# The Madras Medical College Magazine

4





Vol. XX. JUNE 1952.

## "REQUEST" of PAVLOV

### to The academic youth of his country.

*What can I wish to the youth of my country who devote themselves to Science?*

*Firstly, GRADUALNESS. About this most important condition of fruitful scientific work, I never can speak without emotion. Gradualness, gradualness, gradualness. From the very beginning of your work. school yourselves to severe gradualness in the accumulation of knowledge*

*Learn the A B C of science before you try to ascend to its summit. Never begin the subsequent without mastering the preceding. Never attempt to screen an insufficiency of knowledge even by the most audacious surmise and hypothesis. Howsoever this soap-bubble will rejoice your eyes by its play, it inevitably will burst and you will have nothing except shame.*

*School yourselves to demureness and patience. Learn to inure yourselves to drudgery in science. Learn, compare, collect the facts.*

*Perfect as is the wing of a bird, it never could raise the bird without resting on air. Facts are the air of a scientist. Without them, you never can fly. Without them, your "theories" are vain efforts.*

*But learning, experimenting, observing, try not to stay on the surface of the facts. Do not become the archivists of facts. Try to penetrate to the secret of their occurance, persistently search for the laws which govern them.*

*Secondly, MODESTY. Never think you already know all. However highly you are appraised, always have the courage to say of yourself, I am ignorant.*

*Do not allow haughtiness to take you in possession. Due to that you will be obstinate where it is necessary to agree, you will refuse useful advice and friendly help, you will lose the standard of objectiveness.*

*Thirdly, PASSION. Remember that science demands from a man, all his life. If you had two lives, that would be not enough for you. Be passionate in your work and your searchings.*

## OUR COLLEGE CREST

**Lt.-Col. C. R. KRISHNASWAMI, M.S.**

*The crest is the Caduceus, the magic wand of the God, Hermes. It was the olive staff twined with fillets which were gradually converted to wings and serpents.*

*Hermes or Mercury was the messenger of Jove. One of his functions was that of conducting disembodied spirits to the other world and on necessary occasions of bringing them back. He was the guider of souls and the restorer of the dead to life.*

*Apollo had originally the wand which was an olive branch around which were placed two fillets of ribbon. Mercury who was the first to make a lyre, exchanged it with Apollo for his magic wand.*

*Afterwards when Mercury was in Arcadia he once noticed the serpents engaged in deadly combat—these he separated with his wand. Hence the olive wand became the symbol of peace. The two fillets were then replaced by two entwining serpents.*

*The serpents, the symbols of immortality are appropriately united with the olive wand which was the symbol of Peace.*

*The serpent has obtained a prominent place in all ancient religions and initiations.*

*From the faculty which the serpent possessed of renewing itself as to outward appearance, by annually casting its skin, it became like Phoenix, the emblem of eternity.*

*Among the Egyptians it was the symbol of divine wisdom when extended at length, and the serpent with his tail in his mouth was an emblem of eternity.*

*In an explanation given of the ancient mysteries, the male serpent represented the great Father and the female serpent represented the ark or the world, the microcosm and the macrocosm.*

*Hence the serpent also represented the perpetually renovated world.*

*Of the serpents in the Caduceus, one is probably the male and the other female.*

*The hand with the eye shows that the doctor should cultivate through experience the power of vision in his hand.*

**DR. R. V. RAJAM, M.S., M.R.C.P. (EDIN.)**
*Dean*
Government General Hospital and
Madras Medical College.

**MADRAS MEDICAL COLLEGE**
MADRAS

*10th March, 1952.*

## *Message*

On the eve of relinquishing office as Dean of the Madras Medical College, I have great pleasure in conveying this message to the students through the columns of the Madras Medical College Magazine.

Please remember your Alma Mater, respect your teachers and do not forget to place service before self in whatever you do.

I wish you all success in your under-graduate career and prosperity after qualification.

*R. V. Rajam.*

Rao Sahib
Dr. D. SIVASUBRAMANIA MUDALIAR,
M.R.C.S. (ENG.), L.R.C.P.( LON.)
*Vice-Principal & Professor of Anatomy.*
Madras Medical College.

MADRAS MEDICAL COLLEGE
MADRAS
*1st April, 1952.*

## *Message*

As I am laying down my office as Vice-Principal and professor of Anatomy, I wish to thank all of you for your very great friendship and kindness that you all showed to me notwithstanding any strictness. During my 32 years of service as a teacher of Anatomy, I have always found that students are all good and genuine in their hearts. Tennyson said, ''All women are cast in the same mould all over the world.'' Likewise students are all just the same all over,—no doubt some are playful, some lethargic, some absolutely indifferent and a few rather attentive. I would not say that only the attentive students were intelligent. You can always pick up quite a lot of ''intelligentsia'' among the other categories as well. I always felt that I was young when I was constantly moving with young students. I don't want to deliver a sermon but I will only appeal to all the students, old and new, *old* and young, that time is precious, competition is becoming great, that they will have to fit themselves in, in the changing world and as such 'get up and be going,' and above all, trust in God and do the right.

Ever your sincere well-wisher,

*D. Sivasubramania Mudaliar.*

# *Editorially*

## SIRS, WE ARE PROUD OF YOU!

IT is hard to reconcile ourselves to the fact that both the Dean and the Vice-Principal of this great institution have retired more or less simultaneously. It was as though we were left suddenly fatherless and motherless. But we rejoice in the fact that both of them are not fading away, as it were, after their well-earned retirement. Both have been called upon to shoulder responsibilities of greater national importance, —Dr. Rajam becomes the Director of the All-India Venereological Institute and Dr. Mudaliar, Deputy Registrar to the University of Madras. We congratulate them on their new assignments and we are sure that both will bring to bear upon their new office the richness and maturity of their variegated experience and add fresh laurels to themselves and to the country.

Dr. Rajam is an international figure of W. H. O. fame and a well-known authority on Venereology. The government could not have made a better and happier choice than Dr. Rajam as Director of the All-India Venereological Institute. Dr. Mudaliar, we hear, will be specially in charge of Examinations and may we give here a friendly bit of our mind to the student population of the State,—not necessarily medical: we will like them to go and read their text-books and not go about hunting for leaked-out Question-papers on the eve of examinations for the simple reason that there won't be any leak hereafter. Dr. Mudaliar is sure to put his strong thumb firmly down on the leak in the dyke!

We welcome Lt.-Col. C. K. Prasada Rao, our new Dean He is one who needs no introduction to you. He is an illustrious alumnus of the institution of which he is now the head and he has seen most of his service here. He knows the hospital and the college only too well. His interest in students,—in their studies, in their sports and in their welfare, —is well-known. He has always placed service before self and he is sure to prove himself popular among the students and the staff of the college and the hospital. We have great pleasure in welcoming our new Vice-Principal, De. Issac Joseph and one with his boundless energy and bubbling enthusiasm is sure to achieve a lot of great things. It is our good fortune to have got them as Dean and Vice-Principal and we wish them a long and successful tenure of office.

Sirs, we are proud of you.

## THE ALL-INDIA MEDICAL INSTITUTE

OUR government spends yearly lakhs of rupees in sending students abroad for higher studies but the question has often been asked, more frequently so in recent years, whether it will not be better to spend the same amount in bringing specialists from abroad to our country where they can train a greater number of students in specialised branches of science or technology. This has a double advantage: one, building permanent institutions on our own soil; two, training a larger number of students most of whom could not have been possibly sent abroad.

Such a permanent institution is springing up now at New Delhi, thanks to the New Zealand Government's handsome gift under the Colombo Plan. We refer to the setting-up of the All-India Medical Institute, which is, as Dr. A. L. Mudaliar so aptly puts it, "an epoch-making event in India's Medical History." Rajkumari Amrit Kaur, inaugurating an Expert Committee to advise the Government of India on the organization and general planning of the Institute, put forward some of her cherished ideals with regard to the Institute. The Health Minister was very much concerned at the overcrowding in colleges and the visible deterioration in educational standards and expressed the hope that the Institute will be a jealous custodian of the highest academic standards; that greater emphasis will hereafter be laid on post-graduate study and research; and that until such time as we have our own personnel of first class qualities, we should not hesitate to ask for help from friends abroad.

Thus the All-India Medical Institute is coming into being not a moment too soon. It is not only to avert a fall in standards that a post-graduate institute is called for; it will effectually prevent most of the doctors going abroad for higher studies. It will also help research in the much-neglected sphere of Tropical Medicine which is but our own concern.

In the hands of such eminent men who constitute the Expert Committee like Dr. A. L. Mudaliar, Chairman, Dr. Jivraj Mehta, Dr. V. R. Kanolkar, Dr. T. N. Banerji, Dr. D. C. Chakravarti and Dr. K. C. K. E. Raja, the member-secretary, the Institute is bound to be planned and nurtured along the soundest and healthiest traditions.

Under such circumstances, will it be too much to hope that ere long not only will there be any need for our students to go abroad for specialization in Medicine but instead students from abroad will clamour to visit our shores for specialization here?

## MATTERS OF MOMENT:

### FOOD, POPULATION, BIRTH CONTROL.

IN this proverbial land of milk and honey, it is sometimes difficult to believe that there exists the food problem; that famine has raised its ugly head here and there.

The food problem is closely associated with that of population. In the course of a century, the population of India has more than doubled itself, from 150 millions in 1851 to 388 millions in 1941. Especially after the secession of the rich, grain-growing provinces which now constitute Pakistan, the problem of feeding India's teeming millions, which was growing more and more difficult with every passing year that saw an increase of 5 millions to the population, became suddenly the dominating fact in our life. There is no doubt that the very future of our country as a progressive, independent nation now depends on the way we are able to tackle the inter-related problems of food and population.

Malthus may well laugh in his sleeve at those who branded his now-famous theory pessimistic. The Malthusian theory postulates that population increased by geometrical progression and had no limits whereas food production increased only at a much lower rate and had definite limits due to the limited availability of the area of cultivation. There are even now people amidst us who believe the population problem is not so acute as is made out to be and that the food problem can be solved by such measures as the opening up of new areas, river valley projects, the application of science to agriculture and so on. The inexorable logic of facts has forced the government to take in hand a comprehensive policy with regard to land and food production. But the related problem of a population policy, without which we cannot succeed, seems to have been lost sight of.

It is herein that birth control enters the picture. Even otherwise, a judicial spacing of children at 4 or 5 yearly intervals with an arbitary maximum fixed at 2 or 3 children per family is highly commendable both from the point of view of the mother and the children themselves. More and more people nowadays subscribe to the necessity of birth control but they seem to disagree only as to the means of practising it, whether it must be natural through self-abstinence (as advocated by Mahatma Gandhi) and the rhythm method (the most suited to our country according to Dr. Abraham Stone of the W.H.O.) or artificial through condoms and contraceptives. Anyhow the duty of the State in this matter is clear, *i.e.*, to impress upon the people the necessity, importance and advantages of birth control and to disseminate ways and means of practising it through a nation-wide network of birth control clinics.

*R. Ramamurthi.*

**MADRAS MEDICAL COLLEGE ASSOCIATION**

*Executive Committee (1951—'52)*

*Sitting (L. to R.)*—Dr. V. P. Naidu, M.B.B.S., (*Hon. Treasurer*), Miss. Ida Rodrigues, (*Vice-President*), Dr. D. Sivasubramania Mudaliar, L.R.C.P., M.R.C.S., Dr. R. V. Rajam, M.B., M.R.C.P., (*Ex-Officio-President*), M. Thomas Kuruvilla, (*Student President*), Miss. K. Sarojini, (*Lady Rep.*), Mr. M. S. Khan, (*General Secretary*).

*Standing 1st Row (L. to R.)*—Mr. B. Chandra, (*II Year Rep.*), Mr. A. Ramachandran, (*III Year Rep.*), Mr, V. S. Kathirvelu, (*Asst. Secretary*), Mr, S. R. Krishnaswami, (*In-Coming General Secretary*), Mr. K. R. Jacob, (*V Year Rep.*) Mr. R. J. Rajasekaran, (*Sports Secretary*).

*Standing 2nd Row (L. to R.)*—V. Ramachandran, (*I Year Rep.*) Mr. P. N. Ramakrishnan, (*Pharmacy Rep.*)

*Absent*—Mr. N. Rajamma, (*IV Year Rep.*)

(4)

# The Future of Medicine

**Dr. V. ISWARIAH,**

B.A., M.B., M.R.C.P., F.R.F.P.S.

**APOLOGIA**: The Editor of the magazine had approached the writer with a request to contribute to the next issue on "Shape of things to come in Medicine". The writer expressed his incapacity for the task, as he felt that he had a precarious hold on Medicine, as against many others with a firmer grip. Sometime later, the editor returned with a bait of help from an artist to give concrete shape to any ideas on the subject. The writer said that his ideas were too woolly for an artist to give shape. The editor persisted; the writer gave in and this is the result.

**Introduction**: One is tempted to look at the Future on an epoch-making occasion, on a significant date, 1900, 1950 or 2000 A.D., or when a shock benevolent or malevolent is delivered. In a sense we have reached a fascinating if baffling moment in the evolution of science. Natural science seems to have abolished the substantiality of matter, while metaphysics is depriving us of the concept of mind. In the void created by immaterial mindless mystery, we live to hear the prophet's mystic song over the unintelligible universe. Artemus Ward several years ago observed that "……the researches of many eminent scientific men have thrown so much darkness, that if they continue their researches, we shall soon know nothing. In the matter of the real, the votaries of science do in fact know precisely nothing at all." Narrowing down to the realm of Medicine, are we getting atleast glimpses of reality in etiology, symptomatology, prognosis or treatment?

To have a glimpse of the future, not necessarily goal, it is relevant for one to look back and survey the space covered. The hiker periodically looks back, else the sunny heights ahead don't thrill. Also patterns of life tend to be repetitions. Is 20th century Medicine like Joshua leading the men to the promised land finding them at the spot where Moses started?

**Is Medicine 'Art' or Science:** Before a look back, one has to be certain of our position vis-a-vis Art *cum* Science. Or are we neither, despised by one, disowned by the other, with the virtues of neither but the vices of both, a standing monument to hybridism?

The pure scientist scarcely troubles to conceal that we are not of their number. Listen to our recent guest Prof J.B.S. Haldane.

In a spirited controversy with Arnold Lunn, a Catholic Bishop some years ago, Prof. Haldane observed '.....you bring the case of Sir Berbert Barker but what has this to do with Science? Medical men form a close corporation. So do lawyers, parsons, locomotive engineers, chartered accountants and stockbrokers. Scientists do not. Or if they do, please tell me about it. I agree with you that the medical profession copied medical guilds rather too closely. I take it that their attitude is that if they admitted Barker, they would have no logical or legal grounds for keeping out other less desirable unqualified men. But what has this to do with Science? *Doctors are not Scientists, Doctors apply science, and so do motor mechanics and seedsmen.*"

Art is defined as 'practical skill guided by rules' or 'human skill as opposed to nature'. Art and science differ essentially in their aim. Science is defined by John Stuart Mill as 'cognisance of a phenomenon and evidence to ascertain its law' while 'art proposes for itself an end and looks out for means to effect it.' Accordingly, the sole aim of medicine is to cure diseases and hence an art. The pure scientist may disdain a clinician, but there is no need to be apologetic for beneficient activities even if they are not strictly scientific. The bedside manner is an art, more often inborn. Art and instinct contribute to common sense. Huxley is of the view that science is nothing but trained and organised common sense. Hence if one pure scientist sets science and art apart, another of their clan approximates the two. Medicine is essentially practical art based on acquired knowledge of science, though science is still engaged in groping for truth and reality. There is a constant acquisition of scientific knowledge and procedure in medicine, while many elements of art are involved in scientific medicine. Diagnosis is sometimes defined as 'Inspired guessing' but considerable knowledge of science is required for this 'inspiration.' In the best scientific thought and activity, there must be insight and imagination, the ability to detect significant patterns, sequence in events, to analyse, correlate and interpret logically. Only a genuine researcher possesses these gifts in their fullness and these gifts are constituent arts in science. A cold data collector in science is no better than a ticket collector with handfull of tickets. Hence the gulf between Art and Science is bridged, as intellectual arts penetrate and inform all our activities and thought, call them common sense or high browed science.



This question of Art *versus* Science turns up frequently in medical education. The importance of educating the medical 'neophyte' in scientific method emphasised by some, raises again and again the place for human, humane and humanistic approach as a counterblast; rather as an indication of awareness that by concentrating on science and despising the art of medicine, it would be quite possible to throw out the baby with the bath water.

**Medicine Yesterday:** We often suffer from a quaint conceit to scorn the medieval mind for its exercising a draconian authority over human activities. Going back to pre-Christian era, Hippocrates, Aristotle and Galen created a stir in the world of Medicine that today provokes admiration, not certainly disdain. The mind then functioned unhampered, not riotously and this has intrinsically sound values. In the dark and middle ages, degeneration is more traced to extraneous smothering influences where mind was led in captivity. Renaissance came as a deliverance. "Sanction of Galen" that one hears for doing anything in Medicine, is an evidence of mind being in captivity even after deliverance. But even middle ages has its admirers like A. N. Whitehead who opines that 'Middle ages were pre-eminently an epoch of orderly thought, rationalist through and through. The trait of definite thought was implanted in European mind by the long dominion of scholastic logic and scholastic divinity, the priceless habit of looking for an exact point and sticking to it'.

In the realm of Medicine, Physiology came late on the scene; for till then disease and death were semi-sacred subjects which should be dealt with by authoritarian rather than rationalistic methods. Vesalius and Harvey in the 16th century, Morgagni in the 17th and Virchow in later 19th century saw the birth of the pure sciences of Anatomy, Physiology and Pathology.

But why go to meddle and dark ages? Samples of medical thought about a 100 years ago in Europe are fascinatingly illuminating. They illustrate the strides in progress. The year 1851 celebrated the first festival of Britain, when a series of medical addresses were given. What strange feelings are provoked by reading them exactly a 100 years later?. The following extracts are from an address by Sir John Charles, Chief Medical Officer, Ministry of Health and Education (Lancet Dec. 22, 1951 p. 1150).

## A HUNDRED YEARS AGO

**Personnel:** There were atleast 3 main groupings, each with its own order and suborder. One might be regarded as comprising the unqualified assistant and the apothecary druggist. The next included the qualified apothecary surgeon for whom social gifts were a distinct advantage..... "A gentleman who hunts will be preferred", "Interested persons should play a game of whist" (from an advertisement for a locum). Finally on the one hand the fossilised and relatively poor fellow of the college in East London, and the fashionable surgeon touching his £10,000 a year, who sees 20 patients in the consulting room from 10 a.m. to lunch with a diary note that the day's bag embraced a Baron, a Viscount, Countess and a Marquis.

**Their Function:** In such an engagement, the young practitioner can practise his eyes in the physiognomy of diseases, attune his ear to the morbid music of the thorax, educate his fingers in the department of obstetrics, study the employment of the light and heavy artillery of therapeutics and learn how to handle those *six* divine remedies of Mercury, Iodine, Quinine, Opium, Tartar emetic and Epsom salt.

During a sojourn of 7 months, the doctor had been disturbed 90 times to proceed on journeys ranging from 3 to 8 miles, had visited, prescribed and dispensed for private, pauper and club patients, had kept the books, written out the bills, dusted the bottle, made the tinctures and had resisted all the time the temptation to which five out of the nine assistants had succumbed *i.e.* either to terminate their lives by the prussic acid bottle or to become confirmed drunkards in wild despair.....to be ready to attend all night to call on the bells, not to lie an hour in the morning even though up all night, to dine by himself or with servants at 2 o'clock (the family time being 5) or alternately to leave the dinner table with the cheese to take supper in the surgery, to give no drugs except the worst to paupers, to use the lancet and spare the leech.

**Ward Clinics:** Dr. Theophilus Thompson at Brompton Hospital 1851: "At our last meeting, Gentleman, I brought under your observation all the hospital patients at present under my care, who have for any considerable time taken cod liver oil. In proceeding to place before you examples of the effects of other analogous remedies, you will be led to agree with me fish oils generally resemble one another in medical properties. Other animal oils are equally effective. In S. America remedial efficasy is attributed to the oil of condor (a large vulture) and in the backwoods of U.S. to that of rattle snake. I have recently received a present of oil of scorpion. The flesh of the viper has been employed from the commencement of Christian era. Galen believed it to be efficacious in elephantiasis and our distinguished countryman, Roger Bacon, describes the case of a young German lady whose constitution was so impaired that her hair and nails came off, but who on a persevering diet of viper's flesh, became in appearance younger and more beautiful than ever. With a view to determine whether remedial effect was inherent in animal oils generally, it occurred to me some time ago to try the effect of oil obtained from the feet of young heifer (cow) neat's foot oil. In the first half of 1849, I recorded the weight of 14 phthisical patients of which 3 derived essential benefit, four were slightly improved, 5 received no obvious advantage and 2 retrogressed rapidly. Here are.....Case reports (1)..... (2).....(3). They left the hospital so much improved as to be able to resume work.".



Our times emotionally and otherwise are removed from our fathers, but our interests in all respects are vitally the same *i.e.* the enlargement of man in length of days, in usefulness and happiness.

**Medicine today:** We are too much in the thick of it for a dispassionate survey. But what a magnificent panorama opened itself in Medicine during this century. The microbe is on the run; avitaminosis like the rat is leaving the ship that is afloat; hormones work magic, a veritable talisman, A.C.T.H. and Cortisone in special. The era has recognised the role of Psyche on Soma and has harmonised this knowledge for the diagnosis and alleviation of innumerbale ailments of different systems. Social factors in determining health are taken cognisance of and elevated to respectable heights. Laboratory aid is freely availed (beware of the snare). Very lately Medicine has manifested a generous large-heartedness in recognising the part that the caretaker of the soul, the priest, has to play in keeping the entire man in health.

To dilate on each item of this progress on a broad front will be to trespass against the limitations enjoined by decorum and paper-scarcity.

Drug therapy at the commencement of this century was gently knocking the portals of medicine for entry; today she has entered the hall of fame and threatens to close the door for other entrants. We will fail to notice when opening the pages of any medical periodical today the announcement of some new therapeutic agent, an old drug for yet another disease or a new improved substitute for a good enough drug. Is the old banter "Medicine sometimes cures, often relieves and always consoles" true today. The aim of therapeutics is no longer 'will do no harm' but 'will do some good'.

How about the laboratory aid that comes to the assistance of the doctor from Biochemistry, Bacteriology, Pathology and Radiology? But this may overdo or tend to derail the progress (*vide* anon).

The concept of hormone function, Pituitary-Adrenal, is sweeping the entire domain of medicine like a Colossus. Etiology, symptomatology and treatment seem to anchor on this slender axis hanging unobstrusively below the brain. (Is this concept going to take us forward or back to the middle and dark ages?)

How about Psychosomatic medicine, rightly called the other half of medicine, though not yet the better half? The pure and simple druggist school of physician is much out of date. The lengthy prescription writer has been relegated to Hades. The treatment of true psychotics is certainly in the province of a psychiatrist, but a working knowledge of psychic states affords the physician the means to detection of ailment at a stage when curative measures will be of some avail. The physician of yesterday felt that every thing upto the eyebrow belonged to him, while all above belonged to the parson, philosopher or providence. Today the effect of psyche on soma is being given a prominent place in peptic ulcer, hyperpiesis, asthma, arteriosclerosis, exophthalmic goitre, urticaria, angina, colitis etc. Personalities have been classified by Jung on a psychological basis, by Kreitschner on a physical and Helmont and Joad on a chemical basis. We do know for certain today that psychological patterns are prone to certain ailments or predilections for certain diseases.

In Pygmalion or the Doctor of the Future there is mourning that 'Medicine in the latter days has neglected life too much. The demand that human beings should be seen as something different from animals has fallen on deaf ears. The doctor in consequence has become frequently something rather less than a man of culture.....the physician of the future will not, as is now usually assumed, be a *Scientist* of the orthodox type.....rather he will be a '*Humanist*', a man with the widest possible knowledge of human nature. He will be a cultured man, ripe in intellectual attainments, but not lacking in emotional sympathy, a lover of arts as well a student of sciences". This criticism as far as it refers to lack of medical man's understanding of the patient's mind, is being corrected in our day.

