

THE
MADRAS MEDICAL JOURNAL

THE OFFICIAL JOURNAL OF THE MADRAS MEDICAL ASSOCIATION

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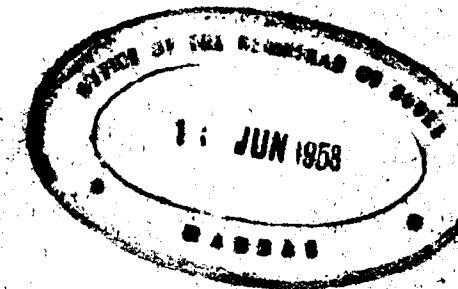
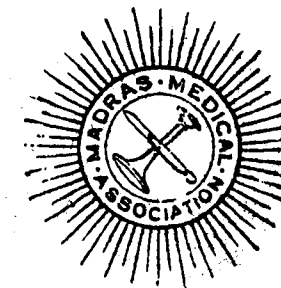
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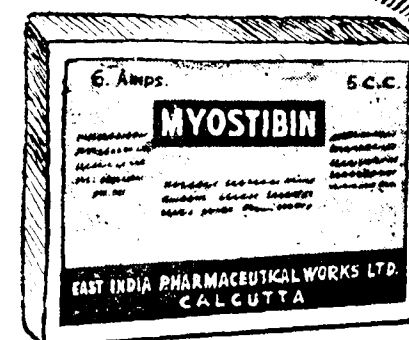
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FOREWORD

The Madras Medical Journal has been in existence for over fifteen years and one must regret the fact that it has had a chequered career in the past. It is proposed to rejuvenate it hereafter and it is the hope of the Editor and the Editorial staff that the Journal would hereafter be so conducted as to serve the objects the originators had in view and fill a very necessary place among the journals in this country.

The Journal is the mouthpiece of the Madras Medical Association and as one intimately associated with the fortunes of this association, its ups and downs from its small beginnings in 1914, may I appeal to all my colleagues in the service to enthusiastically support the central organisation which has striven, through good report and bad, through criticism and comment, to uphold the highest interests of the medical profession and protect the just aspirations of its members?

The Journal should command a warm corner in every member and I join in the appeal of the Editor and the Editorial board in earnestly requesting one and all to extend their hearty support and make the journal worthy of the traditions of the service reflecting the good work that the members of the service are privileged to carry on. To the medical profession in general we extend a cordial invitation to contribute to the Journal articles of scientific interest.

The journal will strive its best to serve the cause of a noble profession and to uphold its best traditions and may its task be made easy by the willing co-operation of one and all.

A. L. MUDALIAR,

President, Madras Medical Association, 1936.

(Culled from our Journal dt. April 1936) 17 years after our Ex-President (now Sir A. L. Mudaliar who continues to be a member of our association) we repeat every word of his appeal to our members attention.

—Edi. Sec.

ANNOUNCEMENT

"Members are informed that a few pages of the Journal will in future be set apart for "SERVICE PROBLEMS". The names of contributors wherever necessary will be kept confidential."

Contributions by way of articles, advertisements, Clinical reports, letters to Editor etc. will be received by the Editorial Secretary for the next issue of our journal till the end of July 1953.

27-4-'53.
Editorial Secretary,
M. M. A.

The Madras Medical Journal

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Nitrite Poisoning in Madras State

BY

Dr. P. VENKAT RAO, B.A., M.B., B.S., M.Sc., F.R.I.C.,

*Chemical Examiner to Government and Professor of Chemistry, Madras
Medical College, Madras.*

Till very recent years, cases of poisoning by nitrite were rare and the first fatal case of poisoning by nitrite in this State was reported in medical literature in the year 1935 by the Chemical Examiner, Madras. Subsequently, cases of poisoning by nitrite have frequently been reported by the Chemical Examiners of Madras, Bombay and Bengal in their respective Annual Report.

Incidence of Nitrite Poisoning.—The incidence of poisoning by nitrite is highest in and around centres predominantly occupied by weavers. A tabular column showing the number of cases of poisoning by nitrite, received in this laboratory during the period 1942 to 1951 from the districts where this poisoning is common, is given below :

District	Ananta- pur	Coimba- tore	Cudda- pah	Goda- vari E.	Gun- tur	Kur- nool	Madras	Nellore	Salem
No. of cases	10	14	27	8	29	6	8	25	33

From the table it will be seen that the districts of Salem, Guntur, Cuddapah and Nellore have a high incidence of nitrite poisoning. The names of places in these districts where nitrite poisoning is common is given below for information.

District.	Names of places.
1. Cuddapah	Rajampet, Proddatur, Vainpalli, Jammalamadugu and Pulivendla.
2. Guntur	Dachepalli, Sattenapalli, Addanki, Chirala, Gurazala, Ponnur, Bapatla, Repalle, Narasaraopet, Mangalagiri and Guntur.
3. Nellore	Kovur, Gudur, Nellore, Venkatagiri, Atmakur, Kavali, Kanigiri, Darsi, Indukur, Buchireddipalayam and Allur.
4. Salem	Tiruchengode, Sendaimangalam, Salem, Thammampatty, Krishnagiri, Rasipuram, Omalur and Sankaridrug.

General.—Sodium nitrite is extensively used by weavers for dyeing purposes. This substance is easily available for sale in the market and forms a convenient source for homicide and suicide. Sodium nitrite is a slightly yellowish white, odourless substance more or less resembling sugar and highly soluble in water. It can easily be mixed with any food or drink causing the least suspicion. Further, the absence of any pronounced taste favours its use as a poison.

