly improved. I must also draw the opposite kind of picture. I have in my mind at least two District Medical Officers whose whole staff worship them. The team work in both those districts was well-nigh perfect. I prayed God that our country should deserve more of this kind. I was so impressed with their work, that I had no hesitation, in putting down, that they almost reached, my ideal, of a District Medical Officer.

It has been my pleasure to note how in a good number of cases many senior officers have taken pride in showing to what extent they were able to train junior officers professionally and in administration. But on the other hand, I have also had examples of officers—fortunately very few indeed—who developed a violent hatred towards such Assistants as wish to show their efficiency in the profession and in administration, and in season and out of season, in their presence and in their absence, vilify and discourage them. The Assistant Surgeon of today is the District Medical Officer of tomorrow and the District Medical Officer of today may be the Director of Medical Services next time. *Hence do unto others as you would be done by.*

Not only should the seniors forbear from such overbearing conduct towards their juniors; but I also feel that etiquette demands that when one goes to a new district, it is in the lowest of tastes to criticise the doings of his predecessor. This often happens when the successor is not as good professionally; and is born of an inferiority complex. Such conduct is not worthy of our Service and does not tend to build up the fame of the members. The I.M.S., specially the European element, was scrupulous in such official etiquette. There were certain things which were *not done* and ill became "conduct of an officer and a gentleman." If our Service should survive, there must be this bond of comradeship and *I pray you to remember this.*

The need for specialising—the importance of obtaining higher qualifications and experience in various clinical and non-clinical specialities need not be stressed here. This is apparent to all. We have distinguished men and women with ability and qualifications, to man a variety of top-ranking posts, in various clinical specialities. But it is becoming painfully apparent, that personnel with equally high qualifications in the non-clinical subjects, are becoming increasingly difficult, to obtain.

The reason for this is not far to seek. Mainly it is one of emoluments and the gross disparity that exists now between the clinical and non-clinical—the haves and the have nots. I have made attempts to solve this problem. But perhaps it is as well that I could not achieve anything in this matter. It is much better that the subject be dealt with and I am sure it will be wisely dealt with by Dr. Arunachalam and Dr. Ramanamurthy who are both clinicians and belong to the category of the *haves*—differing only in quantity! For, a solution of this problem by a non-clinician like myself, might have been looked upon with disfavour. But, it is a sad state of affairs, that, among our young men and women, who pass brilliantly from our colleges, the call to do research and excel in the non-clinical departments has come to practically none. It is a travesty of truth, to imagine, that any one can fill, a non-clinical, teaching, or research post. Our service has been a failure in this direction.

Just look up the well-known research workers from the I.M.S. who have toiled in this country in the bacteriology and research departments and see what has happened to these departments after their departure. The same sentiments, which sway members of our Service seem to work to this sad end, elsewhere also in our country!

On the other hand, there is quite a rush for post-graduate courses in clinical subjects. Quite a laudable object no doubt—and if it were possible, to secure the required opportunities for those, as would reasonably be expected to benefit from such postings, there should be no complaints; and we shall be obtaining the personnel required for advanced clinical work and teaching. A candidate, if he is in Service, is posted for the required period of 2 years to ward work and appears for the examination after this period. It may be, that those who fail at the first attempt might get through next time. But a number continue to appear several times and at the same time retain their position in the wards to the detriment of other deserving candidates. This has become a real problem. A certain number of deserving candidates, have had to be denied such a chance, because those who have influence, can by these means, circumvent the intentions of the head of the institution or department. The solution is not as simple as it might seem. It rests only with those who have had the good fortune to stay more than the stipulated period,—*being willing to vacate their places, for the less fortunate.* I leave it to the good sense of the

junior members of the Service to whom my observations might apply. This is also in the interest of the Service so that a larger number may get the training and qualifications, which are now, the gateways, for preferment, in various special appointments.

I have here presented some rambling thoughts on some of the problems of the Service. It is my ambition to see our Madras Medical Service grow in strength and perfection and not only be an ornament to our country but be really imbued with the spirit of service which is required by our motto.