Not merely is the importance of Psyche on Soma is noted, but today the aim of medicine in relation to society and the repercussions of social conditions on medicine is being recognised. The expression "Social Medicine" to some is a synonym for 'State Medicine'. This error is presumably due to Social medicine coming to its own in Britain about the same time as the Nationalisation of the profession or its being brought



under state control. Social medicine according to the first Professor to occupy the Chair in Oxford (Ryle) is concerned with ".....many and varied problems created by sickness in the family and community as a whole. It embodies the idea of medicine applied to the service of man as a fellow, with a view to better understanding and more durable assistance to all his main and contributory troubles which are inimical to health, and not merely removing a present pathology". It embodies the idea of medicine applied in the service of community of men with reference social, genetic, environmental and domestic conditions with a view to lowering incidence of preventive diseases and raising the general tone of human fitness. Social medicine seeks to promote measures other than customarily employed in the practice of remedial medicine, for the protection of individual and community against such forces that interfere with full development and maintenance of mental and physical capacity.

Yesterday the 'Social' aspects of medicine would have been spurned by the medical profession as belonging to the scope of Sanitary Inspector, Social service league, Guild of service or Salvation army. Today the premier university of Oxford with the aid of Nuffield grant created a chair of Social medicine; others not excluding our own have followed.

In searching for the etiology of diseases in a patient or community, physicians of yesterday were hunting for a microbe, a vitamin or tracing a pathology to an organic cause. Other tracks, the lives and conditions of people, the family, domestic environment, occupation were mere by-paths, not worth rummaging for detecting the ultimate factors that cause unfitness, subhealth and later actual disease with organic pathology. For example, if over-crowding is a determining factor in the causation of rheumatic fever, it is the business of medical men today to discover this fact, take it into account, point out the position to those in authority and honestly try to avoid those conditions, rather than stop short of salicylates and Aschoff nodules in P.M. room.

Nathaniel Hawthorn gives a lively description of an ideal doctor-patient relation in Scarlet Letter. The doctor '.....deemed it essential to know the man before attempting to do him good. Wherever there is a heart and an intellect, the disease of physical frame are tinged with the peculiarities of these.....thought and imagination were so active and sensibility so intense that the bodily infirmity would be likely to have its groundwork there. He is a good doctor who guided in his work by the light of science can also be human, probing into the several ways of living, who could say quite boldly with Abou Ben Adhem "Write me as one who loves his fellowmen".

**Medicine Tomorrow—Whither?:** If a point blank question "Do you see hope in the future of Medicine" is levelled, the answer will be "yes" without many mental reservations, but not willy nilly. Trends there are to cast doubts, shadows at present no bigger than a man's hand on an otherwise sunny horizon.

As early as 1915, Sir James McKenzie, the eminent cardiologist had published a book "The Future of Medicine" (Oxford Medical publications) where he bemoaned the improper conception of the aims of medicine and a consequent employment of methods that fail to advance the subject. So far, greatest endeavours are made according to him in elucidating the later stages of diseases, but progress demands that the predisposing and early stages should be understood with equal thoroughness and energy. In order to achieve this Sir James is of the view that other fields must be explored, other methods used and even other individuals employed, than have served so far, investigation and teaching. Sir James among others deplored (1) neglect of physical exam. and history of the patient and preferring laboratory aids, (2) specialisation of a 'high order' tending to disintegrate medicine and narrowing the outlook. (3) neglect of general practice which is the background for a sound doctor and even for research and (4) over emphasis of post mortem examination.

Says McKenzie "It is indeed instructive to report that while men undergo a long special training to enable them to recognise the appearance of diseases after the patient has died and other men undergo training for a considerable time to recognise diseases after the damage is established, few or no attempts are made to train men for detecting disease when there is hope of cure" (One wonders if McKenzie had in mind neglect of out patient clinics or contact of a patient at home).

**Specialism:** Reference Specialism sometimes identified with fragmentation. Medicine has become so complex that it requires a large and ever increasing number of individuals to undertake its teaching and many more (possibly) to undertake the examining of a patient. Its methods are so numerous that it needs special training for individuals to acquire a knowledge of but a few, while the phenomena which are revealed are so many and so varied in type that even specialists are baffled.

Traquair (1941-Edin. Med. Jl. 48, p. 52) classified specialists into (1) organ specialist *i.e.* oculist, dermatologist, otorhinologist, cardiologist, gynaecologist, neurologist, urologist (2) disease specialist *i.e.* venereologist, tuberculologist, psychiatrist, specialist in infective fevers, (3) treatment specialist *i.e.* radiotherapist, psychotherapist, vaccinetherapist, balaenologist

If Specialism goes unchecked, one could conceive a modern Bernard Shaw in his drama depicting the doctors of the future as eminent consultants who have specialised in rouget cells of capillaries discussing diagnosis with erudite colleagues who had devoted their speciality to a single uriniferous tubule and its response to a sympathetic twig, or a specialist in the slit for the olefactory nerve discussing in the Medical library with authorities on hair krowth on the dorsum of middle phalanges.

(spa treatment) (4) diagnosis specialist *i.e.* pathologist, bacteriologist, biochemist, radiologist (to be distinguished from radiotherapist) (5) stage specialist *i.e.* paediatrist, geriatrist, climacterist.

(Indian conditions generously admit sometimes specialists in asthma, elephantiasis, haemorrhoids, urticaria, cataract).

The American medical faculty in 1941 has recognised and conferred post graduate qualification in the following speciality including Anaesthesiology, dermatology, internal medicine, neurological surgery, obstetrics and gynaecology, ophthalmology, orthopaedic surgery, otorhinology, pathology, paediatrics, plastic surgery, psychiatry and neurology, radiology, surgery, urology, cardiovascular diseases, gastroenterology, tuberculosis and allergy. (It is interesting to watch internal medicine and surgery, the parents nestling with their offsprings or a tree shorn of all its branches becoming just another branch without foliage.)

We know the sneer of the older physician—A young doctor returned to his native village and called upon the family physician. "I suppose you intend to specialise" remarked the latter. "Oh, Yes" replied the young man, "in the diseases of the nose; for the ear and throat are too complicated and extensive for purpose of study and treatment". Thereupon the family Physician enquired "Which nostril are you concentrating on?"

The National Health service Act announced "……for every citizen there must be available whatever medical treatment he requires and in whatever form he requires it, domiciliary, institutional, general, specialist or consultant". Walshe F.M.R. has caricatured this "The citizen from cradle to grave and at the price of a weekly stamp, may hope to be accompanied in his harassed journey through life by relays of specialists; the obstetrician, the paediatrician, soon of course the pubertician and the climacterician (subgroup of the species endocrinologist) and other experts in school and factory until finally he declines, decrepit and exhausted into the eager hands of the geriatrician and his sequent colleague the post-mortician; having enjoyed through all stages of the unequal contest, a wide choice of psychiatric first aid……The paediatrician passes us on at the age of 12 to his successor on the medical conveyor belt……till the hour strikes for us to pass to the geriatrician and the mortician" (Lancet 1950, II, p. 781).

If Specialism goes unchecked, one could conceive a modern Bernard Shaw in his drama depicting doctor of the future as eminent consultants who have specialised in rouget cells of capillaries discussing diagnosis

with erudite colleagues who had devoted their speciality to a single uriniferous tubule and its response to a sympathetic twig, or a specialist in the slit for the olefactory nerve discussing in the Maudlin library with authorities on hair growth on the dorsum of middle phalanges.

Some one said that a specialist differs from an all rounder as '*pose*' differs from '*poise*'. Only an 'i' distinguishes the two, but it is a capital 'I' for while a specialist is often a poser or an egotist, the all rounder is one with a poise, a philosopher and an artist. Clinical science may often be inimical to clinical sense or even common sense.

The Future of Medicine has to guard against this unchecked Specialism.

**General practice**: Associated with this aspect is the emphasis by McKenzie that general practitioner is better qualified to be a teacher, 'practicer', even a researcher in medicine. General practitioner is often thought a superior orderly of the consultant, a subordinate motile member of medical profession. In U.K. after the publication of Cooling's report, the tide has turned and it is felt that the pressing need is to revive and sustain good general practice and secure conditions in which it will flourish. McKenzie instanced Harvey, Hunter and Jenner in support of his contention that a general practitioner alone had opportunities for exploring the field essential to the progress of medicine. Instance comes to mind of the etiology of epidemic dropsy, when eminent researchers were hunting for the new microbe or the toxic amine or missing vitamin, a 'crude' licentiate rural general practitioner offered the theory of admixture with oil of Argemona mexicana, which is proved correct.

In U. N. a college of academy or general practitioners has been suggested to provide an academic headquarters for general practitioners, run by general practitioners. "It should give them leadership, develop policy, play a part worthy in medical education, encourage research and serve as a repositoy for tradition and ethics". (Lancet Dec. 8, 1951; p. 1071—Fragmentation or Integration).

The Future of Medicine has to take note of this issue *i.e.* forces for Integration or Fragmentation.

**Laboratory Aids**: How about the abnormal values attached to instruments of diagnosis wrongly termed appliances of scientific precision? Exaggerated importance of laboratory reports results in neglect of history and physical (including mental) examination of patients.



Excitement over the discovery of an organism, change in blood chemistry or radiological findings often results in forget of entire patient with an integrated body and mind. The modern patient has progressed so far that he has long passed the stage of 'bottle of medicine' or a stethescope applied to the chest. He wants 'photo' or 'blood analysis' or an 'all round check up'. The doctor is tempted to abandon himself to the patient's phantasy. Here are two types of patients. (1) A 'modern' lady who consulted a doctor when asked by the doctor to show her tongue replied "But no uptodate doctor asks a patient to do this nowadays". Her handbag had innumerable medical reports and obviously she wanted some more. (2) Against this an 'intelligent' man who had shifted two doctors on approaching the third said "Doctor, I do hope you will be different from the other doctors whom I have consulted. I trust you will look less at X ray and biochemical reports and more at me". (Here one has to beware of thoughtless experimentation on patients). A common example of neglect of scientific method is the tendency to embark on a range of laboratory tests without a thorough history, imagining that he is very scientific. Pencil and notebook can be an effective instrument of investigation as electron microscope and electrocardiograph, indeed often more so. The good physician appreciates that he deals in probabilities and not certainties. There is no such thing as 'cast iron diagnosis': for the dogma of today is the doubt of tomorrow.

Platt studied the value of patients' history apart from physical exam. leave alone laboratory exam. as a general guide to diagnosis and came to the conclusion that in 68% of cases an accurate diagnosis confirmed subsequently was made on the basis of history alone and in only 6% was it found impossible to diagnose or wrongly diagnose. (Platt—Lancet Vol. 2, 1947, p. 305).

And so, is the future of Medicine going to produce a doctor who, at the other end of the phone with laboratory reports spread out, is going to treat or even diagnose a patient whom he has never seen?

**Chemotherapy**: The jubilation over advances in Chemotherapy today is well founded: but is it going to be short lived? The present rate of advances in chemotherapy may in the next half a generation make parasites of little consequence. Mortality and morbidity due to microbial agents may be considerably reduced. (Such a change may have other consequences—food shortage, housing, care of the aged, over population.) No disease may also mean no incentive for more research; conditions of scientific research may dwindle as health improves.

Progress may also be impeded by increasing dominance of drug fastness. The possibilities of mutation may defeat the dexterity and the vigilance of chemotherapy. This is no mere alarmist attitude.

International pharmacopias that tend to systematise drugs and render them uniform in nomenclature, dosage and use, are welcome trends Drastic reduction in the number of curative agents may sometimes do good. More is not always merrier but often woolier. It is good to remember the old sneer of Oliver Wendell Holmes " Throw out opium which the creator himself seems to prescribe, for we often see the scarlet poppy growing in the cornfields as if it were foreseen that whenever there is hunger to be fed, there must be also pain to be soothed, throw out a few specifics which our art did not discover, throw out wine which is a food, and the various vapours which produce the miracle of anaesthesia, I firmly believe that if the whole of Materia Medica as now used could be sunk to the bottom of the sea, it would be all the better for mankind and all the worse for the fish". (Oliver Wendell Holmes remains acquitted of cynicism as these words were uttered in 1860 before the chemotherapeutic era).

**A Novel trend:** For many centuries in Christendom, priest and doctor worked side by side in tending the sick. In the last two centuries, these two 'ministering angels' gradually became estranged. Recently a book " Psychology, Religion and Healing " was published by Dr. Leslie Weatherhead M.A., D D. (Hodder and Stoughton—1951) which was given wide publicity in medical press. The author (it may interest some to know that the author was a resident in Madras from 1920—25) tries to clear the common ground on which the doctor and priest may ally for curing man's ailment. He is not an advocate of the so called 'Faith healing' or 'Spiritual Healing' where the devotee prays beside a patient to surrender himself with the suppurating appendix to God. For Dr. Weatherhead, man is composed of body and mind and spirit working in unity and while doctors are doing their best for body and mind, the priest can sometimes minister to third component in a man that benefits the entire man. We are recognising, says Dr. Weatherhead, that sickness to mind can produce bodily disorders, psychosomatic ailments: health of spirit can make the ills of the body more endurable! He does not countenance the healer of the spirit who incites the patient to do without a doctor, but he feels that some patients will recover more quickly and completely while others will bear their ailments more easily (not with the Spartan fortitude) if the priest is allowed to collaborate with the doctor and to reinforce his treatment with the ministrations of the priest.

Who knows if this viewpoint will not gain ground in the Medicine of tomorrow? It is hoped that Medicine of the Future will not present an undignified spectacle of retreat from honour and glory for the unborn posterity to wonder in disdain.

—★—

## *The Great Challenge:*

"If you could introduce something of your healing art in the treatment of the mind of man, both as an individual, and in the mass, then indeed medical science would have done tremendous service to humanity. You function merely in the limited sphere of waiting for somebody to be struck down and then trying to lift him up. Somehow it seems to me that is not enough. Why not prevent him from being struck down?

War has given a tremendous push to progress in the sphere of technology generally and in the art of healing. This shows that if we are confronted with a grave situation or crisis, we can rise to higher levels of creative efforts.

I am told that today, more than ever, one deals with the whole organism, not the particular part affected, even the mind of man. If you succeed in affecting the mind of man rightly then you may also succeed in healing the diseases which affect the mind, not the normal diseases, but the diseases which lead to conflicts and destruction. Medicine today becomes more and more preventive. We do not want a person to fall ill, we want to improve health, sanitation and all kinds of preventive measures. Why not apply that in the larger sphere and prevent something which you will have to deal with later in a more difficult form? That will take you to sociological and other spheres of human activity and doctors have to face all these problems."

*—Jawaharlal Nehru, in an address to Medical Historians.*

## *The Scientific Spirit :*

"The mystic, the lover and the poet are also seekers after knowledge,—not perhaps very successful seekers but none the less worthy of respect on that account. Science in its beginnings was due to men who were in love with the world."

—*Bertrand Russell.*

"In spite of the testimony that it was curiosity which lost us Paradise, I am sure that all who are aware of the fruits of the Tree of Knowledge would agree that they have become abundant because of the spying and trying of inquisitive scientists. The New England expletive "I want to know" expresses in the investigator a persistent passion. He sees events and changes in his field which seem to him strange and mysterious. Instead of ignoring them as most people do, he wonders about them and sets to work to learn their characters Curiosity is the mainspring of his initiative and persistent industry. It is a prime requisite for a career of exploration."

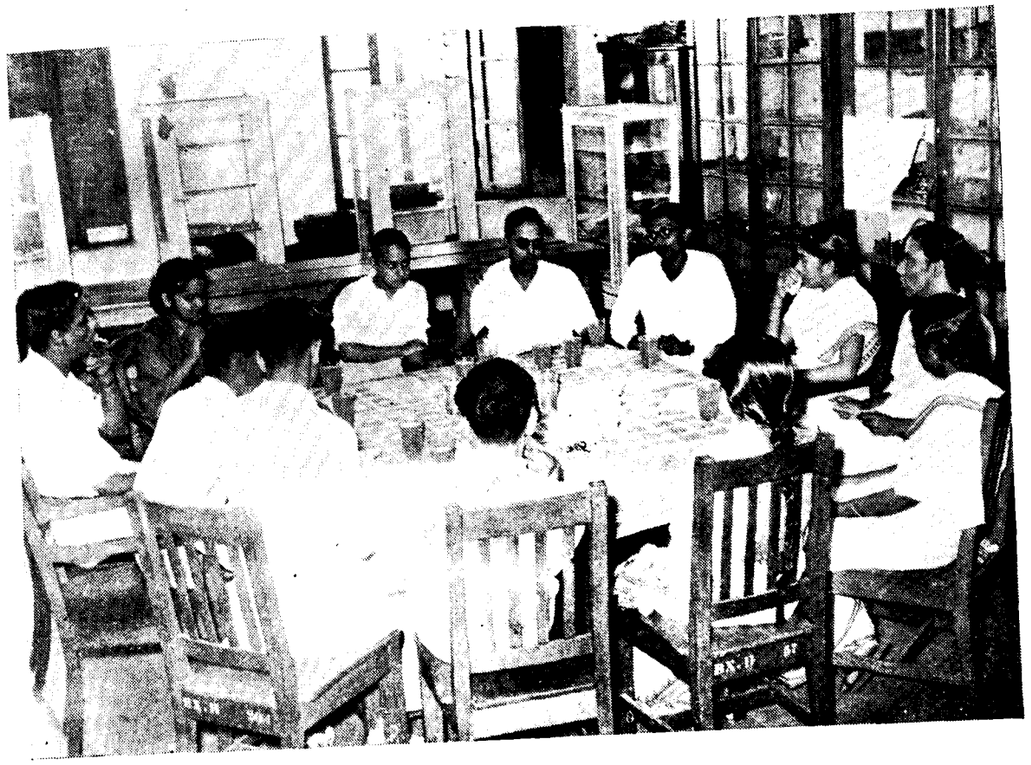
—*W. B. Canon.*

"Do not let yourselves be tainted by a barren scepticism, nor discouraged by the sadness of certain hours that creep over patients. Do not become angry at your opponents, for no scientific theory has ever been accepted without opposition.....Say to yourselves first, "What have I done for my instruction?" and as you gradually advance, "What am I accomplishing", until the time comes, when you may have the immense happiness of thinking that you have contributed in some way to the welfare and progress of mankind."

—*Louis Pasteur.*

"In 200 years, I think we shall be in a position in so far as we are willing to take a scientific point of view, to clear up on our character, as we can now to a large extent clear up on our health.....The scientific point of view is the point of view which has been taken up by scientific men first about their own problems and later about the problems of the world in general.....The scientific point of view is lofty enough to satisfy any of the aspirations of the human spirit. I believe that the future of civilization depends upon whether or not it can assimilate that scientific point of view."

—*J. B. S. Haldane.*



A discussion in progress.

# *The Madras Medical College Magazine Forum*

*Chairman:*

Dr. B. RAMAMURTHI, M.S., F.R.C.S.

# THE PANEL

**Chairman :**

Dr. B. RAMAMURTHI, M.S., F.R.C.S.

**Convener :**

R. RAMAMURTHI, General Editor.

**MEMBERS**

**First years :**

V. RAMACHANDRAN. B. K. MUTHAMMA.

**Second years :**

M. KANNAN KUTTY. M. MEERA BAI.

**Third years :**

V. JAYAKUMAR. N. INDUMATHI.

**Fourth years :**

H. SADANANDA BALLAL. C. R. SARASWATHI.

**Final years :**

A. P. BRAHMAM. S. RADHA.

**House-Surgeon :**

Dr. K. GOPALACHARI, M.B.B.S.

*On special invitation, Lt.-Col. D. S. Iyer, M.S., F.R.C.S. was kind enough to grace the occasion and take part in the discussions on "Extra Curricular Activities" and "The Future" and Lt.-Col. C. R. Krishnaswami, M.S. on "The Future."*

I wonder before penning these few words whether the Forum needs any introduction; whether, like all good things in the world, it can't speak for itself.

But I feel I must tell you the fascinating story of the birth of the Forum. In the beginning, I was not sure whether it would work. I put forward the idea rather diffidently to a few collegians whom I thought I would invite to take part in the discussions. They encouraged me and they were very enthusiastic. Then when Dr. B. Ramamurthi kindly consented to be the Chairman of the Forum, my joy knew no bounds. He is such a born mixer with students, one who makes you feel at home with the first charming winsome smile of his and already you begin to feel as though you have known him for years. Such a Chairman is indispensable, I think, to the success of any College Forum, especially if you want to draw out the best from the student-participants. Encouraged by the success of the earlier discussions, I made bold to invite Lt.-Col. C. R. Krishnaswami and Lt.-Col. D. S. Iyer for the latter discussions and their joining them has been a tremendous asset to the Forum.

In convening the Forum, I have had the extreme good fortune of drawing upon the large-hearted co-operation and unstinted support of Miss. K. Sarojini, the Ladies' Representative. The discussions you will hear in print were originally taken down verbatim by a stenographer and they have but undergone the least revision and editing. They were conducted in a spirit of happy comraderie, gay informality and in an atmosphere of give and take. At times a member might have lost his or her temper but there was always plenty of wit and humour to get over the

situation and the subject on hand was never lost sight of. I will like to suggest that though the present discussions were held *in camera*, future ones may well be thrown open to others who may like to attend them.

The subjects chosen for discussion were "Medical Education," "Student Health," "Extracurricular Activities," and "The Future." I think they are fairly representative of the numerous problems that beset us and await solution. Great thinkers, educationists and parents the world over are thinking about these and many other allied problems. They are not content with the *status quo* and are disturbed by a strange divine dissatisfaction. They want to shape things nearer to their hearts' desire. More and more of them are taking up the challenge of changing times and changing values. Even now, they are grappling with them in lecture-halls, conference-rooms, in reports that run into many volumes, over the radio and over the television.

It is our humble belief that the students themselves whom these questions affect most intimately have got a say in the matter and that they can help the elders in arriving at far-reaching conclusions which may well alter the very shape of things to come. Hence this Forum. We are too conscious that this is only a beginning of the beginning. We wish the Forum catches the imagination of students and that it becomes a permanent feature of our college activities. In the prophetic words of Dr. B. Ramamurthi, "With enthusiasm, lots of things can be achieved and I am sure the staff of the college are always ready to help you and join you in your activities to make life fuller and more worth living." And we leave it at that.

—*R. R.*

# Medical Education

**Chairman**: To-day we are discussing medical education,—a thing educationists and medical men the world over are thinking and talking about. It will be very interesting indeed to know what you, as medical students, have got to say on the matter. What do you hope yourself turned out to be? In other words, what is the purpose of medical education?

**Indumathi**: I think the purpose is to turn out good doctors, good at their job, always trying to do their best, treating the patients not as mere cases but as human beings with a richness of personality all their own. Above all, a doctor must be full of the milk of human kindness and understanding.

**Saraswathi**: For that a training in social service must be given to students while in college so that it becomes their second nature to be of selfless service to the society later on in life.

**Ballal**: But he must earn his livelihood.

**Brahmam**: I do not believe in sacrifice. Man must be selfish. Charity begins at home. A doctor must be able to maintain himself before he thinks of selfless service.

**Radha**: I fear we are drifting away from the issue. The purpose of medical education is, I think, to provide a basic knowledge of all the medical subjects. I go a step further and suggest he should specialize in one particular branch of his liking.....

**Chairman**: I don't think it will be advisable for him to specialize during his undergraduate course.

**Editor**: He may not know which to choose and pick.

**Gopalachari**: I feel and many agree that the aim of undergraduate medical course must be to produce a medical man with a basic grasp of the subject, able to make a correct diagnosis. But he must be also sincere and honest enough to own up that he doesn't know when he doesn't and to direct the patient to a better guy if necessary.

**Editor**: Some talked of self and others of service. I fear the prospectuses of medical colleges neither assures you of a safe earning nor expects from you selfless service. Medical education just provides the medical student with a basic knowledge of the art of healing and there is the whole oyster of a world before him which he, with this sword, can open.

### *The Present System*

**Chairman**: If we take that the purpose of medical education is to turn out intelligent and good general practitioners, with a broad idea of medicine, the question arises whether the present system serves the purpose.

**Muthamma**: I think the present system is grossly inadequate for the purpose we have defined. The "first years" and the "second years" live in a world of their own, a world of dead bodies, carefully formalined and preserved or at the most in a world of pithed frogs and rabbits. The hospital is a sort of *sanctum sanctorum* which we pre-clinicals are not allowed to enter. We hover like the spirits of the dead on the wrong side of the river Lethe and wonder as to when the ferryman will ferry us across. We must be taken to the wards right from the very beginning, from the very day we set our foot into the medical college. We must be shown the practical importance and application of the mass of theory we are learning in the first two years.