Toxicity and fatal dose.—A series of experiments conducted on dogs, by oral administration of sodium nitrite, revealed the presence of methaemoglobin in the blood, taken from the heart after death. A common symptom in these experimental dogs was respiratory distress probably the result of methaemoglobinaemia. Death was rapid occurring in about half an hour after the administration of poison. The experiments also revealed that in the case of oral administration very little of poison was left in the viscera, most of it having been eliminated or otherwise destroyed. From the experiments conducted on dogs it was found that the fatal dose to dogs worked out to one milligram of nitrite ion per ten grams of the body weight of dogs, there being no difference practically, whether the poison was injected under the skin or administered by mouth. Calculating according to Meeh's formula, the fatal dose for human beings would probably be about 2 grams of sodium nitrite for a ten stone man.

The animal experiments further showed that healthy dogs died after half an hour after administration of the nitrite, only very small quantities of nitrite being detected in the stomach and contents and traces in the liver, kidney and intestines and yet death was due to nitrite poisoning. These facts confirm the findings in human poisoning cases, that small quantities of nitrites detected in the viscera do not contra-indicate death by nitrite poisoning.

The commencement of symptoms in animal is very rapid, setting in, in three or four minutes after the administration of the poison, irrespective of the fact whether the poison was given orally or under the skin. Vomiting is the first symptom as it is the first line of defence of the organism against poison. A second line of defence appears to be spasm of the pylorus as is evidenced by the comparatively insignificant quantities in the intestines in spite of the very considerable quantities found in the stomach and contents. The absorption of the poison into the system gives rise to methaemoglobinaemia and the train of symptoms that follow, namely, respiratory distress, giddiness and unconsciousness are probably due to methaemoglobinaemia and cardiovascular collapse, in addition to direct action on the brain. As a consequence of this, death occurs rapidly, the fatal period observed in dogs being half an hour and the fatal period in man being about half an hour to three hours. As symptoms observed in experimental dogs and those mentioned in post-mortem reports of fatal cases of human poisoning by nitrites are similar, it is not unlikely that human beings are as susceptible to nitrite as dogs.

Symptoms.—The general symptoms noted in cases of poisoning by nitrite are vomiting, giddiness and unconsciousness with convulsions. Blueness of the lips and finger tips may also be observed.

Post-mortem findings.—The post-mortem findings in cases of poisoning by nitrites are discharge of bloody fluid from the nostrils and the mouth. The right side of the heart is full and contains red, dark red or cherry red blood. The left side of the heart is empty. In some cases bloody fluid is seen in the pleural and peritoneal cavities. Abnormally fluid blood is found in the large vessels. In many cases the lungs are congested and exude dark red blood on section. The stomach is congested in many cases and in some cases vascular in patches. The liver, kidney and spleen are congested. The brain and its membranes are congested and the ventricles full.

Distribution of nitrites in the viscera.—Analyses of viscera in case of poisoning by nitrite indicate that stomach and contents contained nitrite in quantities much larger than the therapeutic dose of sodium nitrite; intestines and contents, liver and kidney showed only very small quantities of nitrite. Only traces of urea were detectable in urine.

Preservation of materials for chemical analysis.—Since nitrite is liable to be easily decomposed or destroyed in the system sufficient proof of poisoning by nitrite could be gathered easily, if the vomited matter of the victim is available for examination. Hence every effort should be made to collect the vomited matter and preserve it in rectified spirit. On no

account should formaldehyde be used as a preservative since it destroys the nitrite thus making the detection of nitrite impossible. Further, stomach and contents, intestines and contents, liver and kidney and urine should also be sent for examination preserved in the same manner as indicated above except in cases where alcohol also is suspected to have been administered along with sodium nitrite. In such cases articles should be preserved in saturated sodium chloride solution and not rectified spirit.

Medico-legal considerations.—In many cases where the symptoms and post-mortem appearances strongly suggest that death would have been due to nitrites, the test for nitrite (though very sensitive) was negative thus showing that the entire poison was destroyed in the system. In such cases the question would arise whether death was due to nitrite or not and this is a very perplexing one to the medical officer in the witness box. In a case in which a person was administered poison in arrack, the person found the arrack to be saltish in taste, expressed a feeling of loss of memory and finally died after 2 hours. Vomit and visceral matters of the man were sent to us and we detected nitrite equivalent to about 240 mgms. in the vomit but no nitrite could be detected in the stomach and contents, liver, kidney, spleen or heart. There is no doubt the cause of death was due to nitrite but nitrite was completely destroyed in the visceral matters and escaped detection, showing thereby that nitrite is easily decomposed and destroyed in the system. In another case where two person partook the same poisoned food, developed the same symptoms and died suddenly, the viscera of one individual showed nitrite equivalent to about 13 mgms. of sodium nitrite in the stomach and contents and traces of nitrite in the liver, kidney and intestines and contents, whereas the viscera of the other individual showed nitrite equivalent to about 1136 mgms. of sodium nitrite in the stomach and contents, about 6.4 mgms. in the intestines and contents and only traces in the liver. These instances point to the fact that greater importance should be attached to post-mortem appearances in concluding whether death was due to nitrite poisoning or not.

Advance in Therapeutics

BY

K. P. SARATHY, M.B.B.S., M.Sc.

Therapeutic marches on with the advent of newer drugs; and old drugs improved for better action and lesser side effects. A review and evaluation of drugs from time to time will undoubtedly give a fillip to the proper use of these drugs. The craze of the day seems to be a never ending search for newer and better Antibiotics and as such it is but right that we should start with this group of drugs.