I am aware of the many problems facing the majority of our men and women serving in the mofussil. In these days of recent democracy, these young medical officers may be tempted or forced or importuned to do certain things not sanctioned by the ethics of the profession. Whatever may be the immediate outcome, there is no need to depart from the path of rectitude. You have your conscience to satisfy and I am sure you can count upon the support of your District Medical Officers and the Director of Medical Services. In no case, where the Medical Officer has not been in the wrong, has the D.M.O. in my experience failed to support the Medical Officer and I know, as the head of the department I have not hesitated to use strong words in supporting my men. Nor have I been remiss in using equally strong language when I considered my Medical Officer to be in the wrong; and if adequate punishment had not been meted out, it is due just to red tapism. And, if any, has reason to feel, that his case has not had the support he had expected, yet he can have the satisfaction that a greater personality would say to him "well done thou good and faithful servant".

I have already referred to the fact that now we have our own D.M.S., one who can be expected to understand the difficulties and grievances of the rank and file of the Service. Both Dr. Arunachalam and Dr. Ramanamurthy have had long years of service with students and they have this in common with me that a good number of junior Medical Officers have passed through their hands as students. There is a great advantage for the Service in this and to some extent some disadvantage to the D.M.S. and the Dy. D.M.S. Knowing the capacity of the Medical Officers, an attempt can now be made and has been made to post them where they would be most useful. In a number of cases what the head thinks on this matter, is different, from the opinion, the M.O. has, about his own capacity. And the moment the posting is made, a rush is made to the D.M.S.'s office or residence with or without recommendations; or the phone rings and a political boss takes up the plea. This sort of thing must stop, if discipline is to be maintained. The D.M.S. or S.G. cannot tell off those who go to see him with the recommendations. It is up to the Medical Officer himself to see that such contingencies do not arise.

Looking back in one case, I asked the person phoning me up, whether he was interested more in the Medical Officer, than in the hospital; when he told me that of course he was interested in the hospital, I had to say that, that was the very reason for the transfer. In another case when much influence was tried on me to post a Medical Officer to a teaching appointment, I had to abruptly inform the person making the request that neither in the opinion of his immediate chief nor in mine was the Medical Officer fit for the appointment for which he was being recommended.

The head of the department who has to maintain his stand in the constant demands made of him in this manner cannot continue to remain a persona-grata with the powers that be; and this must be recognised by members of the Service who are more anxious to better their own prospects in the face of adverse opinion and to the detriment of certain other members of the service. I demand of you that you give the same respect to the Head of your Service who is also the head of the Department as you would have given, to a member of an alien service—not the servile respect of the old days—but a wholesome respect encouraged with the knowledge that no one's rights would be jeopardised. Discipline is absolutely necessary for the development of our Service, as much, as it is necessary, in the political life of our country.

The Madras Medical Service has a great future. It has received additional reinforcement by the unification of the two cadres of Assistant Surgeons. We have talents in all specialities and it is a shame that our journal has not been so far upgraded to the level of similar journals overseas. The ban on our members being holders of office in scientific societies or editors of learned magazines, I understand is likely to be removed. I am glad of this because I know to what extent the fight has been carried on to prevent this ban from being enforced. I therefore reiterate that the service has a great future and the future lies in your hands. I shall not stand before you again at such a gathering, but I assure you that I shall eagerly watch the progress of the Service in the future, towards its destiny—to count among its members the leaders of the Medical Profession and to be identified as the embodiment of Service to our motherland.

THANK YOU!



Dr. G. R. DINKER RAU, M.D.

Dr. Dinker Rau

(a tribute)

BY

Dr. G. D. VELIATH,

The demise of Dr. G. R. Dinker Rau, M.D., has removed from our midst a unique personality whose labours for the cause of the Madras Medical Service and medical profession in general in South India have been incalculable. Dr. Dinker Rau was born on 20th May 1890, the youngest son of Dr. G. Rama Rau, the first Indian to occupy the Chair of Anatomy in Madras. Under the example and discipline of his illustrious father young Dinker early developed a lofty and fearless independence in outlook and expression which characterised him throughout life and marked him out in the multitude. He joined the Madras Medical Service in 1917 as a temporary assistant surgeon and after 28 years of devoted service spent mainly in the three Government Medical Colleges of the Province—in each of which for varying periods he held the Chair of Medicine—retired in May 1945 as Principal and Professor of Medicine, Stanley Medical College. Early in his professional career he came under the influence of Col. Elwis, a noted Physician from whom he learnt the great art of clinical teaching and instruction.