**Jayakumar**: Even on the clinical side, we are taught a fund of facts rather than the methods of examination. I think a study of psychology is not out of place in medical colleges because many of the diseases may have a psychological background.

### *Theory* vs. *Practice*

**Indumathi**: There must be more practicals and demonstrations than lecture classes.

**Ramachandran**: I suggest visual education, — the greater and more frequent use of the epidiascope, the lantern projector and the film. I suggest film divisions and film libraries.

**Ballal**: If we are to become good and intelligent general practitioners, I think we must know at least to give injections, to apply dressings and to do the commoner operations like hydrocele etc. I wonder whether the present-day medical student when he becomes a house-man knows that much. He has the four letters M.B.B.S. after his name no doubt, but he is entirely at the mercy of the nurses who know much better the practical side of things than himself. The student must practise giving injections and applying bandages on the patients posted to him. Moreover he must be allowed to assist in the operations.

**Saraswathi**: For that the student should spend more time in the hospital.

**Radha**: Necessarily so. I suggest internment in the General Hospital as is being done in the Maternity. I suggest the student be in complete knowledge of his patient from the time of his admission to the time of his



discharge from the hospital and even afterwards by instituting a close follow-up. I also think instead of having long three months postings under a few bosses, we can have shorter postings under all of them.

**Editor**: I feel the importance given to regional diseases is minimal under the present system. In a tropical country like ours, we must give more importance to Tropical Diseases.

**Chairman**: I am very happy that all of you have emphasized the practical side of things. That is as it should be because most of the theory must be perforce left to the post-graduate or the research scholar who may like to drink deep in the Pierian spring.

**Editor**: But a sound, solid, theoretical knowledge is essential to understand and appreciate the finer side of things.

**Ramachandran**: Moreover there is the danger of our being turned out into mere technicians.

### *The Teacher and The Taught*

**Chairman**: I do not decry theory at all but I say that it must be limited to the needs of the general practitioner whom we have taken as the goal of undergraduate medical education. But even when we have remoulded the present system nearer to our heart's desire, there is the important question of the teacher and the taught. Whatever may be the excellence of one particular system or other, I think a lot depends on them, the men who will be actually working out the system on the spot. And much depends I should say on the professor-pupil relationship.

**Ballal**: I have no quarrel with the teachers. They are all good.

**Chairman**: In what way?

**Ballal**: They are all highly qualified.

**Chairman**: Is that the only criterion?

**Kannan Kutty**: No doubt they do their job efficiently, the teachers their teaching and the students their cramming. But there is something missing. The soul....the personal touch.

**Saraswathi**: To bring about closer contact between the teacher and the taught, I suggest Residential Universities or at least Residential Colleges.

**Jayakumar**: Since many of the professors are also examiners, there is an innate fear on the part of the students towards these professor-examiners. This fear complex must go.

**Radha**: Another difficulty is that many demonstrators enter the various departments only to mark time till they are transferred to the hospital side or till they pass their post-graduate examination. If they don't succeed in either, well, they are down and out. Their work becomes a dull, drab routine and with their scanty pay, they can't even make both ends meet. It is no wonder they lose interest.

**Brahmam**: First of all, the pay of teachers must be increased. So also their numbers. I suggest we introduce the tutorial system obtaining in England for centuries where the tutor is in personal charge of some half a dozen of students, encouraging their observation. memory and clinical instinct. He is practically their friend, philosopher and guide.

### *Examinations*

**Chairman**: We may have established cordial professor-pupil relationship. But there is the thorny problem of examinations. Are they really necessary?

**Gopalachari**: Examinations are necessary as there is no other better method. The only alternative for examinations is more examinations.

**Brahmam**: Every month or so, on every portion done, the student may be examined. That will go a long way in reducing the stress and strain and help the students to be assessed all-round the year. Then examinations will tend to become less and less of a gamble. Moreover failures in examinations cost a lot materially and psychologically. The practice of failing candidates for want of one or two marks must go.

**Chairman**: But my idea is that there must be no failures. If there are failures, it reflects on the teachers.

**Editor**: I am afraid it is not only a question of the sower but of the seed and the soil as well. Those who go on persistently failing times without number are misfits. They must be persuaded to leave the course and take to some other line where their capabilities will be turned to better account. I am for limiting the number of appearances to any examination, be it three or thirty.

**Chairman**: I don't think there is any necessity for such extreme measures. I will suggest that a more rigid selection of students and more personal attention to failing students in understanding their particular difficulties and helping them over their weaknesses, will see to a great extent that there are as few failures in examinations as possible. Well, now, shall we go on to certain allied topics?



### *Cost of Medical Education*

**Editor**: Can we take up the cost of medical education?

**Brahmam**: The cost of medical education is simply enormous. It makes big holes in the small purses of many of our parants.

**Editor**: I suggest a scheme of "Earn while you Learn" programmes for relieving the financial burden on the family.

**Chairman**: Is it possible especially for the medical student to earn while he learns? He doesn't simply have the time.

**Editor**: Where there is a will, there is a way. The State and the Society must come forward to help such of those students who are willing to take up part-time jobs and mustn't look down upon them.

**Gopalachari**: But under the present circumstances, it will mean only more unemployment for others.

### *Vernacularization*

**Chairman**: Have you any ideas on vernacularization of medical studies?

**Gopalachari**: I think it is possible but must be proceeded on gradually and cautiously.

**Editor**: The fundamental question is whether vernacularization is advisable or not.

**Chairman**: It is not advisable for the present. When the whole population of our state is well educated, then it will be time to consider. Meanwhile, if we change the medium, international contact and progress of thought will be made difficult.

**Ballal**: Vernacularization will be helped if we are ourselves the original workers and if we think and write in our own tongue.

**Chairman**: Concluding this very interesting discussion, we have agreed that the aim of medical education is to turn out good, general medical practitioners and that reorientation of medical education is necessary, so that greater emphasis is laid on the practical side of the art and science of medicine. The art of medicine must be taught round the craft. A better cordiality between the teachers and pupils is highly desirable and special individual attention is necessary to help a failing candidate. I am sure that all medical educationists are thinking along these and similar lines and that soon we can expect a change for the better in the direction you have pointed out after much deliberation.

# Student Health

**Chairman**: We have elected to discuss in this session the subject of student health which has been assuming tremendous importance of late. Attention to health is an integral part of any sound scheme of education specially in a strenuous course of study as Medicine. Let us begin by defining Health ?

**Ramachandran**: I would say, a layman's understanding of health varies greatly from that of a doctor and I am afraid the construction a doctor places on health varies from that of a public health man. The layman is generally not bothered about health so long as he is up and kicking, the doctor is apt to view disease as an entity by itself and the public health man has begun to beat about the bush somewhere in between the two. Where it is all leading to, I don't know. But I think there is some sense in what they think, taken individually.

**Editor**: Like the seven blind men of Hindusthan, who went to see an elephant and described it, each according to his light ?

**Indumathi**: The Ancients have defined health as "a sound mind in a sound body."

**Radha**: Here obviously the public health man has not arrived yet on the scene. Otherwise we would have had something more on environment and society. Social medicine is only of recent development.

**Gopalacahari**: Modern conception of health is all comprehensive. The W. H. O. has defined health as "a state of complete physical, mental and social well-being". I think that gives quite a complete picture.

*Importance of Students' health*

**Chairman**: Having arrived at a definition of health, we as students have to think of our health in particular.

**Muthamma**: I wonder whether student health deserves special consideration and treatment apart from other problems of other people. Are we not tending to give too much importance to ourselves and to claim too much attention, if not sympathy ?

**Jayakumar**: Certainly not. The student passes through the growing age and several stresses and strains play on him during this peculiarly delicate period of life. Therefore, his health problem is of necessity different from others.



**Ballal**: Moreover, I venture to say without fear of patting ourselves on the back that the student is the cream of society and he deserves special attention and care.

**Gopalachari**: Exactly ! The great importance of student health and the role of students in the building up of a healthier and a happier world is recognised. The World University Service has taken up this question in right earnest and is rendering yeoman service to the student community at large. A tuberculosis ward for university students has already been opened in the Tambaram Sanatorium and there are, I hear, many more proposals in the offing.

**Kannan Kutty**: I will like to emphasize the importance of the medical student in particular. As one dedicated to the prevention and cure of other's ailments, as one who in this noble pursuit hazards contact with many dangerous communicable diseases, he has a right to expect that his own health should receive top priority.

**Editor**: But there is a great stumbling block in the proper discussion and organization of student health. I refer to the apalling lack of information and statistical data on the subject.

**Ballal**: Woeful state of affairs indeed !

*Deterioration Factors*

**Chairman**: But we can begin with a study of the factors that lead to the deterioration of student health ; for example, I cite the great physical and mental stress and strain during growing age, the multitudinous worries about examinations, finance, family and the future.

**Brahmam**: There is the other great factor of neglect—a personal carelessness which, in the minds of some, borders on heroism and the incorrigibly fatalistic attitude to life so characteristic of Eastern philosophy and thought.

**Radha**: I personally feel that the crime is not entirely one of the individual. What contributes to the undesirable state of affairs now prevailing is the utter lack of periodic check-up by the officials at the helm of affairs. The want of statistics referred to above is also a result of this neglect.

**Brahmam**: I reiterate my stand on individual responsibility. Cooped up in his room with his studies or outside in stuffy, smoke-filled cinema halls with luscious visions of Hollywood, exercise and yoga are thrown to the winds. It is always a case of neglect, neglect and neglect.

**Radha**: I would like to point out that even if there is the inclination, there are no facilities. Where are the playgrounds, the gymnasia, the stadia that we hear and read of as plentiful in foreign countries? After the weary succession of classes, where is the time or mind for play? To expect proper exercise and a robust physique under the existing conditions is foolish.

*Whose responsibility?*

**Kannan Kutty**: And it is even more foolish to lay it all at the doors of the student. When students fall sick, there are no arrangements for their hospitalization and treatment. All medical aid must be made free and adequate.

**Gopalachari**: Whose responsibility is all this—the state or the university?

**Ballal**: The state is, of course, responsible for any national health service and as an important part of it, students' health should be specially attended to.

**Editor**: We have at the outset decided that student health forms a distinct issue with its special problems. Planning of health must certainly go hand in hand with every scheme of education. Therefore, to provide a Students' Health Service is certainly the responsibility of the University.

*Students' Health Service*

**Chairman**: That is the recommendation embodied in the Goodenough Committee report. It holds that "it is the responsibility of the university to provide a properly organised student health service quite apart from any National Health Service." Shall we pass on to outlining the functions of such a Students' Health Service?

**Editor**: The first thing to be done is a special medical check-up of the students with particular emphasis on malnutrition and tuberculosis.

**Saraswathi**: Tuberculosis specially seems to have an unfortunate affinity to students. A special drive should be organised for detecting cases and free medical facilities like expert advice and treatment, sanatoria and rehabilitation must be provided.

**Gopalachari**: The organisation must make a special study of student health problems and help in the compilation, systematisation and dissemination of statistical data related to student health. It will provide a mine of useful information when subjected to analysis on an almost unexplored field of investigation of a group living through one of life's most critical ages.



**Editor**: It is all a question of co-operation between the students and professors on the one hand and the University and Government on the other.

**Chairman**: Well, we have discussed most of the aspects of the problem of student health. It only remains for me to sum up. The ancient conception of a sound mind in a sound body serves to define health wonderfully. To maintain such a state of positive health, during the strenuous periods of a medical student's life, is the combined responsibility of the student, the state and the university. The University can help by providing the proper atmosphere of mental and moral cleanliness in its institutions and instilling a positive attitude towards health. The State and the University must combine to provide proper recreational facilities for its student population,—and specially so for the medical student, who, as you have so well pointed out, is exposed to greater risks. Periodic, well-organised, medical check-up with facilities for treatment of any detected ailments, and making available of a positive advice on health problems are very essential for good health of students. Lastly the students themselves must take a pride in being healthy and robust. Unfortunately this tradition of the body beautiful that existed in our land has disappeared from our schools and colleges. This has again to be built up. Thus by co-operation of the state, the student and the university, much can be done towards our objective of positive health.

——★——

SAYONARA—

Of all the good-byes I have heard, the Japanese *sayonara*—"Since it must be so"—is the most beautiful. Unlike *auf widersehen* and *au revoir*, it does not cheat itself by any bravado "till we meet again," any sedative to postpone the pain of separation. It does not evade the issue like "farewell," which is father's good-bye—"go out into the world and do well, my son." It is encouragement and admonition, but it passes over the significance of the moment; of parting it says nothing. "Good-bye" and *adios* say too much: they try to bridge distance, almost to deny it, Good-bye is a prayer: "You must not go—I cannot bear to have you go! But you shall not go alone, unwatched. God will be with you." But *sayonara* says neither too little nor too much; it is a simple acceptance of fact. All understanding of life lies in its limits; all emotion, smouldering, is banked up behind it. It is the unspoken good-bye, the pressure of a hand, "sayonara".

—*Anne Morrow Lindbergh, North to the Orient (Harcourt, Brace).*

# Extracurricular Activities

**Chairman**: Today's subject for discussion is Extracurricular activities, which are as variegated and as numerous as are the individuals, as the sands on the seashore. Perhaps the saying "one man's food is another man's poison", is truer in the case of extracurricular activities than in any other form of human endeavour, but before we go further, will some one define for us extracurricular activities?

**Radha**: I for one will take extracurricular activities to include all activities other than strictly curricular.

**Editor**: Which may be physical or mental.

**Kannan Kutty**: The important thing, I think, is that they must afford relaxation.

**Lt.-Col. D. S. Iyer**: How does activity cause relaxation? After the day's work is done, if you recline in an easy chair, that may be excellent relaxation but it may not constitute an extracurricular activity. Any extracurricular activity must be capable of relieving the monotony and drudgery of a dry routine life. It depends naturally on the type of work one is doing. A purely mental worker, a professor, for example, may take to gardening with profit and pleasure whereas a manual labourer may find interest in reading and following the trends of the world across banner the headlines of the newpapers.

**Chairman**: That brings us to the importance of extracurricular activities. They not only relieve us of the monotony and drudgery of life, as Col. D. S. Iyer so aptly puts it, but also act as fruitful outlets of surplus energy and help in the development of the vast potentialities of man. In short, they help to discover and develop ourselves and the best time for cultivating an extracurricular activity of our liking is, I think, during school and college life.

### *The question of time*

**Ramachandran**: But the general complaint, at least in our college, is that there is no time for anything except studying textbooks.

**Indumathi**: I am in full sympathy with those unfortunate few who fight against time and complain that a day after all consists of only 24 hours. But nobody reads all the 24 hours and we can easily allot a certain amount of time especially in the evening for extracurricular activities.



**Jayakumar**: The difficulty I fear, is not so much the lack of time but a general lack of knowledge or misconception about the proper, constructive utilisation of leisure. People who do not know how to use their spare time grow into introverts and even neurotics in later life.

**Ballal**: I think the complaint against time doesn't hold much water. We may not have lots and lots of time to ourselves but scattered throughout the day we find tiny little islands of leisure which we can use to our fullest advantage.

**Editor**: I will like to draw your attention to the very real danger that is being overlooked in our enthusiasm for extracurricular activities, namely, the danger of their assuming greater importance over curricular activities themselves and exacting a large slice of our time as their due. Medicine is a jealous mistress indeed and so long as we remain her lovers, she may not tolerate our winks and glances at wayside maidens, however glamorous they may be.

### *Constructive and purposeful*

**Chairman**: But I take it is generally agreed that there is some time for extracurricular activities. Shall we pass on to an examination of the activities themselves?

**Lt.-Col. D. S. Iyer**: I will like to lay it down as a fundamental principle that extracurricular activities must be constructive and purposeful and as we belong to the medical profession, they must be such as to add lustre and bring greater glory to the profession. Moreover since after your collegiate career the professional demands are great and exacting, I, will suggest to you to take up such activities as will go to stimulate and strengthen your knowledge of medicine. For instance, if your hobby is photography, instead of wasting time in taking useless photographs of groups of friends, birds and trees, you can collect an album of clinical photographs of interesting cases that you may come across in the hospital with legends attached to them for future guidance and reference.

### *Social Service League*

**Chairman**: Lt.-Col. D. S. Iyer has put forward the ideal principles underlying the choice of an extracurricular activity and he has given the brilliant example of how a simple hobby like photography can be harnessed to augment our professional knowledge. I think the formation of Social Service Leagues is another example.

**Ramachandran**: It is a pity that whereas other medical colleges like the Vellore and the Stanley are having Social Service Leagues, our college doesn't have one.

**Kannan Kutty**: It's a question of funds, I suppose.

**Indumathi**: How have the others managed the necessary funds? I think it is a question largely of enthusiasm. Students must be fired with a missionary zeal for service amongst the sons and daughters of the soil. I will even go to the extent of suggesting a compulsory form of social service, only after undergoing which the university shall award the degrees to the graduates.

**Editor**: An idea I won't commend—I see no meaning in whipping a dead horse. Compulsion in any sphere kills spontaneity and initiative that should characterize the highest and noblest forms of human effort. And after all every one may not be as interested in social service as we are and we have got to make allowance for them.

**Chairman**: What's the nature of work that you expect these College Social Service Units to turn out?

**Indumathi**: In the first place, the unit must be properly staffed and manned, mainly by senior students and a few doctors and nurses from the hospital. It must be provided with the commoner drugs and dressings and a mobile ambulance van. Visits can be made to the neighbouring villages or the city slums where diseases can be diagnosed and minor ailments treated. Patients who need hospitalization can be directed to the hospital.

**Jayakumar**: That's not all, I will like to emphasize the preventive side of things. Villagers must be taught the fundamentals of Hygiene and Preventive Medicine. They must be taught clean and healthy personal habits and the importance of environmental sanitation.

**Chairman**: I will like to draw your attention to the need for a proper relationship between the Social Service worker and the villager, which is very important. Many of you may have seen in the Information Films News Reels gorgeously dressed ladies and gentlemen distributing food and clothing to the half-naked villagers on the verge of starvation. What a glaring contrast in their conditions is being emphasized by such dress and demeanour! No wonder the villager, though he receives the food and clothing with thanks, doesn't feel at home with the visiting sahibs from the city but burns with an inborn animosity towards them. The important point is that the social worker must obtain the confidence of the villager before he does anything else.



### *National Cadet Corps*

**Ballal**: I think the National Cadet Corps forms yet another purposeful and constructive activity.

**Indumathi**: We will like to know its aims.

**Ballal**: The aims of the Corps are threefold, *viz.*, to develop character, to give a training for leadership and to build up a reserve of Army Officers for times of national need and emergency. It does a lot of good to our muscles as well as our minds. Especially the annual camps we have are rich lessons in corporate living. And, mind you, it has absolutely no strings attached to it, no obligations to be fulfilled in the future. It is a purely voluntary organisation. It is a pity however that the Madras State which is forward in so many aspects, has not thought fit to start a Girls' wing of the N.C.C. But, before blaming the Government, I will like to know the inclination of the ladies.

**Radha**: I am for the starting of the Girls' wing of the N.C.C.

**Indumathi**: I welcome it.

**Meera Bai**: I will join it and exhort others also to join.

### *Debates, dramas, discussions*

**Editor**: Shall we take up some extracurricular activities in the College itself, like the activities of the College Association?

**Jayakumar**: My ideas about a college association and its functions are entirely different from those obtaining here in our college. Standing for elections, conducting a Graduates' Reception at a prohibitive cost and arranging two addresses a year, an inaugural and a valedictory—that in short, sums up the activities of our College Association. My idea of a college association is that it must hold the mirror unto the manifold talents of the various members and offer a free scope for the development of the same. Our college can have a debating society, a dramatic society, a clinical society and so on.

**Lt.-Col. D. S. Iyer**: We may have debates, but who will attend?

**Radha**: The interested few, even though it may be only a handful. We want inspired leadership from the staff. Students' interest in these activities will grow once the imagination is roused and becomes alive to the immense possibilities that lie ahead of us.

**Editor**: I visualize a time, not in the far dim future, when our college campus and its common hall will not be dead and silent as a grave as they are now after 4 o'clock but be humming with dance and music, debates and discussions, play and festivity, long after the sun has set. I do not say all the students will take part in all the extracurricular activities but every student will find some activity or other to his or her liking, in the pursuit of which they can discover and develop their talents for play, public speaking, histrionics or art.

**Indumathi**: Extracurricular activities should not be confined to college alone but must be carried into home also.

### *Politics?*

**Chairman**: There remains one extracurricular activity, rather a controversial one, in which more and more students are getting interested. I refer to Politics. The question is whether students must take an active part in it.

**Ballal**: I am all for students keeping themselves well-informed about things happening around them, but I strongly deprecate the idea of their taking sides.

**Editor**: Politics is a dirty, messy cesspool. I am against students entering it and getting themselves caught unawares. Especially medicine and politics are poles apart. Even in later life I will suggest doctors to keep off Politics.

**Chairman**: We have the question of "The Future" to discuss later, so perhaps it would be a good place for me to sum up what we have said on 'Extracurricular activities'. I am glad to note that we are all agreed that there is time for extracurricular activities. The facilities for extracurricular activities are woefully inadequate. All may not be interested in athletics and it is but right that your college association provides channels for the development of talents which are so plentiful amongst medical students. With enthusiasm, lots can be achieved and I am sure the staff of the college are always ready to help you and join you in your activities to make life fuller and more worth living.

—★—

*Facing Camera* (*L. to R.*)—Lt.-Col. C. R. Krishnaswami, M.S. Lt.-Col. D. S. Iyer, M.S., F.R.C.S. Dr. B. Ramamurthy, M.S., F.R.C.S. R. Ramamurthy. Miss K. Sarojini. V. Jayakumar...

*We heard the thundering of C. R. K.*
*We listened to the music of Iyer's tongue.....*

# The Future

**Chairman**: This is our last meeting and we will discuss "The Future." I am sure you must be having some ideas on your future and it will be interesting to hear what you will like it to be. After all, it is the ambitions and ideals of to-day that become the realities of to-morrow. Graduation from here leads you to the cross-roads and, of the many ways that stretch before your eyes, you will have to make up your mind which to follow. Say for example, which would you prefer,—setting up private practice, enlisting in the Armed Forces, joining government service, going to the villages or specializing . . . ?

*At the cross-roads*

**Ramachandran:** I think I will enter government service. It holds out security and an opportunity to gain experience without the attendant risk. I fear I may be too inexperienced to venture on private practice immediately after graduation. As for the army, an emphatic "No." I don't like the business of war at all.

**Kannan Kutty:** I am not very positive about what I would like to be in the future but I am definitely against the idea of going to the villages for there are better amenities in towns.

**Meera Bai:** To eke out one's livelihood,—that is the great problem of the future. You must have the wall before you think of painting on it. The young, raw, inexperienced graduate is not the fellow to be asked to go to the villages when there are more competent men at the top who have had their day, who have made their reputation and who are sure of their livelihood. Any Rural Medical Service programme must begin at the top,—the top men must show us the way.

**Jayakumar:** A general practitioner,—that is what I will like to be, with a small hospital of my own. I am not for the army or government service.

**Chairman:** Why not government service? There seems to be a lot of hankering after it nowadays.

**Jayakumar:** I want some amount of independence and that is exactly what I will have to sacrifice if I enter the army or the government service. I fear to be buried in a mass of red tape and get caught up in the cogwheel of that big machine where human beings are not individuals but just tools . . . Independence and real service—only private practice can ensure that.

**Lt.-Col. D. S. Iyer:** Let us not blind ourselves to some practical aspects of the problem in chasing the will-o'-the-wisp of independence. Experience in the army has very great value. The Army will make disciplined men and women out of you. You learn to control and manage your subordinates and that stands you in good stead when you run a nursing home of your own.

**Brahmam:** Moreover, there is the financial aspect. The Army offers a higher pay than any other service. A judicious saving from it will be helpful when we start a clinic of our own. The good training that is offered and the self-confidence that is induced in you,—there is a lot to be gained from the Army.



**Editor:** I will prefer to stick on to our General Hospital where, day in and day out, you have the excellent opportunity of rubbing shoulders with the kings and captains of your profession. To live and work with the master spirits of the age is a rare privilege indeed and I will certainly not like to exchange it for any lucratives practice outside. I will like to specialize . . .