A Newer Penicillin under trial.—(N. N.—Dibenzylethylene diamine Dipenicillin G) for aqueous injection intramuscularly. Each vial contains 2,400,000 units of N. N'—Dibenzylethylene diamine Dipenicillin G with Sodium citrate. The contents of the vial may be reconstituted with 6.0 c.c. of water for injection. A single dose of approximately 8 c.c. containing 2,400,000 units may be withdrawn from the vial and given as one injection. It is said that such an injection gives an effective blood level which lasts for 14 days.

Hypo-allergic Penicillin.—Crystalline Potassium Pinicillin G. 100,000 units/c.c. of diluent, consisting of 0.1 or 0.2% chlor—trimeton in Saline. Patients noted the local anaesthetic effect of chlor-trimeton. Even with a 6 ml injection there were no complaints of pain or residual tenderness. No side reactions, such as follow antihistamines given orally, were noted. Therapeutic result were as good as with any other type of penicillin.

Penicillin O.—It is said that unsuccessful cases with the original Penicillin G compound may respond to this new compound. Penicillin O can also produce toxic reactions by itself or following Penicillin G.

Aureomycin Calcium Caseinate.—A new preparation associated with low incidence of Nausea and Vomiting. Each tablet contains 125 mg. aureomycin calcium caseinate, 200 mg. calcium caseinate and 50 mg. calcium carbonate. Quite a good number of patients who had previously had nausea and vomiting while taking regular aureomycin, were completely free when aureomycin calcium caseinate was used.

Erythromycin and Carbomycin.—These two new anti-biotics have recently been described. Both are active against gram-positive bacteria and certain gram-negative organisms and erythromycin has been reported

to be effective against Rickettsia and large viruses. Erythromycin and carbomycin are both produced by strains of streptomyces. From the results obtained it can be seen that erythromycin has a bacterial spectrum very similar to that of Penicillin and is more effective against streptococci and Pneumococci than the other broad spectrum anti-biotics like aureomycin, terramycin and chloramphenicol. It can be further observed that carbomycin in most cases requires a higher concentration to inhibit the growth of most of the test organisms than does erythromycin.

Erythromycin is comparatively stable and is effective when given orally. Apparently there is no cross resistance between erythromycin and other antibiotics, and organisms resistant to them may be fully susceptible to erythromycin. Erythromycin is remarkably active against carynebacterium, and it also appears to be effective against large viruses. Evidently it will be effective against *Diplococcus pneumoniae* and the streptococci, with the possible exception of *Str. faecalis*. Apparently it will also be effective against strains of *Micrococcus pyogenes* which are resistant to other antibiotics. Erythromycin given orally is fairly readily absorbed from the intestines and diffuses throughout most tissues. It appears to diffuse through the placenta and into the ascitic and pleural fluids; with the meninges non-inflamed, however it does not readily diffuse into the spinal fluid. It is excreted in the bile and urine. Recommended average adult dose in 0.4 to 0.5 Gm. every six hours. Doses above this level may cause gastro-intestinal irritation. No systemic toxic reactions after erythromycin therapy have as yet been noted.

Methorphan.—Has been found to equal the effectiveness of morphine in the ultimate control of severe pain. Methorphan is an effective analgesic which can be given by mouth and usually affords longer and more complete relief from pain than morphine. A striking characteristic is its ability to produce cheerfulness in pain-depressed patients the morning after an evening dose. Its primary function is the relief of pain. It is unwise to prescribe methorphan together with a barbiturate. Methorphan should not be used in cases of colic. It is not so useful as codeine. Neither is it so good as morphine in the allaying of extreme anxiety and restlessness when pain is not a feature. Dose 1.5 to 2 mg. N. Allyl-Normorphine in *Treatment of Morphine or Demoral Narcosis*: N. Allyl-morphine may prove helpful in treating the circulatory collapse which sometimes follows administration of morphine and demoral, particularly in elderly individuals. N. Allyl normorphine is the ideal analeptic for treatment of acute narcotic poisoning; it is effective in small doses and does not produce in man the convulsions that may occur if Nikethamide or Pentylene-tetrazol is used. The effect is well sustained for two to three hours. Against depression produced by Pentothol, cyclopropane or ethyl ether, N. Allyl. Normorphine was in effective.

Vit. B₁₂ in Management of Neurologic Manifestation of Diabetes Mellitus.—Crystalline Vit. B₁₂ intramuscularly or subcutaneously was given in various dosage. The most effective schedule was 15-30 mg. daily for 7-14 days followed by a maintenance dose of 15-30 mg. once or twice weekly. None of the complications of diabetes except the neurologic condition were affected by Vit. B₁₂. Improvement of neurologic manifestation in diabetes is apparently on neither psychic nor vascular basis but due to the action of Vit. B₁₂ on the deranged intrinsic nerve metabolism.

A new Synthetic Curarizing Agent.—Compound 20 (Laudolissin). It is a true curarizing agent with a potency in man just half that of d-tubocurarine but with a duration of action slightly longer and that it is antagonized by neostigmine. Maximum abdominal relaxation evident only after 5 minutes after injection. Relative action of abdominal muscles and diaphragm seemed no different from that of d-tubocurarine. Compound 20 was not miscible with thiopentone, Pethidine or succinylcholine. Toxic effects remarkably absent as with other relaxants.

Ultra-Short acting muscle relaxants.—Relaxation can be maintained with a continuous infusion of Succinylcholine chloride in 0.1% Soln. Reports from Stockholm say succinylcholine by continuous drip infusion is superior to all relaxants. It has no secondary effects on sympathetic; parasympathetic or C. N. S. or circulation; no histamine release and there is immediate recovery of full muscle tone and reflex activity at end of operation.