Dr. Dinker Rau will always be remembered by his innumerable students as a great clinical teacher whose clear and lucid lectures and forceful and impressive demonstrations can never be forgotten. With perfect mastery of the subject he focussed attention on fundamental and practical points which were repeatedly emphasised and stressed till they made an indelible impression on the students mind. He always relied more on bedside findings and stimulated the powers of observation, curiosity and reflective faculty of the students. It was not unusual to see Dr. Dinker Rau going round the wards alone examining the case sheets written by the students and correcting them.

As a man Dr. Dinker Rau always evoked respect and affection. His sterling character, integrity and professional rectitude lifted him high in the estimation of both students and colleagues. There was nothing about him even vaguely suggestive of smallness or pettiness while his serene countenance, frank straight talk and evident sincerity infused trust and confidence. He was President of the Service Association during the hectic days of the last war when patriotism was very often mistaken for disloyalty and always fought for its rights and privileges even courting official displeasure on many occasions.

Dr. Dinker Rau was a keen and enthusiastic sportsman, and his love for cricket and tennis remained to the last. It was indeed a pleasure to be in his company watching a game of cricket or resting after a set of tennis, when all his old boyish enthusiasm and exuberance will return and with characteristic earnestness he would explain and demonstrate the flaws and merits of each individual stroke. As a companion he was pleasant and entertaining with his fund of anecdotes and experiences which he related with realistic vividness.

He was exceedingly fond of children - though he was himself childless - and to the numerous boys and girls that learnt medicine at his feet, he was indeed a spiritual father - sympathetic and understanding, a tower of strength and support.

Dr. Dinker Rau lived a happy and harmonious life rich beyond measure in the influence for good he exerted on generations of medical men and women. He is no more, but the shining example of his noble life will live for ever. Truly it can be said of him that he has joined

'The choir invisible'

of those immortal dead who live again, in minds made better by their presence.

Association Notes

THE MADRAS MEDICAL ASSOCIATION

The annual general body meeting of the Madras Medical Association for the year 1951 was held on 26-12-1951 at 6 p.m. in Madras Medical College. Having had no voting the President-elect of the year, Dr. A. Ananthanarayana Iyer was proposed to the chair and presided 71 members were present. Of these, two were from the mofussil, Dr. A. Umapathy Mudaliar, District Medical Officer, Guntur (on leave) and Dr. Ganapathi, Virudhunagar.

The meeting first passed a condolence resolution standing silent for a minute on the demise of (1) Dr. K. N. Krishnan (2) Dr. G. Dinker Rau (3) Dr. Venkatagiri (4) Dr. B. Ramamurthi and (5) Dr. G. W. Roberts.

The President then referred to the retirement of the following members from the service:

1. Dr. Miss A. B. Hardy.
2. „ J. C. David.
3. „ K. Vasudeva Rao.
4. „ C. Vareed.
5. „ T. V. Mathew.
6. „ B. H. Padmanabha Pai.
7. „ C. K. Prasada Rao and
8. „ S. Rama Rao.

The Association then congratulated the following members for their promotion to higher offices—

Dr. K. Vasudeva Rao and Dr. Arunachalam to the office of the Director of Medical Services and Dr. M. V. Ramanamurthi to the office of the Deputy Director of Medical Services.

The Secretary Dr. G. D. Veliath then presented the annual report and the audited statement of accounts. Dr. C. Raghavachary moved that the report be passed and Dr. Mahadevan seconded. The house then passed the audited accounts unanimously.

The appointment of the auditors for the year 1952 was then taken up. Dr. C. K. Prasada Rao moved that the auditors who have been auditing the accounts of the Association in the previous years i.e.

Y. Ramaswamayya & Co., be appointed in the old scale of remuneration for the year 1952. Dr. G. D. Veliath seconded. The house voted unanimously in favour of the resolution.