*Motives analysed*

**Lt.-Col. C. R. K.:** I have been at some pains to analyse the motives behind your going in for this or that. Many prefer government service because it offers security in what is otherwise a gamble. Then there is the glamour associated with certain places and people, institutions and the like. In government service there are set holidays and leisure hours and more than all these, the opportunity to work with better facilities and without risking your reputation; to carry on experimentation and research the do not endanger your income. But with all these, you must slip out of government service at the psychological moment,—just before you loose your initiative and become routine cogs in the wheel. As regards Army life, during war time it is exciting and educative,—better pay, disciplined life, good work etc. But in peace time, it tends to be dull and monotonous. A word about specialization. I think it must come only after general experience for about four or five years. Look round the whole field first, then choose a spot and pitch your tent. I will not go to a village myself to plough a lonely furrow in a barren land. The environment must have to change first and be more attractive before I think of going to the villages myself or advising others to follow suit.

**Chairman:** Can't we create the environment when we go there?

**Lt.-Col. C. R. K.:** No, people say that going to the villages is service to the country. I say, service to yourself first, then it will be time to attend to others. In the rural areas, with no proper roads, you will have to break your neck trying to travel from one part to the other. There is no electricity. Worst of all, you are practically lost to the world and what is happening outside. Certainly not a bright prospect to be stranded like Robinson Crusoe on a little island.

**Brahmam:** One can join the army short service commissions. After having made some money, one can open a private hospital. Or better still some four or five can join together on a co-operative basis.

*Co-operative Co-prosperity*

**Lt.-Col. D. S. Iyer:** That is what I saw in a Calcutta clinic recently. Six doctors have joined together, gathered share capital from some hundred influential members of the locality and opened a Nursing Home in Calcutta.

The share holders are given 12% interest on their capital. One of the six will be the R.M.O. looking after emergency cases. He will be paid some amount as salary. The scheme is sound and is working all right.

**Lt.-Col. C. R. K.:** More than cartels or corporations being formed in the city, such a co-operative clinic will be the ideal answer to the rural medical aid problem. I am convinced that it is the only salvation for villages. A central place common to a group of villages, provided with all the modern amenities of life; a batch of disciplined young graduates working on a sound co-operative basis; a modest capital,—these are all that are needed, as I have made clear in my "*Blueprint for Co-operative Co-prosperity*".

### *Nationalization of Health Services*

**Editor:** Will not Nationalization of Health Services answer the problem better and permanently?

**Lt.-Col. C. R. K.:** I am awed by the word "Nationalization". I am not in favour of it. Particularly in our country, I don't think it is possible.

**Lt.-Col. D. S. Iyer:** I am for nationalization. For one thing, it does a lot to eliminate the large degree of quackery that is prevailing now in our country. And what about the huge problems like malaria, tuberculosis, leprosy etc.? No private practitioner or groups of practitioners can ever attempt to tackle them. Nationalization will help to fight these huge problems on a gigantic war footing.

### *Certain trends*

**Editor:** Shall we pass on to certain trends that have been rearing their heads of late in our profession? I refer to the disappearance of the family doctor, the decline and fall of the general practitioner and the phenomenal rise of the specialist. Do they forbode any good?

**Chairman:** I am sure that these trends have not yet appeared in our country. They may apply to an advanced country like America but in our country the need of the hour is more doctors,—general practitioners as well as specialists. We are woefully lacking in both have roles to play for a long long time to come.

### *Between the Scylla of Politics and Charybdis of matrimony*

**Editor:** I will like to refer to yet another alarming trend, *viz.*, the desertion from the existing meagre ranks. I am afraid men doctors fall easy victims to the Scylla of Politics and women doctors to the Charybdis



of Matrimony. Can anything be done to prevent this migration into the parlours of politics? I think it is high time we start a "Leave-not-your-profession" campaign.

**Brahmam:** I fear an unduly exaggerated picture of the situation has been rather vividly painted before you. Moreover the number of men doctors who enter politics and women doctors, matrimony, throwing their profession to the winds, is rather negligible. But it beats my imagination how on earth we can prevent them.

**Lt.-Col. C. R. K.:** Is it not man's birthright to practise whatever profession he likes? And, after all, a doctor, in his fortieth year, may discover he is more interested in Politics than in Medicine. By all means, let him go, it does no harm. But I must emphasize that Medicine is a jealous mistress and if a doctor hankers after the limelight or Politics, he must give her up.

**Lt.-Col. D. S. Iyer:** After all, it is not so bad for a doctor to enter Politics. We certainly want some doctor-politicians in our midst who will be the guardians of our professional interest and keep an ever-watchful eye over our profession. Rarely does a hardboiled politician understand the peculiar difficulties that confront our profession and rarer still to redress them.

**Editor:** What about women doctors who once they get married forget all about their profession?

**Brahmam:** I fear again the percentage is negligible and nothing need or can be done in the matter.

**Radha:** I refute the allegation as baseless. I don't think it is necessary for a lady doctor who gets married to forsake her profession.

**Editor:** But it does happen. Especially in those cases in which a lady doctor happens to marry a layman. More often than not, he fails to appreciate his wife administering to the needs of the patients rather than to his own personal comforts. And the result is one more desertion. Will not marriage between members of the same profession help in the matter?

**Brahmam:** If this suggestion is carried out, apart from its sheer impracticability, and impossibility, it will help to create one more class of people in this country which is already over-riddled with countless classes. I am strongly against it.

**Lt.-Col. D. S. Iyer:** Marriage depends on individual choice. A hard and fast rule cannot certainly be enforced. However if your wife happens to be a lady doctor, I am not sure whether it will be of any help to the

profession but it will be of help to you for she may be your anaesthetist or laboratory assistant or the like. I am sure our Chairman is in a position to enlighten us in this matter.

**Chairman:** Well, if a girl happens to be as good, sweet and kind as my wife, and if the boy and the girl like each other, I don't see any reason why they should not get married.

**Jayakumar:** The vital question is whether you like. It can't be forced down your throat. I personally don't like marrying a lady doctor but I fear some of us will have to help them lest they remain spinsters for life.

**Chairman:** We have had an extremely interesting discussion on the Future, ranging from personal ambitions to politics and matrimony. I should say it has been a very interesting discussion and has given us the opinions of all levels of medical profession, ranging from the inexperience of preclinical studies to the studied wisdom of veterans like Lt.-Col. C. R. K. and Lt.-Col. D. S. Iyer. All of us must thank them for giving us this opportunity to meet them and get their suggestions. The exact future chosen by an individual doctor will depend on his mental make-up, spirit of adventure, and his ability to maintain himself. There is no need to fight shy and try to hide the fact that all of us want a living wage with some amount of security before we talk of service to the country. As regards Nationalization, it is futile to talk of it now till there is enough medical aid going round to be nationalized. In conclusion, I may say that wherever a doctor is placed or whatever path he chooses, he has a large part to play in treating and preventing diseases and in educating and moulding the society round him and he must be determined to play it well.

——★——

**FOOTNOTE PHILOSOPHY—**

"God has committed some work to me which he has not committed to another. I have a part in a great work; I am a link in the chain, a bond of connection between persons. He has not created me for naught. I shall do His work."

*—Cardinal Newman.*

* * *

Have a real reserve with everybody and a seeming reserve with almost nobody; for it is very disagreeable to seem reserved, but dangerous not to be so.

*—Lord Chesterfield.*

# Opinion Quiz

**WILL YOU LIKE TO WRITE TO YOUR EDITOR ON THE FOLLOWING POINTS?**

1. Q: *Do you like the idea of the Forum? Will you like it to become a permanent feature of our college activities?*

   A:

2. Q: *What useful purpose in your opinion will be served by such discussions?*

   A:

3. Q: *This time the Forum had a Chairman from the staff. Do you prefer the idea of a rotating chairmanship from among the student—participants themselves with observers from the staff or will you like the present system to continue?*

   A:

4. Q: *This time two students,—a lady and a gentleman,—from each year of study and a house-surgeon were invited to take part in the discussions. Will you like to suggest any other way of constituting the Forum?*

   A:

5. **Q:** *Which is better, in your opinion: discussions held in camera or thrown open to all?*

**A:**

6. **Q:** *Certainly, you'll be having your own views on the subjects discussed this time. May we know what they are?*

**A:**

7. **Q:** *What subjects will you like to be discussed next time by the Forum?*

**A:**

8. **Q:** *Finally, if invited, will you like to become a member of the next Forum and take part in the deliberations?*

**A:**

**Signature:**

**Date:**

**Year of Study:**

## Estimates:

"A leader of his people, unsupported by any outward authority; a politician whose success rests not upon craft nor mastery of technical devices, but simply on the convincing power of his personality; a victorious fighter who has always scorned the use of force; a man of wisdom and humility, arrived with resolve and inflexible consistency, who has devoted all his strength to the uplifting of his people and the betterment of their lot; a man who has confronted the brutality of Europe with the dignity of the simple human being, and thus at all times has risen superior. Generations to come, it may be, will scarce believe that such a one as this ever in flesh and blood walked upon this earth."

*—Albert Enistein on Mahatma Gandhi.*

"Winston Churchill is a living defiance of all the ordinary rules of human existence within the confines of history. He is one of history's immortals—immortal because of what he has done, and immortal because of the superb record he has made of his achievements and his time. In this aspect of his fame—and it is only one aspect—he ranks alongside Thucydides or Caesar. In another aspect—as an innovator in the art and practice of war—he probably ranks alongside Alexander. In yet another aspect, as the defender and unifier of his country in a time of peril, he ranks in British history besides the younger Pitt, in world history along with Belisarius or Abraham Lincoln. And today in his memories and his achievements he strides a tremendous bridge between the present and the past, the living and the dead. He was, and is, living history."

*—John Connell on Winston Churchill.*

## *Insults:*

"Underground we have coal for 600 years. Above it we have Mr. Shinwell. Reversal of these positions would solve our present troubles."

—*R. A. Whitsum in the Yorkshire Post.*

"I am not going to blame the secretary of State. That would be unfair, and it would be assuming that he knows what goes on in his department.

—*Colonel Wigg, M.P.*

"In the Commons, truth must be tempered by expediency. That is not to say that we tell fibs. But we practise a due economy in the utterance of truth."

—*W. J. Brown, M.P.*

"As a Scot I do not overrate the intelligence of the English, but I admire their solid characteristics and their honesty. Stupid they may be, but they never panic."

—*H. McKinnon Adams, in a letter to the Scottish Sunday Express.*

"You must not miss Whitehall. At one end you will find a statue of one of our kings who was beheaded; at the other, the monument of the man who did it. This is just an example of our attempts to be fair to everybody."

—*Sir Edward Appleton at a Stockholm luncheon.*

"During the first scene last night the curtain came down for no apparent reason. Unfortunately, it went up again."

—*Cecil Wilson in the Daily Mail.*

"What he said was irrelevant; but I didn't interrupt it because it carried so little weight."

—*The Speaker on Mr. Platts-Mills, M.P.*

"That stroke of Toshack's reminded me of an old lady poking at a wasp's nest with an umbrella."

—*John Arlott in running commentary on the fourth Test Match.*

# Some Factors About Hypertension

Dr. K. RAMACHANDRA, M.D.

THE fashionable disease of the day in the aristocratic circles of society swings towards Hypertension replacing Appendicitis, which was once considered the most popular disease. Axel Meinthe, the great Italian Physician who practised in the highest rungs of society, became popular by introducing a label known as Colitis, which spread like an epidemic among his clientele. Not to suffer from hypertension has also become a disease as the nobleman feels ashamed of himself in the society of hypertensives. At the age of forty to fifty years, the term "High Blood Pressure" hovers in the minds of the well-to-do and by itself leads on to various forms of Neurosis—Cancer is a disease and the fear of Cancer has become a greater disease. In the same manner, Hypertension and the idea of developing Hypertension have become greater scourges to the population. More than these factors is the "doctor-created-hypertension". The doctor who warns his patient to be careful and moderate in his activities, food and frivolities at the age of forty or fifty years as a prophylactic to prevent the development of vascular tension has contributed a great deal to the stress and fear in families where no such warning is required. The undue precautions taken by the laiety have created a fear in the educated and partially educated populace that hypertension is an inevitable sequel in the absence of a regulated and ritual life, a life devoid of the pleasures and passions. Such a strict ritualism has contributed more to the genesis of hypertension rather than towards its annihilation. We come across individuals who have taken up to vegetarianism due to this fear and who have given up eating eggs, meat, sometimes even salt so essential for the metabolism of individual cells. Greater fanatics have been giving up supper or have introduced "miss-a-meal-a-day" in order to combat this demon and what is the result? Many more diseases have preyed upon them, diseases of malnutrition, Cirrhosis Liver, Tuberculosis etc. More than organic diseases, mental conflicts have occurred due to the compulsive avoidance of essential foods leading to the development of hypertension.

So it is advisable not to be unduly careful about the essential requirements but to be calm about the incidents and episodes in life, to cultivate the habit of being insensitive to the pain and pleasures of life rather than introducing a regime which may prove detrimental to the body and the mind. Even this is not a practicable piece of advice as individuals cannot acquire a thick skin but can only be born so. To be sensitive by nature is always a handicap and contributing to such a personality are the family background and the environmental factors which have operated in his youth, at home and at school. Boys have also been trained in Indian homes with the utmost gentleness that later in life the man becomes unfit for society, especially if he happens to be the sole heir to the family. The children in Indian homes should be treated well but not with reverence or sacredness. They should have the proper education under suitable conditions of liberty and freedom for their minds to develop. It is often noted that children are dealt with too strictly by parents or fondled too fondly and gently, both contributing later to maladjustments in life and if he does not become a lunatic, he becomes a hypertensive. Boys brought up far away from home in a hostel or boarding school have been better off in life than those who lived with their parents.

Turning to the poorer elements of society, the middle and the lower classes, hypertension has an equal preponderance. To each class of society, factors exist which contribute to its incidence. The struggle for existence in the middle class, the burden of taxation, the heavy mental and physical fatigue endured and the many unhappy incidents in their homes have shattered the equilibrium in the vascular system making it vulnerable to disease. Children in such families have suffered from the results of such discord and chaos among parents in early life, manifesting them later on as a vascular disease. Indian families are so constituted that litigation is rampant, adding to the economic burden of the family, throwing the individual into the throes of insecurity and unhappiness. These vicissitudes which the lower classes suffer greatly contribute to this disease.

In every walk of life at the present day, there exists the feeling of insecurity, the feeling of jealousy and hate—whether he be a businessman, labourer or of any other profession; whether he be rich or poor. The incidence of hypertension is thereby increased. The contributing factors are:

1. Family background.
2. Environmental factors.
3. Type of individual.



Essential Hypertension is in every respect a Psycho-Somatic disease with a particular type of personality in the background—the tense, aggressive, ambitious, insecure type, who tends to worry unduly but does not give way to his emotions. Beneath an energetic, confident exterior, many of these patients harbour an emotional insecurity.

There has been a common finding in all countries hypertension runs in families, adding the genetic background to its aetiology. Many brothers have died at the same age and of the same disease of hypertension. Fathers and sons and grandsons have all died of Congestive Heart Failure, corroborating the layman's words that heart disease runs in families.

**What Initiates Hypertension?** Psycho-somatic factors are alone responsible, the other factors such as Kidney, Endocrines etc. are only contributary or may be intermediary in its development and persistence. So far as is known, the Hypothalamus is the seat where all psychosomatic influences act, irritating the sympathetic nervous system as a protective phenomenon. Fear, anxiety, frustration all have to be counterbalanced and the only mechanism available during waking hours is the induction of sympathetic stimulation. This leads to vaso-constriction of all peripheral vessels, and the increased outpouring of a pressor substance from the Adrenal medulla, Adrenaline, which further increases the vascular tonus As these psychosomatic factors fail to operate, the vessels again relax and the blood pressure falls. So paroxysmal rises of blood pressure always precede the permanent stage of hypertension. The secondary factors which control the maintenance of blood pressure are

1. Sympathetic nervous control,
2. Hormonal control,
3. Reno-humoral control,
4. Intrinsic vascular control,

each one being intimately related to the others.

The paroxysmal rises of blood pressure ultimately lead to vascular damage which, involving the renal cortex, may lead to the persistence of high blood pressure. Rennin, a hormone secreted by the ischaemic renal cortex, has a pressor action maintaining the blood pressure at high limits. This leads to further vascular damage as the vasculature has to compensate for the increased tension on its walls. This is brought about by the hypertrophy of all the layers of the arterioles with reduplication of internal elastic lamina, producing the condition known as diffuse

hyperplastic sclerosis of Jones and Evans or arteriocapillary fibrosis of Gull and Sutton. So, eventually, the peripheral arteriolar bed progressively diminishes, with a decrease in the blood supply to the various tissues and organs.

The musculature in the vessel wall loses its function of contractility as a result of rigidity or lack of suppleness of its wall. If the musculature is still intact, the sustained blood pressure is liable to vary from time to time depending on the psychosomatic influences which continue to act upon the controls. Many and varied symptoms result from such a labile blood pressure which may prove fatal at any stage. The spasmodic contraction of the vessel cuts off the blood supply to vital organs and deprivation for a sufficiently long time leads to pathological changes. Damage to the vascular area is often noted in the cerebral, ocular, cardiac, and renal tissues. Characteristic sequelae and episodes occur due to vascular occlusion.

| | |
|---|---|
| *Cerebral* : | Encephalopathy. |
| | Thrombosis |
| | Haemorrhage. |
| *Ocular* : | Retinal damage. |
| | Optic atrophy. |
| *Cardiac*: | Left Ventricular failure. |
| | Congestive failure. |
| | Myocardial fibroses, arrhythmias. |
| | Angina Pectoris, Coronary Thrombosis. |
| *Renal*: | Nephrosclerosis. |

Other syndromes produced are not so common and are rarely met with.

**Pheochromocytoma**: Much work is being done in fixing the aetiology of hypertension. Many cases are passed off as essential without proper investigation being done to exclude the classical causes which are often rare and met with occasionally, such as

1. **Endocrine disorders**: Pituitary Basophilism.
   Thyrotoxicosis.
   Menopausal hypertension—Hypogonadism.
2. **Renal causes**: Chronic Nephritis and other forms of renal damage.



Chromaffinoma of the Adrenals is a condition which can give rise to hypertension without any disturbances in the general frame of the individual, differing from other endocrine disturbances. Such tumours are referred to as Pheochromocytomas and are said to arise from the Sympathetic-formative cells. These may be found in Adrenals and also in extra-adrenal locations. The characteristic feature of this tumour is the paroxysmal secretion of Adrenaline under some definite stimuli such as fear, anger, exertion, exposure to cold etc., With paroxysmal rises in blood pressure. This "Adrenal-sympathetic-syndrome" gives rise to a variety of subjective symptoms as throbbing in the head, precordial pain palpitation, epigastic discomfort etc., which last for a few minutes to more than twenty-four hours.

Various diagnostic techniques have been described in the detection of these chromaffin tumours which are extremely elaborate, requiring the use of many drugs which stimulate the outpouring of Adrenaline.

**Piperidyl methyl Benzodioxane Test**: The substance is infused intravenously into patients with hypertension. Where the cause is pheochromocytoma, it produces a depressor effect. In other cases, there is a pressor effect. This test is very valuable separating the so-called essential hypertension, which at present is seen quite frequently in young individuals. Without the test, it may be impossible to separate out those individuals with pheochromocytomas.

**Histamine test**: Injection of Histamine (0.05 mgms. I. V.) produces a rise in bloodpressure individuals having pheochromocytomas instead of a fall in blood pressure normally noticed. In the same way, T. E. A. B. produces a rise in blood pressure in individuals with the tumour.

**Mecholyl**: produces a similar response, in spite of its being a depressor drug.

With the above tests described it would be easy to diagnose pheochromocytomas, surgery would be very beneficial in these individuals hitherto being treated with various vasodilators or lumbo-dorsal sympathectomy. Bearing in mind the existence of this condition and the increase in the incidence of hypertension, it is but to correct to investigate the cases of hypertension for pheochromocytomas instead of labelling all of them as Essential Hypertension. The development of hypertension in the younger age group, referred to as malignant hypertension, whether paroxysmal or sustained, is the one which should be eyed with suspicion as being due to chromaffinoma. As better techniques are available, the percentage of Essential Hypertension will be considerably lower than at present and the majority of them will be curable by surgery.

——★——

# Psorospermosis Follicularis Vegetans

Dr. K. S. SUBRAMANIAM, M.B.B.S.

*(Department of Dermatology, Govt. Genl. Hospital.)*

## (SYN. KERATOSIS FOLLICULARIS; DARIER'S DISEASE.)

THIS rare clinical condition is described briefly, after which a case is reported—perhaps the first proved case of this disease in the skin department of this Hospital.

**Historical:** The condition was first described independently by Darier and by White in 1889. Darier thought that the cause of the disease was a parasite in the nature of a coccidium and he therefore called it a 'Psorospermosis'. This was disproved a few years later when the supposed organisms were shown to be imperfectly keratinised epidermal cells.

**Definition:** It is a chronic skin disease characterised by the development of follicular hyperkeratotic papules and an abnormal keratinisation of the epithelium.

The disease is very uncommon in dermatological practice. The incidence of the disease is greater in the male. Familial out-breaks have been reported, lending support to the view that the disease may be a congenital abnormality. It usually commences in the second decade of life.

**Aetiology:** We do not yet know the exact cause of this disease. The view that the peculiar large round cells seen in the epidermis are a result of virus infection, has not been established. More recently, the observation of Peck and a few others that in most cases there is gross deficiency of serum vitamin A and the fact that many of them respond to massive vitamin A therapy, is strong evidence that a deficiency of vitamin A is an important factor though certainly not the sole cause of the disease, for, not all cases of vitamin A deficiency develop the disease, and not all cases of this disease respond to this treatment. It has been suggested that there is an impairment in the formation of vitamin A owing to some liver dysfunction in many of these cases.



**Pathology:** The main feature appears to be a "lack of cohesion" between cells of the deeper layers of the epidermis along with premature keratinisation of the cells in these layers. The histological changes are therefore predominantly epidermal.

It would appear that certain splits or 'lacunae' are formed in the region of the prickle cell layer. In this zone, the nucleii of some cells undergo disintegration so that the cells appear homogenous, and possess a highly refractile cell membrane. These are the cells which have undergone premature keratinisation and are called the "Corps Ronds" of Darier. These cells may be present even as superficially as the horny layer. Along with these are found certain shrunken cells which are often nucleated, and called "grains". In the more superficial layers, these grains are mixed with ordinary thickened horny epidermal cells to form the top of the crust. The condition is not essentially follicular. Some degree of acanthosis may be present which accounts for the presence of occassional tumor-like masses.

The papillae in the dermis are hypertrophied.

**Clinical Picture:** The primary lesion is a papule of about the size of a pinhead with a greyish or brownish crust on top, on removing which a minute pit is left behind. Some suggest this is a dilated sebaceous orifice.

The lesion first appears over the face, especially over the naso-labial furrows, the scalp, and the neck. They then spread over the chest, arms, small of the back, sacral region and down the thighs and legs. The papules are discrete at first, but may coalesce later to form plaque like lesions. Sometimes they form fungating masses in most regions like the perigenital areas and axillae, giving off an offensive odour. There is never any loss of hair. The hands and legs including the palms and soles also show generalised hyperkeratosis. The nails are usually fissured and thickened. The buccal cavity rarely shows white papules on its mucous membrane. There are no general symptoms.

**Course:** The eruptions are subject to remissions and exacerbations. Often they remain stationary indefinitely. The general health is not affected.

**Diagnosis:** The peculiar crusted papules, which, on microscopic examination, show the typical "Corps Ronds", "Grains" and dyskeratosis, help in the diagnosis.

**Differential Diagnosis:** (1) A condition which might lead to confusion in the early stages is Icthyosis. In Icthyosis however the lesions are more marked on the limbs and there is not the same amount of keratosis.

(2) The lesions on the face may suggest a seborrhoeic dermatitis. The presence of horny plugs on the lesions and the lesions on the trunk should help to exclude this lesion.

(3) A condition which simulates Darier's disease more closely than the above is Acanthosis migricans, which however affects the intertriginous areas more, and shows greater degree of pigmentation.

(4) Perhaps the lesion which is difficult to differentiate on histological examination is the condition called Benign Familial Pemphigus of Hailey and Hailey. Some authors believe that this is only a bullous variant of Darier's disease, and they classify this latter disease accordingly into dry and a vesicular type. The justification for calling this a different clinical entity has therefore been questioned.

**Treatment**: (1) Vitamin A Therapy: Many cases show marked improvement with large doses of vitamin A. A daily dose of 200,000 units of vit. A has been recommended for prolonged periods.