Succinylcholine was given for 3½ days to a patient with tetanus. Continuous infusion reduces muscle rigidity and severity of spasms. Administration needs constant medical supervision and artificial respiration given immediately when there is necessity. Thus given the drug seemed to be a valuable contribution to recovery of patient along with ATS etc.

Milontin: A new drug in the treatment of Petit Mal.—Found to be of great use in controlling the seizures and in lengthening the duration between seizures. Initial dosage 0.3 G, 3 times a day increased at intervals of 2 weeks to 0.6 G; 0.9 G, and 1.2 G; t.d.s, until the greatest effect was got or toxicity resulted. Toxic Signs are increased frequency in micturition; drowsiness, nausea, dream like state, dizziness, pyrexia with macular erythematous rash and vomiting.

Treatment of Intractable Peptic ulcer with Methanthelene (Banthine) Bromide.—Methanthelene bromide effectively relieved symptoms in the initial treatment of these intractable ulcers where other measures of medical therapy had failed. But it is of limited value as a substitute for Surgery because of the high percentage of relapse and development of

tolerance to the drug. Dosage—400 mg. a day. The drug did not appreciably diminish the volume of gastric secretion or acidity as compared to atropine. The action in inhibiting gastric and small bowel motility was striking and in a way explains its mode of action.

Kutrol.—An extract of pregnancy urine, also known as anthelone. Effective in the treatment of crateriform duodenal and jejunal ulcers. In man does not inhibit gastric secretion when given by the oral route. For use in duodenal and jejunal ulcers. Each kapseal contains 75 mg. of Kutrol. Administered orally 2 Kapseals four times daily $\frac{1}{2}$ hour before mealtime and at bed time.

Tablet Neohydrin—a new oral Mercurial Diuretic.—It now appears that Neohydrin, an oral mercurial diuretic, will either supplant the parenteral mercurial entirely, a markedly decrease the number of parenteral injections. The most effective dose in early congestive failure was 1 tablet t.d.s. till 'dry weight' is established. Tablet Neohydrin is so effective that dietary limitations appear to be unnecessary. 13 patients Neohydrin (oral) was combined with Mercuerhydrin parenteral injection. However once, the patient had reached 'dry weight' the Neohydrin Tablets were used alone as the maintenance dose.

Though the advent of newer drugs is not so rapid and dramatic as the early ones like Penicillin; A C T H and Cortisone etc., yet we are in a more settled and calm atmosphere to assess and evaluate the care in the use of New Drugs.

IN MEMORIAM



Dr. P. RATNASWAMI, M.D.

Dr. P. RATNASWAMI, M.D.

We mourn his loss

DIED AT GUDDALORE ON 21-3-1953

Soon after delivering a lecture to the members of the Medical Profession.

Dr. P. Ratnaswami was born at Pondicherry in July 1902 in an orthodox and strictly religious Catholic family. In his early educational career he imbibed a very notable discipline.

He passed the B.A. of the Madras University in 1922; joined the Madras Medical College and completed his course successfully in 1927. During his college career he was the recipient of several prizes and finally, the most coveted of the college medals, viz., the Johnstone Gold Medal. He joined the Service in 1929; took his M.D. in General Medicine in 1930 and served in the Madras Medical Service in the various hospitals and departments. For a time he was in the Maternity Hospital Egmore. As a record of his work while he was in that institution, Dr. Sir A Lakshmanaswami Mudaliar eulogized him on the occasion of his unveiling the portrait of Dr. Ratnaswami at the Madras Medical College Students' Hostel this year.

His work in the various departments of the teaching hospitals of Madras (General Hospital and Stanley Hospital), the authorities know the excellence and the high quality of efficiency he has given to any post that he handled. In 1946, he was chosen for foreign studies and specialised in Social Medicine, a subject of immense future possibilities in which he is so far the only specialised teacher in this State, perhaps, even in the whole country.

After his return he was appointed in the Madras Medical College as Professor of Social Medicine and Physician, Govt. General Hospital. Later he served as the Professor of Therapeutics and Additional Professor of Medicine. As a teacher, he was unequalled in his method of teaching; in the lucidity of thought and clarity of expression and the inspiration that he evoked in his students. As an Administrator, he handled situations which baffled his predecessors and brought order and efficiency into them. As a man, he was one full of integrity, profundity of knowledge, erudite scholarship and culture. As a colleague, he was most trusted and helpful. His advice was always sought and taken with great avidity by his superiors.

He leaves behind 5 children and his widow. In his death, the Madras Medical Service as a whole sustained an irreparable loss."

COMMUNICATIONS & LETTERS TO THE EDITOR.

Congenital absence of Arms.

This rare congenital anomaly reported by Dr. A. A. Iyer in the issue of this journal in January 1952, as occurring among siblings in a family of two sisters and a brother is of great interest to a genetist. The following case reported by Harry E. Mock in the Journal of American Medical Association, February 20th 1926, pages 541-544, will be of interest to a surgeon, who will be able to fit artificial limbs and to an anatomist, on account of the probability of its occurrence as a sequel to an unfortunate maternal impression gained during the pregnancy of the mother.

I quote below the following version of this remarkable case of a rare congenital anomaly assisted by modern surgery.

The Case.—"Henry Wiegman was born with complete absence of both upper extremities. In addition to this deformity he had congenital clubfoot and extreme equinovarus. His feet were short and thick, with absence of toes except for a short great toe on the left foot. On the right foot there was a long digit which was a typical thumb, lying along the inner aspect of the ankle. He had utilized this thumb and ankle as a hand in preparing such acts as bathing, washing his teeth and occasionally writing and drawing.