Some important resolutions relating to service conditions were then taken up for discussion. Dr. S. Govindarajan then moved the following resolution given notice of.

1. The Association requests the Director of Medical Services to represent to the Govt. that when the members of the Madras Medical service are directed to carry on the duties of an officer going on leave in addition to their own, they should be given in all cases the officiating pay of the higher cadre in addition to their own as it is done in all other depts. in compliance with the Fundamental Rules.

He mentioned how in the Medical Dept. alone of all the Depts. it is specified on every occasion when an officer goes on leave that the leave was granted and some other officer asked to carry on the duties without extra expense to the Govt. thus depriving the officer officiating to do extra work the benefit of the sanctioned officiating pay. Dr. Manjunatha Rai seconded the resolution, which was put to the house and was passed unanimously.

He then moved his second resolution:

2. The Association requests the D.M.S. to represent to the Govt. that when members of the service carry out any work for private medical practitioners in the hospitals or laboratories, the concerned staff be paid a reasonable portion of the charges collected by the Govt. from the patients or medical practitioners.

In moving this resolution he pointed out that in the years past this sharing of the fees by the staff of the dept. concerned was allowed and he said that in this resolution he was not asking for the innovation of a new practice but renewal of an old practice that was suspended for the last few years. This resolution was seconded by Dr. Narayana Pai and was passed unanimously by the members.

Dr. G. D. Veliath then moved the following resolution:

3. The Association requests the D.M.S. to represent to the Govt. the peculiar position of the Professor of Forensic Medicine, Madras Medical College, who is made to do work for two colleges without any extra remuneration, and obtain the sanction of a special pay for that post.

Moving this resolution Dr. Veliath explained the genesis of this peculiar position and pointed out the unfairness of making an officer do double work for one remuneration. Dr. Mahadevan seconded the resolution. Dr. Manjunatha Rai proposed to move an amendment to the effect that in as much as the Professor of Radiology also is in a similar position as that of the Professor of Forensic Medicine, the wording of the resolution be changed to make it applicable to both.

A discussion followed. Dr. C. Raghavachary moved at this stage that Dr. Veliath's resolution be considered as such and that Dr. Rai be permitted by the house to move a fresh resolution to cover his contention. Dr. Raghavachary's amendment was seconded by Dr. Sanjivi, put to vote and was passed by the house. Dr. Veliath's resolution was then passed unanimously.

At the request of the President Dr. Manjunatha Rai then moved the following resolution:

4. The Association requests the D.M.S. to represent to the Govt. that the Professor of Radiology, Madras Medical College is asked to give lectures to the students of both Madras Medical and Stanley Medical Colleges in addition to training candidates for various diploma courses without any extra remuneration. So the Association requests that the Govt. may be pleased either to create a new post for the Stanley Medical College or sanction an extra allowance in consideration of the extra work.

Dr. C. Raghavachary seconded the resolution which was put to vote and was carried.

Dr. A. Umapathy Mudaliar then moved:

5. This meeting is of the opinion that considering the rapid strides the medical science is making and in the interests of service, every medical officer, paid or honorary, should be given an opportunity to take up a post-graduate course, or a refresher course of 6-8 weeks once in 3 or 5 years as a part of his duty in one of the teaching hospitals of the state.

Moving this resolution Dr. Umapathy Mudaliar pointed out the difficulties experienced by both junior and senior members of the staff especially in Mofussil hospitals by not having facilities to brush up and acquire newer knowledge.

Dr. S. Govindarajan seconded the resolution, which was put to vote and was passed.

Dr. Umapathy then moved the following resolution :

6. This meeting recommends that it is desirable to revive the annual conference of the District Medical Officers, to discuss the problems relating to the Head-quarters Hospitals, Taluk Hospitals and Primary Centres and to see for themselves the actual working of the various depts. of the teaching hospitals every year.

After Dr. Umapathy Mudaliar finished speaking Dr. Manjunatha Rai seconded it. The President at this stage spoke in support of this resolution and suggested that this desired conference may be held at the time of the annual meeting of the Association so that the Mofussil members may find it convenient to attend it.