(2) Local application: Keratostics in the early stages and astringents and antiseptics in the later fungating stages have been recommended.

(3) Temporary improvement has been seen with Grenzray irradiation.

## CASE REPORT

**Chinnappan**, Hindu male, aged 23 years, labourer, attended the Hospital about June 1951 for skin eruptions with itching, and pigmentation of the skin of three years duration and was subsequently admitted on 15—12—51.

**History of the illness**: Patient gave a history that three years ago he had itching of the scalp, when he noticed the presence of minute eruptions over the whole of the scalp. These than developed over the face, neck, trunk and extremities in that order. All these lesions were so itchy that he was unable to sleep. He had no fever either proceeding or after the appearance of the eruptions. He does not complain of falling off of his hair or of scales coming off on scratching.

His appetite is good. Bowels are regular. Micturition normal. General health not impaired after appearance of eruptions.

He is a non-vegetarian and smokes in moderation.



His parents are dead. He is not married. He is the sole living member of his family and does not remember any relatives having had a similar affection.

## CONDITION ON ADMISSION

**General**: He is a fairly well nourished individual, anaemic, xerosis present, teeth dirty, no pyorrhoea alveolaris, tongue pale and flabby, moist, koilonychia present, longitudinal fissuring and splitting of nails, no palpable lymph glands on the neck or axilla, no oedema of the feet, no tell-tale penile scar. Buccal mucous membrane also shows minute whitish papules on the hard palate, soft palate and tongue.

**Skin Condition**: The primary lesion is a crusted brownish-black papule, about the size of a pinhead, darker than the surrounding skin, the skin itself being dark brown. The lesions are diffusely scattered in some places, densely aggregated in other places like a nutmeg greater, flat topped, without evidence of pigmentation.

The papules are firm to feel, not tender, not easily detached; but on detaching the papule a minute pit is left in the skin. They are not adherent to the deeper structures. No induration or thickening of skin. There is no apparent relationship to the hair follicle. The hair over the scalp is scanty, dry and brittly. *No Alopecia.*

The lesions are distributed over the whole of the scalp, inside of the ears, forehead, malar ragions, beard area, body of the sternum, middle of the anterior abdominal wall; dense aggregation over scapular and interscapular regions, middle of back, small of back and waist.

The back of ears, nape of neck, axillae and groins are practically free of lesions.

In the upper extremity lesions are predominantly on the extensor aspect. The skin of the palms is thickened with a suggestion of papular eruptions. On the extensor aspect of the forearm the papules have coalesced appearing like plaque-like lesions, very like pigmented verruca plana.

In the lower extremities the thighs and legs are involved. The sole shows hyperkeratosis with fissuring suggesting a mosaic pattern.

There are marks of excoriation. The secondary changes are a few raw areas over the interscapular region and over the waist and sacral regions.

No evidence of suppuration now. No secondary lymphadenitis.

**Respiratory System:** Trachea not deviated. Normal resonance on percussion. V.F. and V.R. Normal. Breath sounds vesicular. No adventitious sounds.

**Cardio-Vascular System:** Heart borders within normal limits. Both heart sounds normal. No adventitious sounds.

**Abdomen:** Liver and spleen not palpable. No masses felt. No tender areas. No free fluid in the abdomen.

**Central Nervous System:** Clinically normal.

**THE FOLLOWING INVESTIGATIONS WERE DONE**

**Urine:** No abnormal constituents detected.

**Blood:** Total R.B.C. count 2·73 million c.mm. Hb. 50%
Total W.B.C. count 9,600 c.mm.
Differential count: $P_{71}$ $L_{24}$ $E_3$ $M_2$.
Blodd smear: Microcytic Hypochromic picture.

**Motion:** Macroscopic: formed, no blood or mucus.
Microscopic: Ankylostoma ova seen.

**Blood W.R. and Kahn:** Negative.
Scrapings from sole of foot for fungus: repeatedly negative.

**X'ray chest:** Nil abnormal.

**E.N.T. opinion:** Palate and uvula appear involved.
Larynx not involved.

**Biopsy report:** Hyperkeratosis with follicular plugging: acanthosis with acantholysis giving cleft formation: acantholytic cells present forming "Corps Ronds" and "Grains" of Darier.

**Treatment:** From 15—12—51 to 18—12—51 patient was given 6 tablets of sulphadiazine a day with alkaline mixture to control suppuration.

26—12—51 to 31—12—51 Patient was running a low temperature owing to suppuration of lesions for which he was given 1 lakh units Penicillin b.d.

Note involvement of scalp, naso-labial fold and chin area, fitting in with seborrhoic distribution.

★

*Note*: 1. Hyperkeratosis of stratum corneum.
2. Splitting within rete malpigi above basal layer giving the lacunae.
3. Presence of spherical cells lying within the lacunae, the "Corps Ronds" of Darier.

The grain cells in superficial layers of epidermis are not very clear in the picture, but were clearly seen in the slide. The dermis shows nothing particular.

**PHOTOMICROGRAPH UNDER LOW POWER.**

| | |
|---|---|
| 1—1—52 to 9—1—52 | Patient was given 8 daily injections of 1,00,000 units of vit. A. conc. along with cod liver oil and yeast by mouth. |
| On 10—1—52 | All these days no local application was given. Patient was discharged considerably improved in general health. His skin lesions appeared less florid. He was asked to report after a fortnight for review. |
| On 29—1—52 | Patient was admitted again for a renewed course of vit. A therapy. |
| 29—1—52 to 9—2—52 | Patient got 9 injections of vit. A. conc. each of 1,00,000 units, with cod liver oil and yeast by mouth. No local applications. |

We discharged him and asked him to report after a week. He reported on 16—2—52 and was readmitted. At the time of writing, he is getting treated for his ankylostomiasis, as also for his skin condition with injections of vit. A.

**Conclusion:** The diagnosis is proved beyond doubt by biopsy.

Patient has had about 2 million i.u. of vit. A conc. up to now. The initial improvement has not been maintained. We are however not yet in a position to assess the value of treatment in this case with vitamin A, since the amount of vit. A given may not have been sufficient.

A review of Darier's disease is given along with a case report with clinical photographs and photomicrographs. In this particular case, itching as a subjective symptom is rather unusual.

I am indebted to Dr. A. S. Thambiah but for whose help and guidance this would not have been possible, and to Dr. Eapen for permission to report this case.

## REFERENCES

1. Diseases of the skin by Sequeira, Ingram and Brain.
2. British Encyclopaedia of medical practice—Vol. IV.
3. Year book of Dermatology and Syphilology—1950.

## *Reasons Why:*

A speed demon on U. S. Highway 40, flagged down by a Kansas state patrolman who demanded why he was going 90 miles an hour, answered: "Well, I just washed the car—was drying it off."

* * *

In Detroit, a man gave his reason for burning down his home: "I don't like the neighbourhood."

* * *

Arrested for carrying a pistol in Hillosboro, Texas, a youth said in his own defense: "I thought all Texans wore guns."

* * *

In Vienna, Franz Devini, 63, could think of only one possible explanation for the fact that he was arrested for robbery: "I've been an honest man upto now, but not long ago I had a blood transfusion—must have been given the blood of a thief."

* * *

Secret Service agents in St. Louis learned from a man they had just caught why he produced counterfeit $ 10 bills. "Good engraving just intrigues me," he explained.

* * *

In London, Wally Farey, fined $ 4 for keeping a horse in his boarding house room, sadly explained: "I was lonely."

* * *

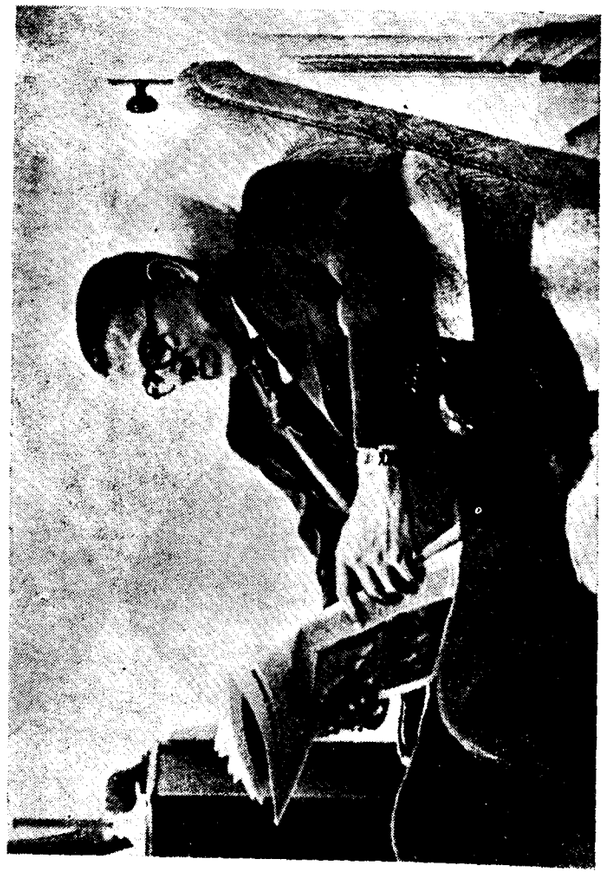
Psychology student: In Tulsa, Motorist Walter Mims explained to police why he had smashed into a car driven by a woman ahead of him: "She signalled she was going to turn right; and then she turned *right*."

Lt.-Col. C. K. PRASADA RAO, M.D.

who has been appointed Dean, Govt. General Hospital, and Madras Medical College, Madras.

*Service, my motto.....*

MANY HAPPY RETURNS



Dr. R. V. RAJAM, M.B., M.S., M.R.C.P. (Edin.)
Dean, Government General Hospital and Madras Medical College who has relinquished his office after a distinguished career in the College and the Hospital prior to assuming charge as Director, All-India Venereological Institute, Madras.

*On to wider horizons.....*

# Dr. R. V. Rajam : Profile

*"He touched nothing that he did not adorn"*

—Dr. JOHNSON.

"I want to work, work hard. I have always loved hard work." These few crisp words give the clue to the dynamic personality of Dr. Rajam, our retiring Dean. To be singled out in his chosen field for international recognition is no mean honour but, for him, it is only a call for greater duty, an incentive for harder work.

To the world at large, March 7, 1952 was just like any other day and in Madras it was as hot as ever. But in our College, an inevitable and painful finale in the drama of human relationships was being enacted—that of separation and farewell. The college and the hospital came to the last man on that day to bid farewell to the last of its Principals and first of its Deans, Dr. R. V. Rajam. The writer of these lines who was fortunate to associate himself with the function said: "I think it is Sarojini Naidu who observed rather facetiously on her being appointed Governor of the United Provinces, that the bird has at last been caged. Though the Madras Government succeeded in caging Dr. Rajam within the Deanship of the General Hospital and College, one day the bird was bound to fly to newer climes and flown it has now. What is our loss in a narrow sphere has become a national and international gain."

For he was not just fading away as it were after his retirement. He was proceeding to Bangkok to participate as one of the five international experts in the W. H. O. Symposium on "Yaws". On his return, it is understood he will be appointed Director of the upgraded All-India Venereological Institute within whose precincts he will follow his chosen field of Venereology "to strive, to seek, to find and not to yield."

Dr. Rajam was born in Kumaralingam, Coimbatore District, in 1894. Rajam inherited in full measure from his father a studious and industrious turn of mind which, with the scholarly family background, stood him in good stead in his later years. He graduated from the Madras Medical College in 1918 at the top of five first classes which was itself a record, with the Johnston Gold Medal and the University Medal to his credit. He was a good tennis player but bicycle-riding from Victoria Hostel to College in the early morning and back again in the late evening was more of a preoccupation than a pastime. Among his classmates were Dr. Pisharoty, Dr. Thambiah and Dr. Kutumbiah.

During the first world war, he served as a Captain in the North West Frontier. He left the army in 1920 to join the Madras Medical Service as a temporary Civil Assistant Surgeon and was Assistant to the

then Professor of Surgery, Col. Niblock, for a year. He was transferred to Tinnevelly as A. D. M. O. where he had a free hand and a golden opportunity to practise major surgery for three years from 1921—24. His record of good surgical work got him the Lecturership in Surgery in the Tanjore Medical School where he consolidated his reputation as an eminent surgeon during '24—'28. Naturally when Col. Bradfield was in search of an assistant, the mantle fell on Dr. Rajam in 1929. He took his M.S. in 1930 but the then Surgeon-General lured him with promises of a great future to the Venereology Department which was just then having its birthpangs in a cowshed. In the same year, he was sent abroad and he took his M.R.C.P. (Edin.) in Venereology in 1931.

For twelve long years (1931—43) he was Assistant Surgeon and Lecturer in Venereology during which time many of his juniors became professors and full-fledged civil surgeons. But he went about building and organising and consolidating the Venereology Department with an astonishing energy, resourcefulness and thoroughness to make it what it is to-day. Meanwhile, international recognition came his way through his many original contributions to various medical Journals including the star-one on "Venereal Granuloma" in the British Encyclopaedia of Medical Practice. In 1943, he was made a Super-numerary Civil Surgeon and in '44—'45, Professor of Venereal Diseases as a mark of personal distinction. In August '48, he was appointed Principal, Madras Medical College. In the same year he had the distinction of serving as a member of the Expert Committee on Venereal Infections of the W. H. O. held in Paris and visited England, France and Switzerland. In the same capacity, he went to Washington in '49 when he had the opportunity to visit various medical institutions in Philadelphia, Chicago, Durham, Memphis and New York. In Jan. '50, he became the first Dean of the General Hospital and Madras Medical College in which office he continued till March 10, 1952.

Dr. Rajam counts the study of History and Biology as his main hobby and has one of the best private libraries in Madras. He is an indefatigable worker with a capacity to take infinite pains which is the true hallmark of genius.

Thus Dr. Rajam's has been a dedicated life. It is a poem for all those who can read it. Just as a poem is subject to the rules and regulations of rhyme and metre, he has subjected the poem of his life to the rigours and austerities of a disciplined life. His motto is "To thine own self be true" and he has led his life true to the principle embodied in the Bhagavad Gita: "Do thy duty. Leave the rest in the hands of God." He has never hankered after office but when it did come and knock at his door, he had taken up the challenge with equanimity and discharged his duties without fear or favour to the best of its abilities. Whatever he touched, he adorned. Whether as a Surgeon or Father of the



Venereology Department or Dean or as a W. H. O. Expert, he has distinguished himself for his hard, tireless work, thoroughness and efficiency. No greater tribute to the Father of Venereology in India can be paid by our country than the decision of the Government to locate the All-India Venereology Institute in Madras under his able care and directorship.

When your editor went to wish him "Bon Voyage" before he left for Bangkok, he was kind enough to receive him in his spacious office and naturally his mind turned reminiscently to the students with whom he had moved for so many years. "I must say my students have been wonderful," he said with a twinkle of joy in his eyes and there was a touch of pride in his voice when he added "they have been so very co-operative with me throughout." Turning to Nationalisation of Medical Services, he said, "The idea of a Welfare State is bound to come. It is inevitable. It is only a question of time". Regarding Rural Medical Service, he issued a warning to M.B.B.S. graduates that if they don't take it up, the L.I.M's. and G.C.I.M's. are there ready round the corner to snatch the opportunity. "The people won't be then grateful to us". As to his own future plans, he said, "I don't want to remain static. Then you begin telling old wives' tales. I want to work, work hard. I have always loved hard work." We wish and pray to God to grant him many more years of active, useful life in the service of Man and the World.—R. R.

—★—

**THE OSLER STORY—**

Sir William Osler, visiting one of London's leading children's hospitals, noticed that in a convalescent ward all the children were clustered at one end of the room dressing their dolls, playing games and playing in the sandbox—all except one little girl, who sat forlornly on the edge of her high, narrow bed, hungrily clutching a cheap doll.

The great physician looked at the lonely little figure, then at the ward nurse. "We 've tried to get Susan to play," the nurse whispered, "but the other children just won't have anything to do with her. You see, no one comes to see her. Her mother is dead, and her father has been here just once—he brought her that doll. The children have a strange code. Visitors mean so much. If you don't have any visitors, you are ignored."

Sir William walked over to the child's bed and asked, in a voice loud enough for the others to hear. "May I sit down, please?" The little girl's eyes lit up. "I can't stay very long this visit", Osler went on, "but I have wanted to see you so badly." For five minutes he sat talking with her, even inquiring about her doll's health and solemnly pulling out his stethoscope to listen to the doll's chest. And as he left, he turned to the youngster, a twinkle in his gentle eyes, and said in a carrying voice, "You won't forget our secret, will you? And mind, don't tell anyone."

At the door, he looked back, his new friend was now the center of a curious and admiring throng.

RAO SAHIB

# Dr. D. Sivasubramania Mudaliar: Profile

YOU enter the Anatomy Dissection Hall in the morning or in the afternoon. Groups and groups of students are seated round dead bodies, dissecting and learning the intricacies of the insertion of a muscle or the course of a meandering blood-vessel. But everywhere silence reigns supreme. Now and then you hear the firm, quick, footsteps of one with an excellent physique and a clean-shaven face. His eagle eyes easily spot out the student in his difficulties and he is always ready to help him out of the woods. But he doesn't tolerate any slackness, any waste of time. He is a stern taskmaster, a strict disciplinarian. He easily impresses you as an iron man. But behind the iron exterior, there gleams a heart of gold, the benefits of which most of his students have felt both in their academic and extra-curricular life. For, his connection with the students goes back over an unbroken record period of 36 years, and whether it is as Professor of Anatomy or Company Commander of the M. M. C. University Officers' Training Corps or as Vice-Principal or as Vice-president and Treasurer of the College Magazine Committee and the Co-operative Club, the students' cause, their education and welfare have always found a warm corner in his heart. It is this very heart that bleeds and doles out the necessary punishment when his students go wrong. But he is also the first and happiest of the lot to welcome the prodigal son home. That is Dr. Mudaliar, our loved, respected and most feared Professor of Anatomy and Vice-Principal, the man who always strove to hide his heart of gold from public gaze behind an iron exterior lest others take undue advantage of it.

Dr. Mudaliar was born in Kumbakonam in 1894. He went to the local Town High School and was among the first batch of S. S. L. Cs. in 1911, coming out first in English and Mathematics. His aunt, who brought him up and who was also his friend, guide, and philosopher, sent him to the Royapuram Medical School (now Stanley Medical College) in 1912 to which he was admitted after a rigorous competitive examination in which he stood first. He was a civil stipendiary medical student and was drawing the magnificent sum of Rs. 9/- per month till he qualified in April, 1916, with honours in Anatomy, Chemistry, Surgery and Midwifery. It was here that he had the good fortune to come under the influence of Sir. A. Lakshmanaswami Mudaliar, who was then a Lecturer in Midwifery. The student's admiration for his lecturer has grown manifold through the years and he has always tried to have the great Vice-Chancellor as his ideal before him.

After serving one year on the civil side, Dr. Mudaliar was transferred in 1917 to the War Service during the first World War. He served in the War Hospital at Dadar which had a strength of about



2000 beds, then the biggest of its kind in India. He was posted to the Registrar's office of the hospital, and it is quite possible that he picked up all his administrative skill, flair for organization and insistent emphasis on discipline while he was working in the Army (1917—'20).

He was reverted to the civil side in Feb. 1920 and was posted as anaesthetist in the Govt. Royapettah Hospital; later, as Senior Asst. Lecturer in Anatomy from May, 1920 to 1926, when he left for England for higher studies on Govt. study leave. During his two years stay in England, besides taking his M.R.C.S. (Eng.) and L.R.C.P. (Lon.), he had the rare privilege of undergoing training in Embryology under the late Sir. Eliot Smith and Professor William Wright, two great professors of Anatomy at that time.

After his return from England in 1928, he was posted to Andhra Medical College, Vizagapatam where he remained till 1934. In 1934, he joined the staff of the Anatomy Dept of the Madras Medical College under the late Prof. Koshy. In those days, he used to engage the senior students daily in their coaching classes and also take lectures daily for the juniors. In 1944, he was appointed as additional Professor in Anatomy and in 1950, as Chief Professor. He was a good teacher, simple, precise and impressive, driving facts straight home with his richness of voice, and clarity of expression. But his *forte* was dissection and no amount of "bookish theoric" a student might have accumulated would condone him before his eyes if he were slack in dissection.

He was awarded Rao Sahib in 1944, a rare distinction for those in the preclinical dept. Another facet of his versatality saw the limelight when he assumed charge as Vice-Principal in 1948 and his administration of that high office was one of remarkable success. He acted for about six months as Principal, Madras Medical College during the absence of Dr. R. V. Rajam on W. H. O. work. He retired on April 2, 1952.

He was always interested in the extra-curricular activities of the students. As Vice-President and Treasurer of the College Magazine Committee and of the Co-operative Club, he did yeoman service and was responsible for the sound financial status of both the bodies. The U.O.T.C. boys will always remember him with pride and pleasure as their Company Commander, who by his personal example in drill and parade, infused life in the ranks and was mainly responsible for winning the Inter-Company Shield for the third year in succession. He was made a Captain in 1944 and it is to his credit that we owe the existence of a separate medical company, *viz.*, 6 Madras Medical Coy., N.C.C.

Dr. Mudaliar is a good tennis player but nowadays, in the midst of his multifarious activities, he has literally to steal time for even an occasional game in the evenings. He is well-versed in religious literature. His motto is "Trust in God and do the right," and he is a firm believer in

that "there is a divinity that shapes our ends, rough-hew them as we may". He is an astonishing human dynamo of energy. Why does he work himself so hard?, I ventured to ask him once. "The more I work, the fitter I feel," came the reply.

It is difficult to think that Dr. Mudaliar has retired. Madras Medical College, especially the Anatomy Department, has hereafter to find its equilibrium without him. We would have wished him a happy and peaceful retired life but it is not to be for we hear he is appointed as Deputy Registrar to the Madras University. We congratulate him on his new appointment which gives him wider scope for his great administrative abilities and we are sure he will win fresh laurels to himself and to the University.—**R.R.**

—★—

**THE MENUHIN STORY—**

Yehudi Menuhin, who entertained vast audiences in India with his wonderful performances on the violin, had an encounter with Customs officials in Rome sometime ago. The incident occurred when the world famous violinist was trying to board a plane at the airport. The story is: The Customs Inspector asked him.

"What have you in that case?"

When Menuhin explained to him the case contained his Stradivarius violin he was asked to open the case.

"Who are you?" the Inspector demanded sternly.

"I am Yehudi Menuhin."

"Yes, yes!" the inspector retorted sarcastically. "All Violin smugglers out of Italy say they are Yehudi Menuhin."

And when Menuhin in protest presented his identification papers the official calmly proceeded.

"All smugglers have their identification papers. If you are a concert artist, prove it to us."

Soon Menuhin was playing the ever popular Caprice Viennoise, which he thought was the right kind of light, effective music for this "audience" which now consisted not only of the customs officials but of several hundred by-standers. The customs inspector seemed still unconvinced.

"Signor,—you play that piece pretty well, but not well enough for Yehudi Menuhin. Look here. I happen to know that Menuhin always plays Bach sonatas for un-accompanied violin."

There was no choice. Menuhin had to play Bach. After he had finished, there were wild and unexpected shouts of "Bravo" from the people, while the Inspector apologized, thanked him and finally, having accompanied him to the plane and kissed him on both cheeks, whispering:

"Caro Signor Menuhin—this whole affair was a bet. There were hundreds of music students in Rome who couldn't get admission to your concert here. Neither could some of us in the customs office. So, knowing that you were flying out of Rome this afternoon, we staged this drama, and are happy that we succeeded. Thanks again! God bless you and please forgive us."

MANY HAPPY RETURNS

Rao Sahib Capt. Dr. D. SIVASUBRAMANIA MUDALIAR,
M.R.C.S. (Eng.), L.R.C.P. (Lond.),

our Vice-Principal and Professor of Anatomy who has retired from service after a distinguished career in the College and who has been appointed Deputy Registrar to the University of Madras.

*Behind the iron exterior, a heart of gold...*

Dr. B. H. P. PAI, M.D.

Professor of Medicine, Madras Medical College and Physician, Govt. General Hospital, Madras who has retired from service after a long and distinguished career in the College and the hospital.

*his towering personality by the bedside...*

*...a sight to be seen to be appreciated.*

# Dr. B. H. P. Pai, —An Appreciation

DR. B. H. P. Pai who has just retired from a long and distinguished career in the General Hospital and Madras Medical College is a great physician and a great clinical teacher. Successive generations of students who went through his hands and who are now spread out throughout the length and breadth of the country practising medicine will bear joyous witness to the fact.