"Henry at the age of 12 was an unusually bright boy, was up with his class, and showed a marked talent for drawing. Already he displayed some real ability as a cartoonist." An examination of his body "showed two small elevations of the chest wall at the poorly formed shoulders, but the skin of the chest passed smoothly over these from front to back. There were no axillae and there was only a slight protuberance at each end of these elevations indicating the point where the arms were intended to be. There was no cicatrix visible over these areas. None of the anterior group of muscles, the biceps or coraco-brachialis seemed to be present but there was a fairly developed posterior portion of deltoid muscles on both sides. The pectoralis major muscles on either side was foreshortened and poorly developed as was also the latissimus dorsi. The shoulders were narrow and drooping and the right was raised than the left, owing to his constant use of his shoulder.

"The roentgen-ray findings showed a small undeveloped upper fragment of humerus 3 inches long on the right side and about 4 inches long on the left. These fragments of bone lay along the outer border of each scapula. The glenoid fossa on either side was shallow and poorly developed. Each head of the humerus was small, underdeveloped and was in close proximity to coracoid process. The right clavicle was bent upward in its outer half, evidently owing to the approximation of this shoulder with his right cheek".

The Operation.—In June 1920. An operation was performed, the rudimentary humeri were freed, a portion of the pectoralis major was brought over then and free stumps with axillae were constructed (for many interesting details see the original). "On the completion of the healing of the wounds following these two operations, the boy now had two small stumps, in circumference about the size of a baby's upper arm with ability to move them in any direction. The Measurements were:—Right stump from axillae to distal end, 2 inches. Left stump, 3 inches. Right stump from acromion process to distal end, 4 inches. Left stump 5 inches. Two months after the operation had been performed, Henry returned to the Spaulding school for Handicapped children. Here Miss Jane Neir, the principal, and Miss Carney, the chief physiotherapist, placed the boy under a most thorough course in muscle training exercises and occupational training. Their untiring efforts are largely responsible for the result obtained. By December these stumps had become firm and muscular; Henry could abduct the little stumps to approximately right angle and he was ready for his artificial arms.....Dec. 23rd, Henry came to the hospital as soon as he received his new arms.....With his new arms in the sleeves, he looked like any ordinary healthy boy.....That noon at luncheon at the school, he grasped a spoon in his right hand and ate like other boys, instead of lapping his food like a kitty'. Since then Henry has grown considerably although he is still undersized for the age of 17. His stumps are much larger in circumference and measure now:—Right stump from axilla to distal end, 4 inches. Left stump 5½ inches. Right stump from acromion process to distal end 5½ inches. Left stump 6½ inches. From a scientific stand point the two most interesting features about this case are the developments in the bone and the shoulder joint and in the transplanted muscle. A recent roentgenogram shows well developed glenoid fossae, and the head of each humerus is well rounded and apparently normal. Each humerus has shown decided growth, the left growing more rapidly than the soft tissues about it, so that now it protrudes more than an inch at the end of the stump and is covered only with skin..... The transplanted pectoralis major muscles can be contracted at will. Henry can make his right transplanted pectoralis stand out like a biceps and he gets the same pleasure out of making a muscle as any boy does who flexes his arm."

The cause.—As to the causation of the anomalies in this particular case, there were no precedent and no obvious causes in the family, but there was a curious instance of mental impression. Maternal impression have always been advanced as a cause for deformities and birth marks of all descriptions. In the case presented here, the boy's mother relates the following experience, and it is corroborated by her husband and niece:—When about two months pregnant the mother confided the fact to an old woman, but requested her not to mention it. The old woman said it was nothing to be ashamed of and related an instance of a young mother who was pregnant and ashamed of it, and when her boy was born he had no arms. As the old woman told Mrs. W. about this case she grasped her by the shoulders and shook her. H. W.'s mother claims that this made a fearful impression on her and she told her husband about it. Shortly thereafter a Chicago newspaper published an article with pictures telling of certain Phillipino tribes that punished parents by cutting off the arms of their children. She brooded over these pictures until her niece burned the paper.

Communicated by—

T. JANARDHANAN,

Dept. of Anatomy Madras Medical College.

The Madras Medical Association

MEMORANDUM

1. **Name.**—The name of the Association is "The Madras Medical Association."

2. **Office.**—The registered office of the Association will be situated in the Presidency of Madras.

3. **Objects.**—The objects for which the Association is established are:—

- (a) To promote the cause of medicine.
- (b) To maintain the honour and interests of the medical profession in general and of the Madras Medical Service in particular.
- (c) To maintain an *esprit de corps* among the members of the Association.

4. **Powers.**—For the attainment of the above objects, the Association shall have power:—

- (a) To promulgate and forward the dissemination of information and knowledge in any branch of medicine.
- (b) To print and publish any periodicals, books or leaflets that the Association may think desirable for the promotion of its objects.
- (c) To aid, stimulate and forward research work in any branch of medicine conducted by any of the members of the Association.
- (d) To take any gifts or property, whether subject to any special trust or not, for any one or more of the objects of the Association.
- (e) To take such steps by personal or written appeals, meetings or otherwise as may from time to time be deemed expedient for the purpose of procuring contributions to the fund of the Association in the shape of donations, annual subscriptions or otherwise.

(f) To accept subscriptions and donations, and generally to manage, invest and expend all moneys and property belonging to the Association.

(g) To sell, manage, lease, mortgage, dispose or otherwise deal with all or any part of the property of the Association.

(h) To establish and support, or aid in the establishment and support, of any other Association formed for all or any of the objects of this Association.