Dr. Umapathy Mudaliar then moved the following resolution :

7. The Association desires to point out to the Govt. that the rules of travelling allowance based on the amount of salary obtained by an officer as they stand today are the cause of legitimate grievance to many junior administrative officers of the service like the D.M.O's and requests the D.M.S. to represent to the Govt. to make the necessary changes so that the T.A. is based on the status of the post occupied by the officer and not on the actual amount of pay drawn by him.

Dr. Umapathy Mudaliar pointed out how sometimes it will be very humiliating to a District Medical Officer to travel in a lower class when another district officer moving on equal terms and of equal official status travels in a higher class.

The resolution was seconded by Dr. Narayana Pai. It was put to vote and passed unanimously.

Dr. M. Krishnamurthy then moved the following resolution :

8. This association requests that the Govt. should be addressed for permission for the following: "A portion of fees that patients in special wards pay towards treatment be distributed to the members of the staff concerned in the treatment of the patient. The charges for operation or other treatment, the charges to be given to the staff etc., are to be hereafter determined on lines parallel to that existing in almost all other provinces of the Indian Union.

Dr. Krishnamurthy made a fervant appeal not to mistake the position of the clinical brother of medical service. He pointed out that the usual belief that these members of the service on the clinical side are in charge of a pagoda tree is absolutely false and in the changed circumstances of the country and the terms of service their position is not so rosy as people imagine.

The resolution was seconded by Dr. M. A. Nair. Dr. S. Govindarajan opposed the resolution on the ground that the time is not opportune and it would be better to content with more modest requests. A very lively discussion ensued. The resolution was put to vote and got carried, Dr. S. Govindarajan alone dissenting.

Dr. G. D. Veliath next moved the following resolution :

9. It is resolved that the President approach the D.M.S. and Govt. on behalf of the junior medical officers to expedite the grant of war service increments on par with other services of the State in compliance with G.O. No. 1261 Public (Services) dated 20-5-48 and G.O. No. 4032-48-2 Public (Services) dated 27-12-48 and G.O. No. Ms. 1925 P.H. dated 27-5-49.

Dr. S. Govindarajan seconding his resolution pointed out that in spite of the above mentioned Govt. orders dated as far back as 1948 the army service members of the Medical Service have not obtained any benefit mentioned in the Govt. Orders and requested the Association to take some steps so that the dues accrued may come to their bank accounts instead of lying idle in the Reserve Bank as has been once remarked to him by an officer to whom he had occasion to mention this grievance. The resolution was passed by the house.

Dr. S. Govindarajan then moved another resolution as follows :

10. The Association requests the D.M.S. to represent to the Govt. that medical officers who give evidence in courts for medico-legal cases in the city or mofussil should be given an allowance of Rs. 5 a day for evidence given in courts within a radius of 5 miles.

The resolution was seconded by Dr. A. N. K. Menon. A discussion followed and finally the resolution was put to vote and passed.

Dr. Manjunatha Rai moved a resolution reiterating the request made to the Govt. last year in the form of resolution V and VI, on which no action seem to have been taken so far.

Dr. G. Victor moved the following resolution :

11. The Association feels that the allowances now sanctioned for the posts of Principals of Medical Colleges and Superintendents of Hospitals are very inadequate and requests the D.M.S. to represent the matter to the Govt. and obtain an enhancement of the allowances in conformity with the status, responsibility and degree of work done by them. It is also requested that the D.M.S. will make representations to the Govt. to obtain an allowance to the Vice-Principals who also have to discharge onerous duties.

Dr. S. Govindarajan seconded the resolution which was passed by the house.

Winding up the meeting the President made a fervent appeal to the members of the service especially those engaged in teaching hospitals and colleges to take a lively interest in the Journal and contribute articles regularly without the Editor going round each time with his hat in hand. He pointed out that if sufficient interest is taken, a service with so many members with high academic distinctions can easily raise this journal to one of a very high standard.

The members then adjourned to dinner, which was attended by the Director of Medical Services, the Deputy Director of Medical Services, and the Dean, Govt. General Hospital and Madras Medical College, etc., After the dinner Dr. J. C. David delivered his oration which was heard with keen attention and interest.

After a vote of thanks to the Speaker, the distinguished guests and other members, the function came to a close.