His approach to the patients was gentle and he healeth that which he toucheth. He was systematic and thorough in his approach to the subject and his towering personality by the bedside treating the eager students to a learned discourse on the subject was a sight to be seen to be appreciated. The large number of students and post-graduates who used to crowd round him to hear his clinics whether it be in the out-patient department or at the bedside in the ward or on Sundays for his general clinics go to show how greatly his clinical teaching was valued. To the undergraduate, it was a clear exposition of the fundamental principles of medical theory and practice and he brought to the notice of the aspiring post-graduates the latest literature on the subject and inspired in them a desire to read and work further and harder.

With his genial temperament, his sympathetic consideration and understanding nature, he had endeared himself to the students. Above all, mild-mannered and soft-spoken, he was a gentleman every inch and to the core. His studious and methodical habits were a source of inspiration to us all.

Thus for many years, he had been an outstanding figure in the college and the hospital. In his retirement, we have lost a great physician and a great clinical teacher. Yet let us hope he will continue to evince the same kindly interest as he had always taken in us and we wish him a long, peaceful and happy retired life of continued usefulness and benefit to his countrymen.—R. R.

—★—

# Heard This One?

Girls at college
Are of two strata:
Those with dates
And those with data.

—*Richard Armour.*

•

When you are away, I'm restless, lonely
Wretched, bored, dejected;
But here's the rub, my darling dear,
I feel the same when you are near.

—*Sam Hoffenstein.*

•

You try to write
No ink will trickle;
Put pen in pocket,
And instantly it'll.

—*Air University Despatch.*

•

The moon is full and lovely
The park looks simply great;
But it might as well be raining.
Because I haven't got a date.

—*Bona Venture.*

•

He only drinks to calm himself.
His steadiness to improve
Last night he got so steady
He couldn't even move.

—*Voo Doo.*

# Personalia

Lt.-Col. C. K. PADMANABHA MENON, M.S., F.R.C.S.

Addl. Professor of Surgery, Madras Medical College and Warden M.M.C. Hostel (Men's Section) who has been transferred to Vizag. as Professor of Surgery, Vizag. Medical College.

Dr. M. KRISHNAMOORTHY, M.S.

Who has been appointed as Addl. Professor of Surgery, Madras Medical College and Surgeon, Government General Hospital, Madras.

## ports:

### PRIZE DISTRIBUTION BY MRS. MOHITE

*(wife of Maj.-Gen. Mohite, General officer Commanding, Madras Area)*

—Bhuvaneswaran., V Year.

Miss. K. Savithri Mardi,

The Ladies' Sports Secretary becomes the Ladies' Champion Athlete of the year.

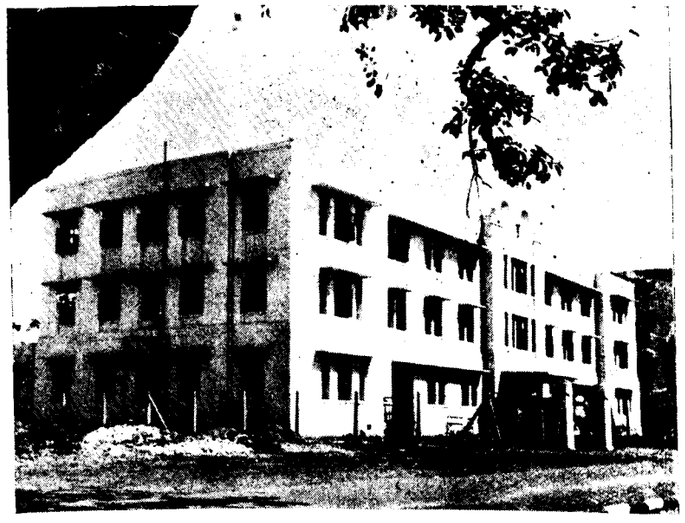
—Bhuvaneswaran. V Year.

Mr. B. S. Wilson,

The Champion Athlete of the year.

## *In the News*

### THE NEW LADIES' HOSTEL



...And Ormes Road lost its interest.

* "*How beauteous mankind is! O brave new world*
*That hath such people in 't!*"

—Shakespeare, 'The Tempest', Act V, Sc. i.

## VITAL QUESTIONS ON MEN AND WOMEN

*(We are all keen observers of human nature, especially of the opposite sex. But has it led us anywhere or is there still the same wonderment of Adam when he got up from his slumber to find Eve by his side? By these provoking questions on various topics put by him, your editor has caught for you glimpses of the working of the mind of the opposite sex. Do they help you to a deeper and better understanding, to correct your slant, to give you the proper perspective? The answers range from the wittiest to the most profound observations but whether you smile at the thrust or smart from the sting, you will certainly agree that they are straight from the shoulder. They may offer you a few plain home truths too in the bargain. But, after all, you beg to differ?)*

K. KURUVILLA

# ANSWERS TEN QUESTIONS ON Women!

**1. End of man's tyranny—Emancipation of women—Equality of sexes—What next?**

Honestly, I cannot *conceive.*

**2. Do you think a cabinet of women can deliver the goods better than the governments of men that have existed so long?**

There may be, today, here and there in this world, women gifted with the capacity to rule the nation. But, in my opinion, it will be an extremely unwise procedure to entrust them with the powers of government for the following reasons:

(*i*) Women are mostly uncertain creatures easily influenced by the superficial things in life.

(*ii*) Petty jealousies and indiscriminate stubbornness usually play an important part in their decisions.

(*iii*) Think of the sheer impossibility of keeping state secrets.

(*iv*) Nobody ever gets a "fair" deal out of the fair sex.

**3. Do women always have the last say in the matter as they usually boast?**

Yes. But, certainly not the last laugh!



**4. Silence is certainly not a woman's strong point. Why?**

The silent woman has invariably something to hide. Curiosity and jealousy—that's what makes them eloquent about other people and the hollower they are, the more noise they make.

**5. Chivalry is dead. Any comments?**

Not yet. It lives and occasionally shows up in buses.

**6. Can you tell a few plain home-truths to the gay, giddy, butterflies that some modern women are?**

There is no harm in being gay—it is a desirable quality. But when the butterflies get giddy, they invariably fall.

**7. Which of those female habits or mannerisms particularly infuriate you?**

Habitual dishonesty.

Injured innocence.

Assumed intelligence.

False modesty.

Grass-hopper mind.

Discussion of the other women's dress and ornaments.

Whispering secrets in company.

**8. Has co-education done much good to women? Will not separate schools and colleges with syllabuses pre-eminently suited to feminine nature be more conducive to a fuller development of the personality of women?**

First of all, let us make them fit to live with as partners for life. Free association in schools and colleges always leads to a better state of mutual understanding between men and women. Co-education abolishes neurotic traits of personality—usually the hall-mark of segregation in institutions exclusively meant for women. Specialization in suitable sciences may be acquired after a general education in a co-educational institution, that is, if the need arises.

**9. What, according to you, are the seven stages of woman as opposed to those of man, described by Shakespeare ?**

| MAN | | WOMAN |
|---|---|---|
| Infant | .... | Paradise lost. |
| School boy | .... | Tom cat. |
| Lover | .... | A serpent heart hid behind a flowering face. |
| Soldier | .... | Society bird. |
| Justice | .... | Equality. |
| Old age | .... | "Sweet sixteen" |
| Second childhood | .... | Plastic surgery. |

**10. What are the ingredients that go to make up the ideal woman of your imagination ?**

Honesty, chastity, sincerity, good humour, artistic tastes and a certain amount of good looks

OR

Good cooking and wholesome stupidity, since the above mentioned qualities are scarcely found.

—★—

**ALL ABOUT EVE—**

Do not ask a woman her age. Ask another woman.

* * *

The average girl would rather have beauty than brains because the average man can see better than he can think.

* * *

A woman who prefers the company of a dozen men to a dozen women knows she can fool the men and not the women.

* * *

Doctors are perhaps the only people who can ask a woman to open or shut up her mouth and yet get away with it.

* * *

Many a girl who loves a man from the bottom of her heart finds room for another at the top.

* * *

All women's dresses, in every age and country, are merely variations on the eternal struggle between the admitted desire to dress and the unadmitted desire to undress.

P. U. SAROJA & A. C. T. THANKAM •

# ANSWER TEN QUESTIONS ON Men!

**1. The golden pages of History are studded with more names of great men—great writers, poets, philosophers and the like—than women. Can you explain why ?**

Yes. Because women, in those days, were but the appendages of the brilliant-plumed, daring male. Their place was the home and they were not given a chance to show their worth. Still, if you turn back the pages of History, you can't help admitting the role played by women in making those men really great !

**2. Do you really believe in Man's age-old saying: "Women are the weaker sex" ?**

Physically, yes. It is too evident to demand proof. But mentally, woman has more courage, perseverance, love and endurance. In spite of the suffering and agony she goes through, a mother's love for her child is legendary. Have you heard anything like that about man ? Even on that one point, if you are really honest with yourself, wouldn't you admit women are stronger ?

**3. Are men justified in saying that a woman cannot combine a successful career with a happy home life ?**

They never said a more correct thing. You cannot eat your cake and have it too.

**4. Do you lament over the fact that chivalry is dead?**

Certainly. Chivalry is nothing but good manners which show good-will and if everyone had observed it, the world would have been a much nicer place to live in.

**5. Is there anything that Men can learn with advantage from Women?**

Yes. Loyalty, Endurance, Sacrifice, Humility, Faith, Veracity and Kindness.

**6. The hen-pecked husband: a figment of imagination, a travesty of truth or simple over-dramatisation out of self-pity?**

We will rather call him a misfit in both home and society.

**7. Are men as dress-conscious as women, despite the lack of rapid change in male fashions?**

In fact, the modern Mr. is more dress-conscious than the Miss, though he lacks originality completely, being used to ape other nations and their change of fashions in clothes. As for cosmetics, you can find a variety of them on the male, as females are growing less and less fond of it.

**8. Is Love—the necessity to love and be loved—as essential to Man as it is to Woman?**

Yes. It is even more so. In all his endeavours, Man needs encouragement and guidance which can only be attained through love. Love can work more of a change for the better in Man than it does in Woman.

**9. If you were given the choice, would you rather have been born a man?**

Good God, No! Not even in our wildest dreams! Where, then, would virtues be?



**10. What are the ingredients that go to make the ideal man of your imagination?**

A gentleman in every sense,

Good charactered, loyal, courageous, sincere, kind and loving.

Intellectual, but not conceited,

With a good personality and pleasing manners:

And lastly, with the capacity to appreciate good things with an unbiassed mind.

—★—

**IT'S A MAN'S WORLD, EH?**

If he doesn't marry he's a "bachelor"—glamorous word. If she doesn't, she's an "old maid."

* * *

When it's his night-out, he's "out with the boys." When it is her night-out, she's at a "hen party."

* * *

What he hears at the office is "news". What she hears at bridge party is "gossip".

* * *

If he keeps an eye on her at a party, he is an "attentive husband". If she sticks close to him, she is a "possessive wife."

* * *

In middle age he is "in the prime of his life." At the same age, she's "no spring chicken."

*"Love is not love which alters when it alteration finds, Or bends with the remover to remove," wrote Will Shakespeare in one of his immortal sonnets. It is purely a matter of circumstance,—if not this girl, another, opines the intrepid writer of this controversial story. But is it not an intensely individualistic and divine experience even after going through which we may be none the wiser? Everyone will agree with Tennyson that it is better to have loved and lost than never to have loved at all and each discovers it, we think, according to his or her light. At the supreme altar of love, there is no room for controversy, for any pre-conceived notions, for pride or prejudice, for anything whatsoever except Love itself.*—Ed.

# Creatures of Circumstance

—M. R. G.

IT happened. The more he thought of it, the more baffling it seemed to him. He was afraid to face it. In fact he had a premonition about it. Yet, when it came, he was unable to stand up against it. It crushed him. He loved her with all his heart. She was everything for him. She was to him flawless, an immortal beauty in the midst of mortals. When I just think of the guilelessness of youth, it moves me to tears. It is so vulnerable, so sure, so generous and so demanding.

At the very first sight, he fell in love with her headlong. As I told him later, it was nothing but circumstance which made him fall in love with her. Man loves to love and when the opportunity comes, woman is nothing more than a symbol. If he had not met this girl, he would have met some other and fallen in love with her all the same. It is only a state of mind into which everybody falls at sometime or other and from that unfortunate moment when one falls a prey, the play begins and one is compelled by circumstances to play the role of the lover or the lass.

My friend Ramesh was strolling alone one evening. He felt strangely elevated in spirits and his eyes flirted over every part of the landscape. Green, lushy paddy-fields stretched all around him. The rich crops bent under their own weight as they wafted hither and thither in the gentle evening breeze, they looked like shy maidens blushing from the kisses of their lovers. There was the strong, silent mountain behind, with its three peaks like the three Sisters, their hands entwined watching the scene below. Peeping from between the peaks, the setting sun flooded the field with a crimson hue.

Ramesh walked past the panoramic landscape towards the mountain. But he stopped suddenly as his wandering eyes were arrested by a lovely vision. Silhouetted against the crimson sky and the black hill, she was



sitting, deeply engrossed in thought. It was a scene that an artist would gladly have spent a lifetime to paint. At the sound of his foot-steps, she turned and saw him. How long they stood like that, they could never know. Ramesh awoke from the trance to hear someone call and saw her darting in the direction of the hill. Throughout that sleepless night he tried to recollect what he had seen but remembered nothing but the eyes.....two beautiful eyes wide with surprise like the lotuses, about to close at sunset blown open by the evening breeze. He decided to go to that place again the next evening.

So there was Ramesh the next evening, dressed up spotlessly in white, hurrying through the paddy fields. Contrary to what the old poets used to say, the modern lover is not so oblivious of his dress or his appearance but, in fact, is scrupulous and even showy. Ramesh reached the place. She was there, reclining on her elbow. He stood rooted to the spot, drinking in all her beauty. When he faced her, she did not run away but smiled at him. That smile put aside his embarassment and shyness. Ramesh had always been so very shy and never used to mingle freely with the girls he met. He told me later that he had no difficulty in talking with her. Very soon they were talking as if they had been friends for many years. (I wonder! Is there anything which the mind is not capable of? It creates enmity with no reason and friendship with no background.) So it came to happen that they met in the same place at the same hour and spent their time talking, planning and hoping. What they talked so endlessly, only lovers can say. I asked Ramesh whether he knew anything else about the girl except her name. I was surprised to hear his answer "Why should I? Is it not enough for you to know that I love her and she loves me?".

I did not meet Ramesh for some time after that. When I ran across him, he was looking sick and worn out, a crushed victim of heaped-up sorrow. I eagerly enquired after his health and his progress with Nalini. He looked at me with his sunken eyes and spoke with great difficulty that all was over with him, life was a misery, despair and dejection were his lot..... With a lot of coaxing, I could learn the story.

Returning from the tryst one evening, he went to bed feeling uneasy and tired. What he remembered next was that he was lying in the hospital with a friend seated nearby. He learnt that for more than a week he was unconscious and still seriously ill. It was a very bad attack of typhoid and full three months had elapsed before he had sufficient strength to walk about. But all day long as he lay in bed, he thought of her and

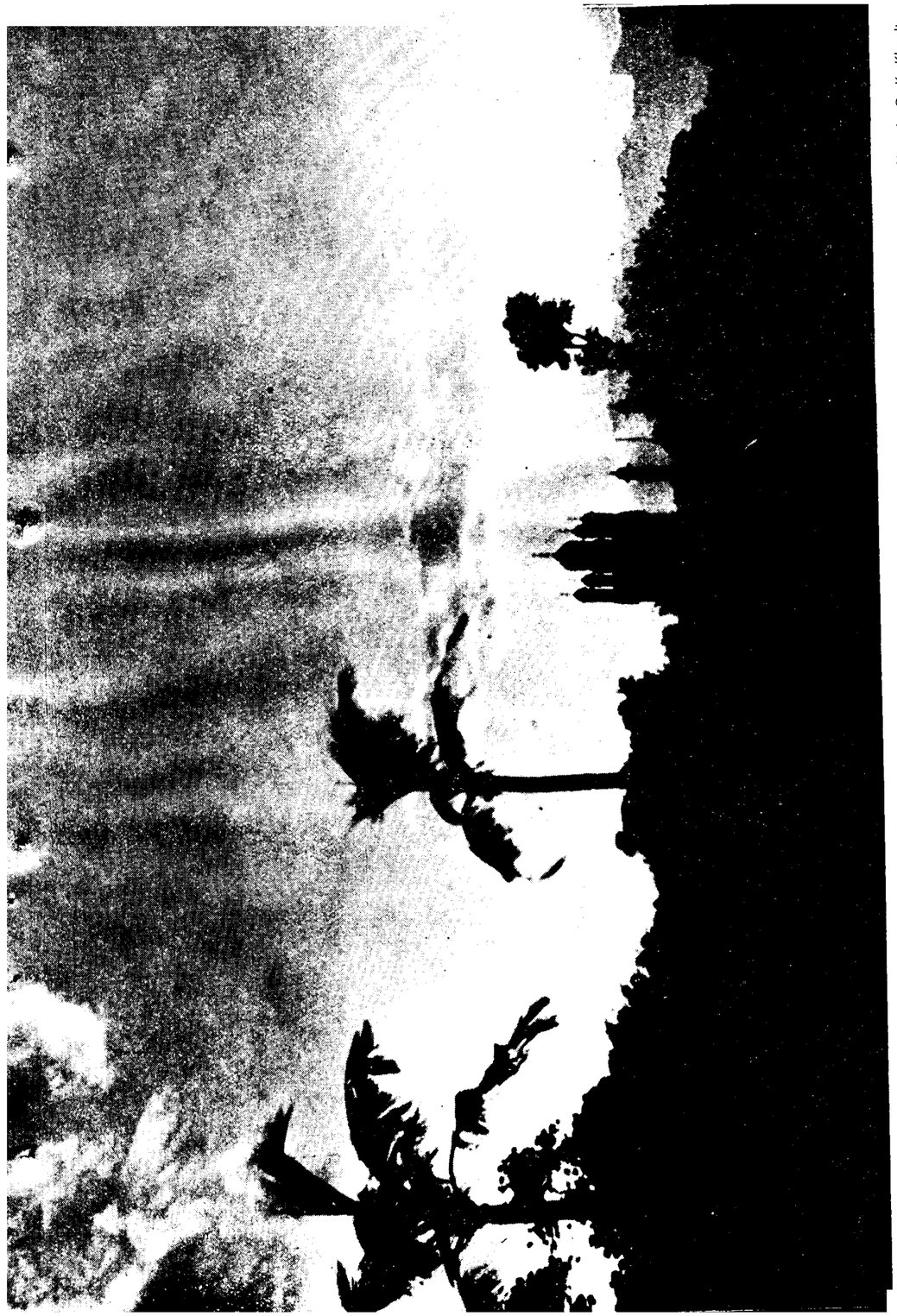
dreamt of the day when he would meet her again. He could not write to her as he never knew where she lived. As he still continued to be shy with others, he did not entrust his secret to others.

When he was well again, he bought a present for Nalini and raced through the paddy fields. He tripped and fell and his present for her lay at his feet in a thousand pieces. He never gave a second thought for it, but hurried on. The scenery did not interest him that day. He was breathless, more with the expectation than with the effort. (How many are beguiled by their expectations! What people expect is only what they long for). He reached the spot but for the first time he did not find her there. His heart was throbbing with excitement, but deep in his heart, he had a sinking feeling. He tried to console himself. "Perhaps....she has not seen him here all these days. She might have forgotten him.... No, it cannot be. She will come...." He sat down to watch the sun sinking behind the hills.

At last, there she was, the spark of his life. At that moment, he thought that life could not be sustained if the radiant smile of hers ceased to shine on him. But she was not alone and she never turned in his direction. He felt his feet giving way under him. A low moan escaped him as he bent down for support.

When he had finished narrating, I tried to cheer him up. I told him: "Ramesh, you taught her to love. Take pride in that. You awakened her capacity to love but you did not stay long enough to appropriate it. In your absence, it is quite natural that she heaped up her new-found love on somebody else. You were nothing but symbols to each other". Ramesh never allowed me to proceed on what he called a cruel joke and a crude sermon at his expense. I left him to enjoy the luxury of his sorrow.

A few months later, I caught sight of him walking with another pretty girl by his side. Love or self-deception? I cannot but smile at these creatures of circumstance.

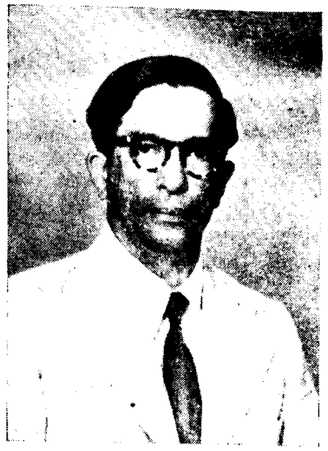


—*Photo by G. K. Khandige.*

The glorious sun
Stays in his course and plays the alchemist
Turning with splendour of his precious eye

SUNSET

OUR NEW VICE-PRINCIPAL



Dr. ISAAC JOSEPH,

Professor of Hygiene, who has been appointed Vice-Principal, Madras Medical College.

# The International Symposium on Yaws at Bangkok and Certain Hot-Weather Impressions of Thailand & Indonesia.

"ARVIOR"

THE flight from Madras to Bangkok *via* Calcutta was uneventful except for the fact that when we arrived at Bangkok at the unearthy hour of 2-30 a.m. there was nobody to receive us at the air-port. But the kindly steward of the Pan-American Airways took us in the company's bus and dropped us at the steps of Ratanakosin Hotel, which is a government-run establishment. We woke up the sleeping clerk at the reception counter of the hotel to find out whether any accommodation has been reserved for us. He looked into a register and gave us a negative reply. Repeated attempts to get at the other hotels in the city through telephone proved a failure. So we settled ourselves in the lounge of the hotel, waiting for the morning to arrive. On the morning of 12th we managed to get temporary accommodation in another hotel. After a hurried wash-up and breakfast, we took a taxi to the UNICEF Asia Regional Office and met the senior medical adviser in-charge of the arrangements. He received us with profuse apologies for not meeting us at the air-port and blamed Delhi for failing to inform him about our exact arrival there. Our depression disappeared when the Finance Officer of the UNICEF, Mr. Winter handed each of us a bundle of notes in Siamese currency to meet our daily hotel and other expenses for ten days. We were bundled in a UNICEF station wagon and taken to the respective hotels reserved for us. The hotel where I was accommodated was nicely situated on the bank of the river Menam and within a walking distance of the shopping centre of the city.

The Yaws symposium was held in the Sahatai Hall of the grand palace kindly lent by His Majesty King Bhumipal Aduldej. Due to the unavoidable absence of the Prime Minister of Thailand, the Minister for Health inaugurated the symposium on 14th March at 10 a.m.

There were two sessions a day from 14th to 22nd March. Around the table were grouped some sixty people in whom all the Yaws world was represented. It was a global gathering, equatorial in its magnitude, extending from Brazil in South America to New Caledonia in the South Pacific.