(i) To do all such lawful things as are incidental or conducive to the attainment of the above objects.

5. **No profits by Members.**—(a) The income and property of the Association whensoever derived shall be applied solely towards the promotions of the objects of the Association as set forth in this Memorandum of the Association and no portion thereof shall be paid or transferred directly or indirectly by way of dividends, bonus or otherwise howsoever by way of profits to the members of the Association, provided that nothing herein shall prevent the payment in good faith, of remuneration to any officers or servants of the Association or other person in return for any service actually rendered to the Association.

(b) No member of the Council of Management or governing body of the Association shall be appointed to any salaried office or any office paid by fees and no remuneration shall be given to any member of such Council or governing body except re-payment of out-of-pocket expenses and interest on money lent.

6. The fifth paragraph of this Memorandum is a condition on which a licence is granted by the Local Government to the Association in pursuance of Section 26 of the Indian Companies Act, 1913.

7. The liability of the members is limited.

8. **Undertaking to contribute to the funds of the Association.**—Every member of the Association undertakes to contribute to the assets of the Association in the event of the same being wound up during the time that he is a member or within one year afterwards, for payment of the debts and liabilities of the Association contracted before the time at which he ceases to be a member and of the costs, charges and expenses of winding up the same and the adjustment of the rights of the contributories among themselves, such amount as may be required not exceeding one year's subscription for membership.

9. If upon the winding up or dissolution of the Association there remains after satisfaction of all its debts and liabilities, any property whatsoever, the same shall not be paid or distributed among the members of the Association; but, if and as far as effect can be given to the next provision, shall be given or transferred to some other institution or institutions having objects similar to the objects of the Association to be determined by the members of the Association at or before the time of dissolution and in default thereof by the High Court of Judicature at Madras.

10. **Association.**—True accounts shall be kept of all money received and expended by the Association and of the matters in respect of which such receipt and expenditure take place and of the property, credits and liabilities of the Association and once at least in every year the accounts of the Association together with a balance sheet shall be examined, audited and certified by one or more properly qualified auditor or auditors. The accounts of the Association shall be open to the inspection of Members at all reasonable times subject to any rules, the Executive Committee may pass in this respect.

The Madras Medical Association

ARTICLES

1. **Interpretation.**—These articles shall be construed with reference to the provisions of the Indian Companies Act, 1913, and terms used in these articles shall have the same respective meanings as they have when used in that Act.

2. **Meaning of certain expressions.**—In the interpretation of these articles except where excluded by the context—

(a) Words including the masculine gender shall include the feminine.

(b) The word "Association" means the Madras Medical Association.

(c) The term "Madras Medical Service" shall mean and include all Civil Apothecaries, Civil Assistant Surgeons and Civil Surgeons (Provincial) in Government employ.

3. The number of members of the Association is unlimited.

4. **Admission of Members.**—The members of the Association shall be of three classes—

(a) Honorary Members.

(b) Ordinary Members.

(c) Associate Members.

Honorary Members.—Any person may be admitted as an Honorary Member, who by reason of his eminent position and attainments, is recommended by the Executive Committee and elected at a General Meeting by not less than two-thirds of the members present at such meeting.

Ordinary Members.—Any permanent member of the Madras Medical Service, or any retired member thereof, may become an Ordinary Member, on applying to the Secretary of the Association in the form prescribed.

Associate Members.—Any House Surgeon, House-Physician or any temporary member of the Madras Medical Service may become an Associate Member by applying to the Secretary in the form prescribed.

N.B.—None but Practitioners registered under the Madras Medical Registration Act, IV of 1914 are eligible to become Ordinary or Associate Members.

5. **Removal of Members.**—The name of any member whose subscription is in arrears for over three years shall be liable to be removed from the list of members at a meeting of the Executive Committee; but he shall be eligible for re-admission on payment of all arrears.

6. **Retirement.**—Any member who desires to retire shall signify his intention to do so in writing to the Secretary and thereupon his name shall be removed from the list of members and he shall be deemed to have retired; but shall be liable to pay all arrears of subscription.

7. (a) **Rights of Members.**—Any member may attend any meeting of the Association but the right of voting at General Meetings shall be restricted to ordinary members only.

(b) Only ordinary members are eligible to serve on the Committee.

8. **Office-bearers.**—The following shall be the Office-bearers of the Association:—

(a) One President.

(b) Two Vice-Presidents.

(c) Nine members of the Executive Committee of whom one shall be the Treasurer and two Joint Secretaries.

9. **Election of the President and Vice-President.**—The President shall be elected from among members resident in Madras. Of the two Vice-Presidents one shall be from among the resident members and one from the non-resident members.

The President and the Vice-President shall be *ex-officio* members of the Executive Committee.

10. **Executive Committee Members.**—Of the Executive Committee Members, at least five shall be from among members residing in Madras of whom one shall be the Treasurer and two the Joint Secretaries.

11. **Election of Office-bearers.**—The election of Office-bearers shall be annual and conducted as follows:—

“Voting papers and lists of the members of the Association resident in and out of Madras shall be circulated to all the members during last week in December each year. The voting paper shall be returned by

each member to the Secretaries with the names of Office-bearers (President two Vice-Presidents, and 9 members of the Executive Committee) for the succeeding year clearly marked out, so as to reach them on or before 15th January of the year following. The President shall nominate three members, who are not among the outgoing Office-bearers, to scrutinise the voting papers and announce the results at the Annual General Meeting. The Executive Committee shall elect the Joint Secretaries and Treasurer from among the abovementioned 9 members”.