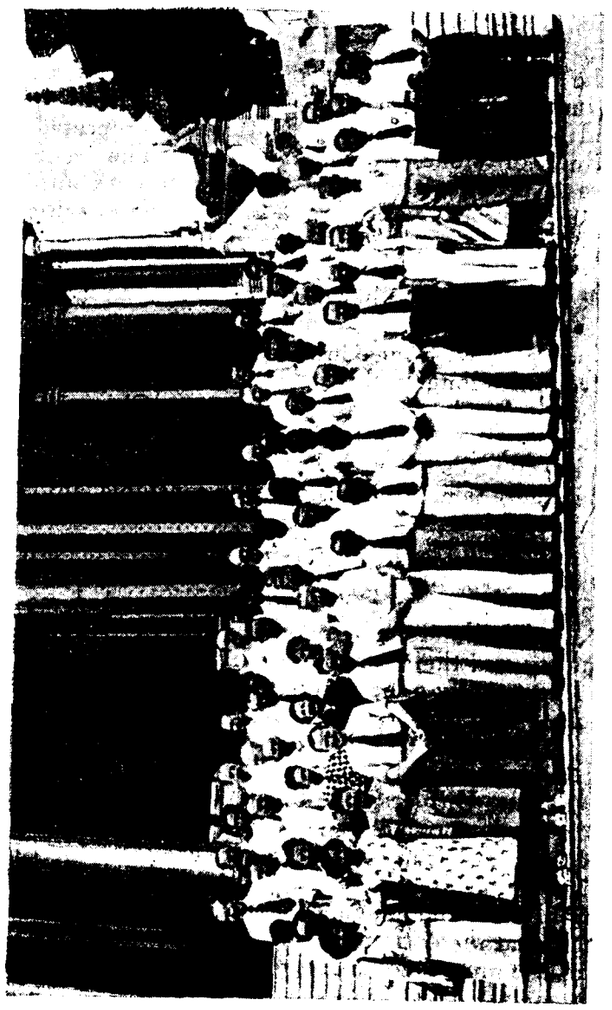
Thirtysix papers were presented during the forenoon sessions followed by round-table discussion in the afternoons. Every aspect of the disease was reviewed, discussed, commented, and criticised, ranging from the biology of Yaws, the nature and extent of the Yaws problem, the role of anti-biotics in the treatment of the disease, development of plans of operation in Yaws control on a mass scale to the role of international organisations. After the termination of the symposium, the members were taken by rail to Ubol, the capital of a province in the North-East Thailand and 300 miles from Bangkok for a field demonstration and seminar at the site of operation of the WHO—UNICEF—supported Yaws control programme in Thailand. During the fortnight of symposium and field seminar, the social and entertainment aspect of our stay in Bangkok was the special concern of the government. Conducted tours to the palace, temples, snake-farm, medical institutions and boat excursions on the river were greatly appreciated by the Yaws experts. Three delightful evenings were spent in cocktail parties given by the Minister for Health, WHO, UNICEF organisations and by the Indonesian Ambassador.

At the party of the Ministry of Health, the dancing girls were brought out. The professionals were there with their traditional poker-faced perfection in their robes of gold embroidery and their many-tiered head dresses suggesting the spires of Buddhist pagodas. But the amateur dancers drawn from the nurses and midwives received the greatest applause when they followed the professional dancers and enacted the epic story of Ramayana in dance and music.

The Siamese are great enthusiasts for boxing and have developed a style of boxing peculiarly their own in which all the four limbs are freely and adroitly used to down the opponent.

The first-rate eating-places are all Chinese and what superb connoisseurs of the culinary art the Chinese are! No wonder Lin Yutang, the famous Chinese writer wrote somewhere that only with a Chinese cook and a Japanese wife, life is worth living.

There are 400 Wats in Bangkok. A Wat is a walled enclosure of many acres used as a Buddhist monastery and containing a temple of



W. H. O. EXPERTS WHO GATHERED AT BANGKOK FOR A SYMPOSIUM ON "YAWS"

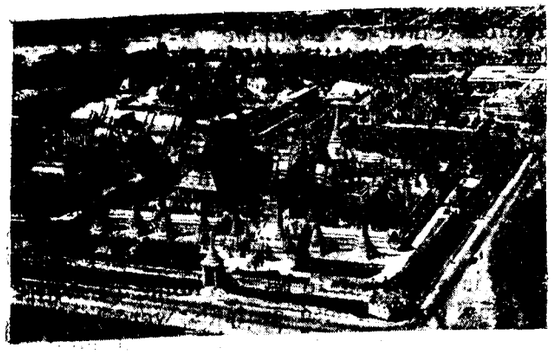
Dr. K. V. Rajam can be seen in the first row, centre.

Buddha, prayer halls, dormitories for priests and pupil-priests, parks and water-ways. Of all the temples visited, the one that took my breath away for its fantastic, gorgeous, stupendousness is the sleeping Buddha, 140 ft. long and 40 ft. high resplendent in gold-plated armour. The Bassrelifs carvings on the walls and galleries of wats and temples mostly depict scenes from Hindu epics and mythology. Indra on an elephant, Vishnu on Garuda, and Naga, the sacred snake are motifs repeated myriad times in these carvings of stone, wood and roof. The roofs in Siamese architecture are its peculiar glory arrayed in three tiers and covered with glazed tiles with their red, yellow, and green colours which are a feast to the eye.

Bangkok just like any other Eastern city is an unholy mixture of the mediaeval traditional East with the modern dazzling West. The population is polygot, with the Chinese leading among the aliens. The New Road, five miles long is the busiest throughfare flanked by shops flaunting American goods, Siamese silverware, Chinese shoe and junk shops and Indian textiles. The traffic is a perpetual jam with trams and automobiles with myriads of tricycle-rickshaws trying to find their way and, believe me, there is no traffic control or constable anywhere in sight. But accidents are rare!

The Thais are a gentle, good-mannered, ease-loving people, getting rapidly Americanised. But the people who impressed me most are the Chinese, both in Thailand and Indonesia. Their stupendous industry, astounding vitality and their economical living are features to marvel at and wonder. I never saw a lazy, squatting Chinese, except in the opium dens of Bangkok.

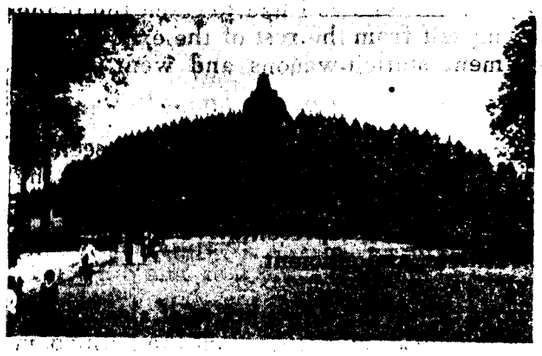
There are two medical schools with attached hospitals in Bangkok and affiliated to the University. The course of study is four years, excluding pre-medical course of two years in which they study Physics, Chemistry, Botany and English. The text-books are in English but the medium of instruction is in Siamese. A hospital Gazette is being published monthly in the language of the country but with a brief abstract in English at the end of each article. In the February number of the journal, there is an article on the vital capacity of medical students in Thailand with comparative figures given from other countries including Madras as reported by Krishnan and Vareed in 1933. The men students of our college seem to have a low vital capacity (1.93) than those of Bangkok and Nanking (2.12 and 2.11) but our women students have retrived the situation with a higher vital capacity of 1.55 as compared with 1.52 of the Thai, and 1.44 of the Chinese women students. Madras medical men students should start doing *pranayamams* to increase their



Siam: A panoramic view of the royal palace and royal Wat at Bangkok on the bank of the river Meanam.

## IN THE LANDS OF SIAM AND INDONESIA

Siam: The sleeping Buddha, 140 ft. long and 40 ft. high resplendent in gold-plated armour.



Indonesia's Buddhist monastery built in the 9th century at Boro Budur.

vital capacity. Going from South India I was struck by the comparative health and well-being of the average Thai men, women and children. Though small-statured they seem to have the right anatomical proportion of torso and limb.

In legend and history, Siam is supposed to be the home of white elephants though the writer never saw one. These animals were held in great veneration in the belief that the souls of their wisest and noblest ancestors inhabit the animals. These animals are waited on, tended and guarded with the utmost care and veneration. Hence the term "white-elephant" has come to mean in English usage a burdensome possession costing a lot for maintenance. I do not know whether the story about the Siamese barber is true or not. When one goes to a barber's shop for a hair-cut and shave, it would appear, the barber shaves the head and pulls the hair of the beard one by one with tweezers. I never put myself to the ordeal and from what I saw of the sophisticated Thai in Bangkok, it cannot be true at least in A. D. 1952.

On the last night before we left Bangkok for Indonesia the lady doctor, an elderly matronly person, in-charge of the V. D. clinic in the City, took us round the brothels. The Thais seem to be realists in the matter of sex and I was told there are 3000 registered prostitutes and an unknown number of un-registered ladies of easy virtue who cater to the sexual needs of the vast population. The registered girls attend the V. D. Clinic for a periodic check-up and a shot of repository penicillin on their posteriors, the cost of penicillin to be paid for by the girls who in their turn recover it from their customers like Sales Tax.

Brothel-creeping went on from 9 till 11 at night and only a portion of the vast organisation was completed. The unashamed drabness and sordidness of the whole racket bored me and as I had to catch the plane at 7 a.m. next morning I separated myself from the rest of the expert gang, got into one of the waiting government station-wagons and went back to the hotel.

The reader should forget all about what he has read or seen of "Anna and the King of Siam". Much water has flowed along the muddy Meenam river since the happenings depicted in that novel. There is a constitutional monarch with a sort of representative government. The Prime Minister is powerful, ruthless, and efficient.

I got into bed in the fond hope of having a few hours of sleep when I heard a rather loud metallic clucking noise emanating from the bath-room on the verandah. I got up, armed with a torch and gingerly stepped into



the bath-room. The noise ceased. I switched on the electric light and to my horror saw a gigantic lizard on the scantling of the asbestos roof, eyeing me rather contemptously, looking like a baby crocodile in the wrong place. I quietly retreated back to my bed with the reflection that the Mesozoie era is still on in the land of the white elephant. The recent memory of the rouged cheeks, the painted lips, and the brassiered busts of the purveyors of pleasure was blotted out and in its place there were the swimming flying and creeping dinosaurs haunting me during the few hours of the disturbed sleep.

Bangkok is a costly place to live in, it is surmised, due to the large influx of dollar-rich Americans. The 'per diem' allowance given by the UNICEF of 250 Ticals (3·6 Ticals - 1 Indian rupee) was insufficient to meet the high cost of living. Bed and boarding easily cost sixty rupees a day not to mention the other expenses for liquid refreshments, laundry, and frequent resort to Chinese restaurants. A cup of bad coffee with a splash of tinned milk costs the equivalent of a rupee and a quarter.

I was glad to get out of Bangkok lest I should be declared an unredeemed debtor and emplaned by the KLM for Djakarta on the morning of the 29th March. I was not thrilled when the captain of the air-liner informed the passengers that the plane was crossing the equator. Equator is a geographical abstraction. You do not see it or feel it.

Java is the most populous and productive island of the Indonesian Republic and Djakarta in West Java is the capital city of the United States of Indonesia. I was one of the three assigned by W.H.O. to review and assess the Yaws control programme which has been in operation in Indonesia since May 1950.

Djakarta is a modern town with wide roads, well-laid out squares and gardens, fine houses built in the Dutch colonial style with only one objectionable feature, a canal running in the centre of the main road looking filthy and misused by the Javanese day and night. The hotels are up-to-date and less costly than in Bangkok. The harbour is few miles away with the Royal Yacht Club where one can go for a swim and relax on the open pier watching the ships.

The hours of work both in government offices and business firms are from 8 a.m. to 2 p.m. It would appear that people come home at 2 p.m., take their lunch and straightway go to bed and this reminds me of the Indonesian lunch which is supposed to be a Dutch invention. It seems to be a gargantuan affair and consists of a mountain of rice heaped up in the

shape of a smoking valcano of their country with about ten to fifteen side dishes representing most of the edible animal and vegetable kingdoms. It is no wonder that after part-taking of such an enormous lunch people straightway go to bed and sleep it off. It is a moot point whether the hours of work from 8 a.m. to 2 p.m. have been fixed with reference to the lunch that follows the day's work. After a couple of lazy days at Djakarta trying to digest the lunch that was taken 48 hours before, we moved to Jogjakarta, the head-quarters of the Treponematosis control project. The journey was performed partly by air and partly by road. The scenery during the motor-road journey was simply magnificent with lovely and changing landscapes of high volcanic mountains, undulating meadows, terraced gardens, and interminable stretches of lush, green vegetation of rice fields, sugarcane and banana plantations stretching for miles on end on either side of road, criss-crossed by innumerable waterways. Jogjakarta has been chosen as the headquarters for the Yaws campaign because of the very high prevalence of the disease in the area round about the town.

Four strenuous days were spent in visiting a number of villages where Yaws work was going on. The villages are situated in the midst of rice and sugarcane fields and surrounded by beautiful groves of mango, aricanut and cocoanut palms. The approach to the villages from the main road is through slushy cart tracts in which even the modern jeep gets bogged. The village headman is a very important and key person in the Treponematosis control project. He wields enormous influence over the villagers under his charge and is able to collect the entire population of the village, men, women and children, in the compound of his house, for examination and treatment by T. C. P. (Treponematosis Control Project) teams. The entire survey, clinical diagnosis and treatment of Yaws is in the hands of trained male nurses who have proved themselves efficient and reliable in their work. The number of doctors engaged in the work are severely limited due to the great shortage of qualified medical personnel and they merely supervise, test and check the work of male nurses in the mass control programme.

The mornings were spent in field work in the villages and the afternoons were gainfully employed in informal round table discussions at the headquarters. It must be said to the credit of the Ministry of Health in Indonesia that under difficult conditions of finance, paucity of trained personnel and the inaccessible terrain of the country where Yaws has its home, work is being carried on with energy and enthusiasm under the directorship of Dr. Kodijat, a seasoned veteran of 62 equatorial summers who has been at this Yaws business before the birth of the W. H. O. and the discovery of penicillin.



Jogjakarta in Central Java is regarded by Indonesians as their national, cultural and political capital. The town and the country round has played a vital role in the history of Java through centuries. It is here that you find the relics of hundreds of temples and the marvellous ruins of Boro Budur which bear testimony to the Hindu-Buddhist civilisation which existed from the 9th till the 15th century when the Arabs swept through the land and the entire population was converted to Mohamadanism. But the influence of the antecedent culture still persists in their habits, customs and manners.

Jogjakarta is the seat of the newly-formed national Gadja Madha University of Indonesia. The chief industry of the place is the weaving and dyeing of the beautiful cloth known as the Sarong. The cloth is woven without loom and the wonderful patterns are made very patiently by dyeing the cloth after the patterns have been covered with a wax that keeps out the dye. Sarong is the national costume worn by men and women in Indonesia except the few sophisticated individuals in the cities. A few miles from the town there is a pleasant health resort built by the Dutch on the elevated foot of the volcanic mountain called Marepo. On a day with a clear sky, smoke can be seen issuing from the crater of the valcano and it is interesting to learn that the chain of islands between the Malay Peninsula and Australia are really the highest peaks of a vast partly-submerged valcanic mountain range.

The next area for observing the Yaws control programme was East Java with Surabaya as head-quarters. The latter is the sea-port town on the East coast which was a naval base during the Dutch regime and is a populous town with modern buildings, shops and a fine harbour. Every day for four days we drove in jeeps to the outlying villages far and near to study the control programme. On the way, polyclinics (hospitals), rural schools, and the hutments of the village population were visited by the group and it is pathetic to find the enormous prevalence of Yaws in the population. In the schools visited we found 30% of children between 4 and 10 years suffering from early infectious Yaws, while in the adult population of the villages tertiary lesions predominated.

A word about medical education in Indonesia: During the Dutch regime there were two medical schools, one in Djakarta and the other in Surabaya. The former was training students for a degree course and the latter for a diploma. In Surabaya there is also a fine well-equipped school of Dentistry. During the Japanese occupation and the subsequent struggle with the Dutch for about a decade, medical education was completely disrupted and institutions like hospitals were taken over for military purposes by the invaders. It is only since 1950 the Ministry of

Health of the new Republican Government have been trying with no little success to establish the National University of Indonesia with headquarters at Jogjakarta to which all the different faculties are affiliated. The resuscitated medical schools at Djakarta and Surabaya, the infant school at Jogjakarta with their attached teaching hospitals, and the school of Dentistry will constitute the medical faculty of the University of Indonesia. Lack of equipment, lack of books and lack of teaching personnel are hampering the even progress of medical education. There is only one doctor for every 70,000 head of population and even this average is rather misleading. The fact that the majority of Indonesians live in the country whilst the majority of doctors reside in the cities makes the actual position so much the worse for the majority of the population. At Surabaya we were taken round the General Hospital, the Medical School, the School of Dentistry and the partly built V. D. Hospital and Research Institute where every prospect pleases but only trained, qualified, personnel is lacking.

The Indonesians are a kindly, polite, hospitable people, full of enthusiasm for the uplift of their country which has enormous untapped natural resources. They are an artistic race, their paintings, carvings on metal and wood and their pattern dyeing on cloth are greatly appreciated.

The writer missed a visit to Bali Island, a 40 minutes journey by air from Surabaya as it was at the time crowded with holiday tourists and no accommodation in the only decent hotel was available for love or money. Outside India, the Balinese are supposed to be the only people who practice a kind of primitive Hinduism. A lot has been written about their beauty, dancing, artistry, temples, and funerals but somehow I was not amused or interested enough to have prolonged my stay to visit the place. After a fortnight's strenuous but interesting sojourn of the country I was lucky to get a berth by KLM for Calcutta en route to Madras and arrived safe and whole at Meenambakkam on 18th April.

To conclude this random causerie here are some facts about Yaws:

1. Half the Yaws patients in the World are in South East Asia,—10 millions in Indonesia, 2 millions in Thailand.
2. The disease is a non-venereal form of Treponematosis, geographically delimited by the Tropics of Cancer and Capricorn.
3. It is global in extent, and occurs among the agricultural peoples of the world, living in warm humid regions with abundant rainfall and lush vegetation.



4. Social backwardness, poverty, lack of personnel or community hygiene, unclothed body, unshoed feet, trauma to the skin, scabies and fungus infections are contributory factors.
5. The reservoir of infection in endemic areas is in the childhood and adolescent populations.
6. The transmission is by contact and the common fly may be a mechanical agent in the spread of infection.
7. Yaws is curable and we have in repository penicillin the best drug for the mass control of infection. A single dose of 1.2 million units of PAM once injected in the place where you sit is yours without question and will control infectiousness in 90% of cases.
8. The childhood and juvenile contacts should also be treated to prevent infection of the uninfected.
9. There is certain amount of cross immunity between syphilis and Yaws.

Here are some tit-bits from the symposium papers that lightened the otherwise grim subject.

1. That many people like to be treated by injection rather than with pills—apparently on the theory that if it does not hurt, it does no good.
2. That in many primitive communities it is believed you must have Yaws first before you can be strong. Hence the children are deliberately exposed to open cases in order that they may not be robbed of their chance in life.
3. It is a popular belief that really underfed people do not have enough strength to nourish a really spectacular case of Yaws.
4. That an old cure for Yaws is to eat plenty of snake meat because the pattern of certain types of snake skins resembles the pattern of Yaws scars on the body.

When I arrived in Madras I was pleased to hear a question on Yaws appeared in one of the papers for M.D. and this sudden awareness on the part of the examiner is sufficient justification for the International Symposium on the disease.

——★——

# Going Abroad

Dr. B. RAMAMURTHI, M.S., F.R.C.S.

*"If you want to educate yourself, the best way is travel, travel, travel."*

—Mark Twain.

PEOPLE go abroad for various reasons, for learning, for experience, for improving trade, for acquiring a new degree or a new car, or at least to get their photos in the newspapers. These people can broadly be divided into two categories, the bigger folk and the lesser folk. The former are the lucky ones as some organisation, like the State or Union Government, or the World Health Organisation (WHO) or UNICEF, or UNESCO or FIL (father-in-law) is sending them. These are also known as VIP (very important persons), because when they visit foreign lands, our ambassadors arrange parties and photographs in their honour. The programme is fixed and all other arrangements are made for these people and they have no care or shadow over their eyebrows.

The lesser folk are those who have to spend from their own pocket and have to make their own arrangements. These are the ones who are subjected to all the stringent rules and regulations which international travel entails, but who probably get more out of their travel in the shape of adventure and experience.

As medical men, whichever category you may belong to, it is better to have a clear conception of the purpose of going abroad. Travel abroad has inherent merits and is useful by itself. Travel widens one's outlook, gives new experiences and new acquaintances, and at the end of it, one is able to look upon his fellow men with more tolerance and sympathy. But travel for its own sake is beyond means for most of us; there is usually an object for which one goes abroad.

There are those who go abroad to acquire a degree or diploma. The number of these has increased recently and the causes are many. The newly-won independence has given rise to a new spirit of adventure



and enthusiasm. In addition, with the advancement of knowledge, the number of people who want to specialise, is also increasing. This tradition of travel to foreign countries is not new to India as we know from Indian History. From China to Arabia, Indian scholars have travelled in the past and interchanged ideas and culture centuries ago.

Lack of opportunities for proper training in our country and also the numerous difficulties of rules and regulations that one faces, prompts our young men to seek knowledge elsewhere, and there is no doubt that in spite of a few well-developed centres in our country, we have to look to other countries for fresh knowledge and better experience for some more years at least. This is especially true in the field of original work and research in which we are at present sadly lacking. Due to years of continuous foreign domination, the capacity for original thinking in our mind has been dulled and it looks as if it will be some time before it can be regained.

In our present set-up and line of thinking, it seems to be impossible for us to realise the atmosphere of research and original thinking that pervades the scientific institutions abroad. There are numerous instances where Indians in foreign lands, who were given the proper research atmosphere, have excelled others and produced results that have contributed to the advancement of science.

Under these circumstances, it is natural for young men to seek to go abroad. There is always the controversy whether one should go abroad with the idea of acquiring a degree or just tour round, observing and learning. It is a good and vigorous discipline to study for examinations in a foreign country. Local prejudices will be absent and being a foreigner oneself, a fair deal can be expected. In addition, the public in India, rightly or wrongly, still give value to these foreign degrees and diploma. But the snag is that while studying for examination, one is apt to concentrate more on the theoretical aspect of the subject and spend most of his time in reading and thus miss the numerous opportunities for practical observation and learning. In addition, the treatment meted out to an observer is different from one who is studying for examination. More things are shown and explained to an observer than to a candidate. But if one decides to seek a degree or diploma, it is best to complete all the necessary theoretical study in India itself before going abroad to give the finishing touch.

Before leaving India, it is better to plan well ahead. In Britain, United States, Canada, etc., corresponding medical associations give their

guidance and put one in touch with various leading personalities in the field. It is best to contact these early and get a tentative programme fixed, if vexatious waiting and waste of time and money are to be avoided.

For young graduates it is wiser to finish at least one year's residency in India before taking up any appointment abroad. Opportunities to work as interne or a resident in foreign hospitals are available in plenty now and the Indian Medical Association is also helping young graduates to get placements in foreign institutions.

Having decided where and when to go, the next step is how to find the money. This question holds even when one had pots of money as rupees. We have got to write to Reserve Bank of India (RBI) for the necessary permission. RBI writes back to you. Then both of you write to the Government of India and GOI write back to you. This goes on till finally you are given the foreign exchange for a minimum amount of money. But the astonishing thing is, after all this trouble, at the end of your travel you land in India with a new motor car.

The next step is to acquire a pass-port that guarantees you as a Citizen of India and offers protection wherever you go. You apply for one and a few days later, a plain-clothed gentleman knocks at your door and asks many questions: 'Did your grand-father have a mole on the nose?' 'How did you acquire the lakh of rupees which you say you got from him?' 'Do you sleep on your right side or left side?' 'Have you ever worn a Red Tie or a Red Ribbon?' 'Or are you in any way associated with anything RED?' and so on and so forth. This ordeal over, if you have applied in good time, you receive the pass-port.

With traveller's cheques, vaccination certificates and the passport with visas stamped on it, one is ready to start. Crowds cheer, tears fall, hands clap, and you steam off from the Central Station on your adventure.

Air journey is costlier but quicker, the plane accomplishing in a day what the boat takes 15 days to cross. But going by sea is cheaper and gives one an opportunity of knowing Western culture and learning Western manners and etiquette on the boat, so that one need not be quite ignorant of these at the other end of the voyage.

Speaking of manners and etiquette, these form a large part of the daily life of the Westerners than ours. To know these makes life for one abroad pleasanter and easier and also gives one the necessary easy frame of mind. Take as an *e.g.*, our manner of speaking. We are all prone to



talk a little loud. This is all right in a country where the windows and doors of rooms and houses are kept open. But in a cold country the loud tone jars in a closed room. Quite often in the train or in a restaurant an Indian attracts attention by his loud conversation. I wonder whether it will not be possible for somebody to arrange for some lectures or classes for people who go abroad, about the etiquette and manners of the country they visit.

More important than the knowledge of these etiquette is a knowledge of our own country. Once outside India, the traveller represents the whole of our culture and civilization of India. He carries the banner of our country and he must carry it high. Quite often he is requested to speak at parties, social gatherings or small clubs or associations about India. He is asked questions about our country and culture abroad and there is also a large amount of misrepresentation. People abroad still believe that tigers walk in our streets and every morning we have to shake snakes off our chappals before wearing them. They also believe that all our women wear purdah and so do not come out in the streets. They have no idea of our culture, civilization or religions. It is the duty of every one of us who goes abroad to know something about our long and glorious history, the various facets of our civilization and culture and something about Indian philosophy. He must be able to explain that Hinduism is not a single religion but is more a philosophy and ethics of life which can suit everybody according to his level of evolution.

Perhaps it is a wise idea to read Nehru's *Discovery of India* and Radhakrishnan's *Geetha* before leaving our shores. People who can carry these messages of India to the people of other countries are probably our real ambassadors than the official ones. There is no need to be apologetic about our country or culture. As an ambassador of a civilization that has survived for more than 1,000 years and as ambassadors of a country that won its independence by non-violence, a country of Gandhi and Ganga, every one of us can hold our head high anywhere on the face of the earth.

Naturally there is a tendency for people from one country to stick to each other when in a foreign land. There is a feeling of home-sickness and a familiar figure is so welcome. But quite often this leads to our young men staying in exclusively Indian Hostels and mixing with Indians only—that is, living in a miniature India. By this the opportunity of mixing with the foreigner is missed. One must enter into the everyday life of the foreigners to know their real worth and qualities—thus to gain

experience, to visualise a different point of view, to acquire the spirit of tolerance and universal brotherhood. By staying in lodges or private 'Digs', by making friends with as many foreigners as possible and thus getting invited to their homes, to their parties, to their marriages and funerals, one comes to know the inner core of the people and is also able to diffuse an idea of our culture. Friends thus made are invaluable and are a pleasant memory life-long. Thus we get to appreciate the beauty of human nature in different lands in the same way we seek to enjoy the beauty of their landscape or the wisdom of their experience. Thus, travel abroad becomes a fuller education.

Till recently most of our travel has been to the West. While this will continue to be so for some more time, already one sees the tide turning and in our Asian neighbours, China and Japan, we have our cultural allies. Visits to these countries will become commoner in the near future and the mutual benefit will be remarkable.

Lastly on return what is the contribution to the Metherland? One returns with high ideals full of praise for the foreigner and the countries visited. But unfortunately in a few months time, one falls into the old rut and routine, probably due to environment, probably due to the climate or other factors.

Before setting foot on the shores of India, I wonder whether one should not set down in a diary what he proposes to do and how he proposes to contribute to the Motherland on return. Probably by refering to these notes often, the old idealism will be maintained. Thus only by each one of us contributing to the Motherland in one's own small way can the past glory of India be made a vision for the future.

——★——

**SHAVIANA—**

Do not do unto others as you would that they should do unto you. Their tastes may not be the same.

* * *

When a man teaches something he does not know to somebody else who has no aptitude for it, and gives him a certificate of proficiency, the latter has completed the education of a gentleman.

* * *

The reasonable man adapts himself to the world: the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man.

** We owe this new section to the suggestion of our Dean, Lt.-Col. C. K. Prasada Rao and to the energy, enthusiasm and ready co-operation of Dr. A. Venugopal who has got up the section on Surgery and Dr. Vasudeva Rao on Medicine. "Current Literature" aims to bring to you the cream of the latest of modern advances in the medical sciences as reported in the Medical Press in a condensed, extremely palatable form. It is our hope that the section will stimulate interest, especially in the ambitious student-readers, to go racing to the originals, not merely to read and to witness Medical History that is in the making, but, when the time, the place and the call come, to partake in it as pioneers, experimenters and researchers to the greater glory of our Motherland. Sections on Pathology, Midwifery etc., will follow in the coming issues*—Ed.

# Current Literature

## Surgery: Dr. A. VENUGOPAL, M.S.

### CLINICAL EXPERIENCES WITH AUREOMYCIN IN SURGICAL INFECTIONS.

(Rutenburg, A.M., Schweinburg, F.B., and Fine, J. *Annals of Surgery*, 133: 344-363, March 1951.)

This report by Rutenburg and Schweinburg in the Annals of Surgery last year deals with the clinical effectiveness of Aureomycin in 263 patients. Some were treated with this antibiotic exclusively from the beginning. Others were given after it was found that other antibiotics had failed and still others were given a combination of chemotherapeutic agents.

Aureomycin is very effective in the suppression of the normal intestinal flora and gave excellent results in 67 cases of gastro-intestinal surgery. Alone or in combination with penicillin, Aureomycin was effective in the therapy of diffused peritonitis. In a variety of urinary infections due to gram-negative organisms, Aureomycin showed clinical and bacteriological improvement in all patients. Aureomycin appeared to be very effective in biliary tract infections and it served as an adjunct to surgery in infections of extremities. Postoperative wound infections responded satisfactorily to Aureomycin.

Other conditions for which it was used were acute infections of the soft tissues, acute osteomyelitis, acute parotitis, Vincent's angina, acute hepatitis and herpes zoster and these infections responded well to Aureomycin.

The drug was administered orally, intramuscularly or intravenously. The intramuscular route has since been discontinued and the authors use the oral and intravenous routes only. The toxicity of parenteral Aureomycin is almost negligible but some of the patients, after oral administration of the drug, had severe nausea; others had anorexia or diarrhoea. The authors also found that after oral Aureomycin therapy, some of the patients developed colitis and severe proctitis; some of them had stomatitis and oesophagitis marked by dysphagia, substernal pain and burning lasting for several weeks. These untoward effects have also been observed during Chloromycetin therapy. This article gives a complete review of the present status of Aureomycin in surgical infections.

## SARCOMAS OF THE STOMACH.

(Jacob Rabinovitch, David Grayzel, Alfred J. Swyer, and Bernard Pines. *American Journal of Surgery*, 1950, 80 : 550).

A diagnosis of sarcoma of the stomach is seldom made preoperatively since the signs and symptoms produced by this type of malignant lesion are almost identical with those produced by other gastric neoplasms. The diagnosis is frequently confused therefore with that of carcinoma, peptic ulcer or benign gastric myoma. The onset of the disease is usually insidious and complications that may occur due to this disease are gastric hemorrhage, perforation or obstruction. A review of the case histories of 9 patients having sarcoma of the stomach indicates that pain is the most constant symptom.

A palpable abdominal mass was found in 5 of the 9 patients. The x-ray examination of the stomach does not suffice to determine the exact character of the neoplasm but it does allow a diagnosis of gastric tumour to be made. Gastroscopy may sometimes be helpful. It has been stated that in a patient presenting gastric symptoms of several months duration with a palpable, freely movable tumour of the stomach without loss of weight, general debility and cachexia common to gastric carcinoma, one should expect a sarcomatous growth.

Lymphosarcoma, Fibrosarcomas, leiomyosarcomas and angiosarcomas may all occur in the stomach. At operation, a tumour can be identified from its gross appearance and differs from that of carcinoma because the tumour is nodular, friable, often necrotic in type. The mucosa is involved with a tendency to ulcerate, hemorrhage or perforate in these cases.

## STREPTOMYCIN IN THE TREATMENT OF TUBERCULOUS SINUSES.

(R, Davis. *Lancet*, England. 257 : 982-984. November 26, 1949)

Streptomycin was given systemically to 11 patients with 26 tuberculous sinuses which originated in bone in 5 and followed thoracoplasty in 3, nephrectomy in 2. The dosage was usually 1 gm. daily. The patient's general condition was improved and the sinuses closed in one month in 2 patients, in 6 weeks in 8 patients, but remained open in 1. The average duration of the sinuses was 11½ months and, after treatment, 3 months, 3 days. The conclusion that one draws from this report is that Streptomycin is of great help in patients having tuberculous sinuses, leading to bone joint or glands.

## TREATMENT OF VERY ADVANCED CARCINOMA OF THE BREAST.

(W. G. King, Ann Arbor, Michigan *Archives of Surgery* 61 : 630-653, October 1950.)

The article by King in the "Archives of Surgery" is concerned with the experiences which he and his colleagues had during the past three years. They have used Testosterone in 18 patients with far advanced carcinoma of the breast and they found that Testosterone has a definite place in the treatment of patients for advanced carcinoma of the breast. Testosterone may be of great value in patients with advanced carcinoma of the breast with metastasis when (1) all surgical treatment practicable has been completed ; (2) benefits possible from Roentgen therapy have been exhausted ; (3) establishment of a post-menopausal status either natural or from irradiation has been brought about ; and (4) there has been pain of cancer origin requiring narcotics for relief or disability requiring nursing care.

The amount of Testosterone given in the University of Michigan Medical School, Ann Arbor, for these cancer patients was 250 mg. intramuscularly every other day. A total of 2500 mg. Testosterone propionate were given. This was followed by a waiting period which depended upon the response of each patient. After this first intensive



course, the patient was given a single weekly dose routine or an intensive course of 2500 mg. in 20 days at intervals dictated by the reappearance of pain or disability. Such "demand therapy" has led to an overall average of 200 to 300 mg. of Testosterone per week for each patient. They have reported that with this type of therapy, 7 out of 13 patients with advanced cancer were temporarily rescued from entering an invalid state or a terminal narcotic status and have become useful citizens for an average of over a year. An additional number of patients received enough benefits to have justified the use of androgen.

## PREOPERATIVE AND POSTOPERATIVE CARE.

(F.A. Coller and M.S. Deweese. *Journal of the American Medical Association*, November 5, 1949 pp. 641-646).

Certain of the vitamins are of importance in the preoperative preparation of the patient. Ascorbic acid is essential in the healing of wounds and should be supplied as much as I gm. per day. Several of the B complex vitamins, notably thiamine hydrochloride, 10 mg. daily, riboflavin, 2 mg., nicotinic acid, 50 mg., per day, aid in the metabolism of carbohydrates. The utilisation of parenterally administered dextrose especially demands these vitamins. Riboflavin also helps in the utilisation of certain of the amino acids. Vitamin K which is a precursor of prothrombin is required by patients with hepatic insufficiency or lesions of the gastrointestinal tract producing obstructive jaundice, diarrhoea or persistent vomiting. The prothrombin concentration of all patients with significant gastrointestinal lesions requiring surgical intervention should be determined preoperatively. Hypoprothrombinemia caused by the inhibition of bacteria which normally synthesize vitamin K within the gastrointestinal tract has also been noted in patients who received orally administered phthalyl-sulfathiazole or streptomycin. Patients receiving intestinal antiseptics should be given supplementary amounts of vitamin K before operation.

## POLYCYSTIC DISEASE OF THE KINDNEY AND ITS EFFECT ON RENAL FUNCTION.

(*Journal of Urology*, by Frank N. Buck, R Carl Bunts, Austin I. Dodson, Balt. 1951—66 : 46.)

In this article, the authors give a complete review of the signs and symptoms of this disease and the methods of improving the renal function and the preservation of the life of the patient by proper pre-operative preparation which includes medical management to improve the renal function as much as possible, transfusion if needed and pre-operative anti-biotic medication. The operation is renal decapsulation, unroofing and penetrating the cysts and painting the cyst cavities with Zenker's solution. Six cases have been reported with definite improvement in renal function.

## A TREATMENT OF PANCREATIC PSEUDOCYSTS.

(Frederick H. Brandenburg, Stephen Maddock and Robert J. Schweitzer. *Annals of Surgery*, 1951, 133 : 219.)

This article is a case report of a pancreatic pseudocyst treated successfully by cystogastrostomy a the Boston Hospital. At laparotomy a cystic mass about 10 cm. in diameter was felt posterior to the distal two-thirds of the stomach. Firm vascular adhesions had completely removed the lesser sac and the lesser curvature of the stomach was adherent to the left lobe of the liver. The anterior wall of the distal stomach was incised. The cyst was attached to the posterior stomach wall. An incision 3 cm. in

length made into the posterior wall emptied the cyst contents into the stomach. The patient remained asymptomatic after the operation. He reported 8 months after the operation for a check-up.

The various forms of treatment of pancreatic cysts have been reviewed by these authors in this journal: (1) External drainage by marsupialisation which resulted in a permanent fistula, excoriation of the skin and infection; (2) complete excision of the cyst which is the treatment of choice for true pancreatic cysts but is not always technically feasible because of the hazards attendant with this operation; (3) partial pancreatectomy in selected cases.

This operation of cystogastrostomy is a simple procedure and avoids the external loss of pancreatic enzymes and electrolytes and this operation is recommended only for pseudo-cysts. Re-examination was done in the case reviewed and it was found that there was no reflux of the stomach contents into the cyst.

## VAGOTOMY VERSUS GASTRIC RESECTION.

(Martin J. Healy, Jr., Sidney J. Hellman and Paul K. Sauer, *Journal of American Medical Association*, 1951, 147: 368.)

This article is a study based on 263 consecutive subtotal gastrectomies and 54 consecutive vagotomies and is presented with a view toward evaluating the relative effectiveness of these two forms of therapy for duodenal ulcer. The follow-up in this series was good and allowed for a long-term study and evaluation.

The mortality rate after vagotomy was 2.4 per cent and after gastric resection 3.2 per cent. The complications after gastric resection were the dumping syndrome in 10.2 per cent of the cases. Vagotomy cases had gastric atony as its most frequent sequal in 46.3 per cent and, in 19.5 per cent of the cases, it was severe enough to make further surgery mandatory. Marginal ulcers were noted in 5.8 per cent of the resected group. Recurrent or persistent active ulceration was observed in 36.7 per cent of the vagotomised patients. Final evaluation of the results showed that 87 per cent of the patients were benefited by resection and 65.9 per cent were benefited by vagotomy. The authors conclude from these studies that in intractable duodenal ulcer, gastric resection can be expected to produce far superior results than those after vagotomy.

## TECHNIQUE OF TREATMENT OF DUODENAL ULCER BY VAGOTOMY AND GASTROENTEROSTOMY.

(Crile Jr., *Surgery, Gynaecology and Obstetrics*, March 1951, 309-313.)

Crile Jr. of Cleveland Clinic discusses the disadvantages when either vagotomy or gastroenterostomy are used alone and then stresses the advantages of the combined use of these two methods for duodenal ulcer. He is of opinion that when a gastro-enterostomy is done with vagotomy, it removes the so-called side effects of vagotomy and helps the patients with complicated duodenal ulcer in returning to normal life. The side effects of vagotomy are the result of gastric retention and can be avoided by combining vagotomy with a well placed gastroenterostomy. The gastroenterostomy should be posterior and antiperistaltic. It should be placed parallel to the greater curvature and at its most dependent point. The vagotomy must be complete to prevent a gastro-jejunal ulceration.

# Medicine: Dr. P. VASUDEVA RAO, M.D.

## INTESTINAL MACROCYTIC ANAEMIA.

(G. W. Watson and L. J. Witts, *British Medical Journal*, January 5, 1952.)

Cameron, Watson and Witts have reviewed 60 cases of pernicious anaemia associated with intestinal stricture or anastomosis. In these 60 case reports, anastomosis was the basic abnormality in 23, while in 37, one or more strictures were present. The strictures were mostly of the small intestine, but 6 were in the colon. Of the anastomoses, 14 were entero-enteromoses or entero-colostomies and 9 were gastro-colic or high jejuno-colic fistulae.

The syndrome of gastro-colic fistula has as its principle features, diarrhoea, steatorrhoea, malnutrition and anaemia. It has been shown that there is little passage of gastric contents to the large bowel and consequently the symptoms could not simply be due to diversion of food from the small intestines; rather they were due to contamination of the stomach and small intestine by colonic matter.

The salient features of pernicious anaemia in association with intestinal stenosis or anastomosis are: Sore tongue, free acid is present in more than 50% of cases, intrinsic factor has been demonstrated in one case (Schlesinjer, 1933). Steatorrhoea is not necessarily present. Subacute combined degeneration occurs in a fairly large proportion of cases. The bone marrow is megaloblastic and the anaemia which is macrocytic responds to treatment with liver, though it is sometimes rather resistant. No information is available about the response to vitamin $B_{12}$, folic acid or antibiotics. The anaemia may permanently be cured by surgical correction of the intestinal abnormality, though this cannot be promised with certainty. The syndrome has declined in frequency in recent years owing to decreased incidence of intestinal tuberculosis which has been the most frequent cause of stenosis of small intestine and to technical improvements in surgery which avoid the formation of stagnant loops of intestine.

The syndrome differs from Addissonian pernicious anaemia in that the secretion of HCl and intrinsic factor by stomach may be normal and from sprue in that there need be no steatorrhoea.

It is not easy to postulate the mechanism for the development of pernicious anaemia in these cases. The decisive event in the production of anaemia may be a change in the flora of the small intestine. There are several ways in which this could lead to anaemia. It might cause the loss of an organism which synthesizes the haemopoietic material. It is possible that a toxin is formed which acts other than by interference with the production or absorption of haemopoietic materials. Recent reports on the therapeutic value of penicillin and aureomycin in pernicious anaemia lend support to this view.

## TOXIC REACTIONS OF PAS.

(*British Medical Journal*, January 5, 1952.)

The most frequent and troublesome toxic reactions to PAS are nausea, vomitting and diarrohoea. Hypersensitivity to the drug as shown by fever or rashes, together or separated, is not uncommon. Muscular weakness or heart irregularities attributed to decrease in the serum K levels have been described but not often encountered. Jaundice may occur.

Manifestations of hypothyroidism are very rare and probably occur only in debilitated subjects or children, when given exceptionally large doses.

Exfoliative dermatitis and possibly jaundice are probably the only indications for stopping PAS permanently. Other toxic symptoms may necessitate temporary cessation.

## ANTICOAGULANTS AND CEREBRAL THROMBOSIS.

(*British Medical Journal*, January 5, 1952.)

In general, anticoagulant drugs are not advised in cases of cerebral thrombosis for the following reasons:

(*i*) The differential diagnosis between intracerebral haemorrhage and thrombosis may in some cases be a matter of considerable difficulty. (*ii*) It is recognized that a certain number of patients who have a cerebral thrombosis may have a cerebral haemorrhage a week or more after the thrombosis, probably due to alterations in the arterial wall in relation to the area of softening. (Lancet, 1948, 2, 561) and (*iii*) in a proportion of cases of cerebral softening, no actual arterial thrombosis is found pathologically although there is atheroma and reduction of calibre in the relavant arteries.

## PARKINSONISM.

(*British Medical Journal*, March 29, 1952.)

Recent work suggests that there is a genetic factor in its production. There is an increasing tendency to take the view that Paralysis Agitans may be essentially a psychosomatic disorder: there are those who claim that a disordered personality precedes the physical disease, suggesting that people of drive and ambition, contained within a rigid moral framework, may develop Paralysis Agitans as a result of frustration.

### TREATMENT

(*i*) **Medical:**

(*a*) **Drugs of the Solanaceous group:** These drugs are most effective when given in increasing dosage upto the point at which toxic symptoms appear. When large doses of the belladona group are being taken, there is paralysis of accommodation and dryness of the mouth; these can respectively be relieved by eserine drops and by adding pilocarpine nitrate to the mixture. The drugs of the solanaceous group, in the approximate order of popularity are stromonium, hyoscine, belladona and hyoscyamus.

Tolerance develops slowly but is lost very rapidly. If for any reason, a patient who has been taking maximal doses suddenly omits his treatment, it is essential that tolerance shall be acquired again slowly, otherwise serious toxic symptoms appear.

Occasionally when a patient omits to take his treatment, a "Parkinsonian Crisis", is precipitated and he becomes totally rigid and immobile. This rare but alarming state of affairs soon responds to a renewal of drug treatment.

The effect of these drugs is usually to give the patient a feeling of increased activity and of lessening stiffness. It is doubtful whether any of them really affect the tremor. Little is really known about the mechanism of tremor. The prolonged use of these group of drugs over a number of years carries with it the risk of chronic glaucoma.



(*b*) Mephanesin ("Myanesin") has been used since 1947. It is usually given in the form of an elixir, the initial dose being 1 drachm t. d. s. which can be increased upto 4 drachms, taken 4 to 5 times a day. The larger doses should be well diluted with water. As with most other drugs, mephanesin may reduce rigidity but is not likely to affect the tremor and on the whole it has not been very popular.

(*c*) **Synthetic drugs:** (*i*) The most popular is trihexyphenidyl ("artane") which has a pharmacological action similar to that of atropine. The initial dose is 1 mgm. on the first day increased by 1 or 2 mgm. daily upto a total of about 12 mgms. divided into 3 or more doses. The toxic symptoms include dryness of mouth, nausea, dizziness and, less commonly, blurring of vision. The effect on tremor is very questionable.

(*ii*) Ethopropazine Hydrochloride ("Lysivane") Initial dose is 50 to 200 mgms. steadily increased upto 500 mgms. over a period of 3 to 4 weeks.

(*iii*) "Parpanit" supplied in two strengths; the smaller containing 6.25 mgms. and the larger ("Parpanite forte") containing 50 mgms. It is usual to start with 6 small tablets daily, (2 tablets t. d. s.) increasing upto a maximum of about 24 tablets a day. Toxic symptoms include dizziness as well as palpitation and tinnitus.

(*iv*) Diethazine Hydrochloride ("Diparcol") has been abandoned because of toxic symptoms.

(*d*) It has been also found that the antihistamine drugs sometimes benefit the rigidity and general slowness. The usual practice is to combine these drugs with one of the previously named preparations.

**Oculogyric crises:** never respond to any of the above mentioned drugs though their frequency is sometimes lessened under the continuous action of amphetamine. If attacks are very frequent and prolonged, electric convulsion therapy is worthy of trial and has often proved effective.

In the very rare Parkinsonian who has serological evidence of neurosyphillis, antisyphillitic treatment must be instituted but it will not be found to reverse the Parkinsonian syndrome.

**Physiotherapy:** is probably as important as medicinal treatment. The essential part of physiotherapy is vigorous active exercises employing all the four limbs and in the very advanced Parkinsonian daily passive movements of all joints are essential. The psychological aspects of treatment have to be left largely in the hands of the family.

**Surgery:** The position of surgery is unsettled.

Surgical procedures aim at abolishing tremor and replacing it by weakness or paralysis and operation may be performed either on the cerebral cortex or on the spinal cord. Surgery should probably be limited to patients under 50 who are suffering from gross tremor which is stationary or only slightly progressive and is restricted to one arm. Such rules will exclude about 95% of all patients.

In assessing the value of any form of treatment in Parkinsonism, it must be remembered that it has always been known that a new remedy is likely to achieve results at first, but that such benefit rarely lasts. There is little doubt that much of the alleged benefit rarely lasts. There is also little doubt that much of the alleged benefit is the result of suggestion.

The Parkinsonian must be encouraged to maintain his physical and mental activities.

## HEAD-DROPPING TEST FOR EARLY DIAGNOSIS OF PARKINSON'S SYNDROME

(*British Medical Journal*, March 29, '52.)

The head of the patient lying supine, completely relaxed, is suddenly and briskly lifted and dropped by the examiner. A slow hesitant movement or a soft fall, a gentle hitting of the surface, is indicative of a lesion of the extrapyramidal system and constitute a valuable diagnostic sign in Parkinson's syndrome. If the head drops back like a dead weight, the syndrome can be excluded.

## FIBROCYTIC DISEASE OF PANCREAS

(*British Medical Journal*, March 1, '52)

It has been shown (Andersen, '42) that trypsin is always absent or low in the duodenal juice in fibrocytic disease of the pancreas and this forms a reliable basis of diagnosis. Andersen has pointed out that the estimation of the enzyme need not be accurate and she therefore adopted a simple modification of Fermis' method for routine estimation of trypsin.

Gorden et al have been using a modification of the method of d' Este Emery which utilizes the gelatin of an X-ray film as substrate for estimating trypsin in duodenal juice and faeces. It has the advantage of ease and simplicity and is accurate enough fer diagnosis.

## PNEUMONECTOMY FOR BRONCHIECTASIS

(*British Medical Journal*, March 1, '52)

Two factors play important parts in the selection of cases for lung resection :

(*i*) The distribution and extent of bronchiectasis : the more localized and limited the disease, the better for surgery.

(*ii*) The age of the patient and the ability to survive on what lung tissue is left behind.

The ideal case is that of a child with cough and sputum and with the disease limited to a lobe. Elderly, emphysematous patients with diffuse bilateral disease are not suitable.

In assessing a patient, complete bilateral bronchograms are necessary and gross upper respiratory disease must be eliminated or reduced. Also pulmonary tuberculosis should be excluded. Patients with toxaemia or excessive sputum are in more urgent need of surgery than those whose symptoms are less ob[illegible]

Too much attention need not be paid to the type of Bronchiectasis,—*e.g.*, saccular, cystic or fusiform. It is the symptom[illegible] and extent of the change that count.