12. **Vacancies among the Office-bearers.**—Vacancies among the Office-bearers of the Association occurring in the course of the year shall be filled up by the Executive Committee as early as possible after the occurrence of such vacancy.

13. **Annual General Meeting.**—An Annual General Meeting shall be held once a year at such time and place as the Executive Committee notify, at least 14 days before the meeting to pass the annual reports of the Association (which shall include a statement of accounts of the Association) and to elect the members of the Executive Committee for the ensuing year.

14. **Ordinary and Extra-ordinary Meetings.**—The above-mentioned General Meetings shall be called Ordinary Meetings and all other General Meetings shall be called Extraordinary General Meetings.

15. **Requisition to President for Meeting.**—The President may, at any time and shall, upon the requisition in writing of not less than seven ordinary members of the Association, convene an Extraordinary General Meeting of the Members.

16. **Special Business.**—All business shall be deemed special that is transacted at an Extraordinary Meeting and all that is transacted at an Ordinary Meeting, with the exception of the consideration of accounts and balance sheets and the ordinary report of the Association and the election of the Executive Committee.

17. **Quorum.**—No business shall be transacted at any meeting unless a quorum of not less than 12 ordinary members is present at the commencement of such business. If within half an hour from the time appointed for the meeting a quorum is not present, the meeting, if convened upon the requisition of members shall be dissolved; in any other case it shall stand adjourned to some date within the next fortnight at such time and place, as shall be notified; if at such adjourned meeting a quorum is not present those present shall form the quorum; but, no fresh subject can be discussed at the adjourned meeting, unless a quorum be present.

18. **Chairman.**—The President shall preside as Chairman at every business meeting of the Association and in his absence one of the Vice-Presidents; if neither the President nor Vice-Presidents are present at the time of holding a Meeting, the members present shall choose some other member present to be the Chairman of such Meeting.

19. **Adjournment.**—The Chairman may, with the consent of the Meeting, adjourn any Meeting from time to time, but no business shall be transacted at any adjourned Meeting other than the business left unfinished at any Meeting when the adjournment took place.

20. **Resolution.**—At any General Meeting, unless poll is demanded by at least three members, a declaration by the Chairman that a resolution has been carried and an entry to that effect in the book of proceedings of the Association shall be conclusive evidence of the fact.

21. **Poll.**—If a poll is demanded in manner aforesaid the same shall be taken at such time and in such manner as the Chairman directs and the result of poll shall be deemed to be the resolution of the Association in the General Meeting.

22. **Votes.**—Every member shall have one vote and no more. All votes shall be given personally, except the votes for the election of Office-bearers.

23. **Executive Committee.**—The management of the affairs of the Association shall be vested in an Executive Committee consisting of 9 elected Members, exclusive of the President and two Vice-Presidents.

24. **Term of Office.**—The term of Office of the members of the Executive Committee shall be for one year but members will be eligible for election at the General Meeting.

25. Any member appointed to fill a casual vacancy shall retire at the next Annual Meeting.

26. **Particular powers.**—In addition to all powers hereby expressly conferred upon them and without detracting from the generality of their powers, the Executive Committee shall have the following powers:—

- (a) To control the financial expenditure of the Association.
- (b) From time to time to fill up any casual vacancy occurring among the members of the Executive Committee.

(c) During the temporary absence of the President and Vice-Presidents from Madras to appoint one of its members to discharge the duties of the President.

(d) To invest the funds of the Association and from time to time vary such investment and to sell, transfer or otherwise deal with such investment and all properties belonging to the Association.

(e) To make rules not inconsistent with any or all of these rules for the conduct of the business of the Association and to vary and repeal the same from time to time.

(f) To delegate any of their powers to Sub-Committees consisting of such member or members of their body as they think fit.

(g) Generally to do such things as they may consider necessary or expedient for the purposes of carrying out the objects of the Association.

27. **Members of the Executive Committee.**—The Executive Committee may meet together for the despatch of business, adjourn and otherwise regulate their meetings and proceedings as they think fit, provided that at least four meetings shall be held every year and may determine the quorum necessary for the transaction of business. Until otherwise determined five members shall form a quorum. A meeting of the Executive Committee for the time being at which a quorum is present shall be competent to exercise all or any of its authorities, powers and discretions by or under the rules for the time being vested in or exercisable by the Executive Committee.

28. **Duties of the Treasurer.**—The Treasurer shall receive all moneys payable to Association, disburse all payments ordered by the Executive Committee, maintain true and correct accounts and preserve all vouchers and other certificates of receipt and expenditure.

29. The duties of the Secretaries are as follows:—

- (i) to maintain all correspondence, books, records, etc., of the Association,
- (ii) to convene all meetings of the Association,
- (iii) to carry on the business connected with the publication of the journal, transaction or any other paper,
- (iv) and carry on such other duties as are authorised by the Executive Committee.

30. The Executive Committee shall apportion the above duties among the Joint Secretaries at its first meeting and may vary all or any of them from time to time.

31. **The Journal of the Association.**—The Journal of the Association be called "the Madras Medical Journal" shall be conducted by an Editorial Committee, consisting of an Editor and five other members, who shall all be elected by the Executive Committee. One of the Executive Committee members shall be appointed by the Executive Committee to act as Secretary to the Editorial Committee.

Every member of the Association shall be entitled to a free copy of the Journal.

32. **Surplus Funds.**—All surplus funds of the Association shall be invested either in Government Securities, the Bank of Madras, or in the Indian Bank, Limited, or the Central Urban Bank, Limited, Mylapore.

33. **Keeping of Accounts.**—The Association shall have true accounts to be kept of all sums of money received and expended by the Association and of the matters in respect of which such receipt and expenditure take place and of all the property, credit and liabilities of the Association.

34. **Inspection of Books.**—The accounts of the Association shall be open to the inspection of members at all reasonable times subject to any rules the Executive Committee may pass in this respect.

35. **Annual Statement of Accounts.**—The Executive Committee shall at every Ordinary General Meeting lay before the members, a statement of the income and expenditure of the Association during the preceding year and also a balance sheet covering the same period together with a report of the Association as to the rate and progress of the Association.

36. **Copies to be sent to Members.**—A copy of such statement, balance sheet and report shall be sent to every member at least 14 days before the Ordinary General Meeting.

37. **Auditors.**—The Association shall at every Ordinary General Meeting appoint one or more Auditors to hold office for the ensuing year, and shall fix the remuneration (if any) to be paid for their services. No member of the Association shall act as an Auditor.

38. **Casual Vacancies.**—Any casual vacancy in the office of Auditor may be filled up by the Executive Committee but while any such vacancy continues any continuing Auditors or Auditor may act.

39. **Duties of Auditors.**—Every Auditor of the Association shall have a right of access, at all times to the books, accounts and vouchers of the Association and shall be entitled to require from the officers of the Association such information and explanation as may be necessary for the performance of the duties of the Auditors. The Auditors shall sign a certificate at foot of the balance sheet stating whether or not all their requirements as Auditors have been complied with and shall make a report to the members on the accounts examined by them and on every balance sheet laid before the Association in General Meeting during their tenure of office, and in every such report the Auditors shall state whether, in their opinion the balance sheet referred to in the report is properly drawn up so as to exhibit a true and correct view of the state of the Association's affairs, as shown by the books of the Association, and such report shall be read before the Association in General Meeting.

40. **Bankers.**—The Bank of Madras or the Indian Bank, Limited, or the Central Urban Bank, Limited, Mylapore, shall, until otherwise determined, be the Bankers of the Association.

41. **Service of Notices.**—A notice may be served by the Association upon any member either personally or by sending it through post in a prepaid letter addressed to such member at his registered place of abode.

42. **Time of Service.**—Any notice if served by post shall be deemed to have been served at the time the letter containing the same would be delivered in the ordinary course of post and in proving such service it shall be sufficient to prove that the letter containing the notice was properly addressed, prepaid and posted.

43. **Alteration of Articles.**—No alteration shall be made in the articles except by a vote of three-fourths majority of the members of the Association present at an Annual General Meeting.

Association Notes

THE ANNUAL REPORT OF THE MADRAS MEDICAL ASSOCIATION

1952.

The Annual General Body Meeting of the Madras Medical Association was held under the Presidentship of Dr. A. Ananthanarayana Iyer, in the Madras Medical College, Madras, at 6-10 p.m. on Saturday the 24th January, 1953.

In his introductory remarks, the President said: "Friends—This afternoon, I wish to say a few preliminary remarks about our Association. 'They always say that the night is darkest before the dawn'. I do not know whether it is true or not, but usually they say 'Night is darkest before the dawn'. Last year we had some dark, very dark, facets in the activities of our Association".

"On one occasion, the Treasurer got two bills from the Printer for which Cheques were issued. The Printer went to the Bank. The Bank dishonoured the Cheque, saying 'you have no money'. I told him 'kindly send the Cheques over here'. Subsequently, of course, we made arrangements and paid him. I wish to say that there was a stage when we were practically hard pressed for funds, but that stage has gone. We have received a good amount of enthusiasm and it is sure we will be able to collect the subscriptions correctly. If we collect the subscriptions correctly, we will run the Journal as a leading one and we will not be subject to criticism. Some people may say 'yours is a services Association', but a large number of services Associations are not quite so. Hereafter, no one will criticise, and so the Association is really in a bright era now. It gives me the greatest pleasure that I will be handing over the charges of the Association to my successor, Dr. Y. Narayana Rao, who, I am sure, will bring it into a brighter phase of its activity".

"As usual, our Proceedings begin with condolence Resolution for our deceased members".

Dr. A. Ananthanarayana Iyer proposed "This Meeting of the Madras Medical Association places on record its deep sense of sorrow at the sad demise of Drs. M. A. Nair, and M. G. Kini who were Members of the Association and authorise the Secretary to communicate the Resolution to the relations of the deceased Members. This resolution was passed unanimously; all the Members of the Association stood silent for a minute in token of respect to the deceased Members of the Association.

Resolution No. 2 proposed by the Secretary, Dr. Janardhanam runs as follows:

"This Meeting of the Madras Medical Association resolves to congratulate three of its distinguished Members (1) Dr. A. Ananthanarayana Iyer, President, Madras Medical Association; (2) Dr. R. V. Rajam; and (3) Dr. R. K. K. Thampan on their recent appointments as Directors of the upgraded Departments of Anatomy, Venereology, Gynecology and Obstetrics respectively".

This Resolution was also passed unanimously with great cheers.

Then the Annual Report and Audited Accounts of the Association for the year 1952 was considered.

Resolution No. 3.—That the Annual Report and Account (already circularised) be accepted by the General Body, subject to written objections being received by the Secretaries on or before 5-2-1953".

In moving this Resolution for acceptance, Dr. Janardhanam said that according to the rules of the Association, 14 days notice is necessary before the report is accepted. Any objections sent to me will be received till 5-2-53. We will pass this resolution that the Annual report and audited accounts for the year 1952 be accepted, subject to no objections being received on or before 5-2-53.

The President said that this is only what you call a technical point. "We cannot as a General Body totally approve of the Annual Report and the Audited Accounts for the simple reason that 15 days have not elapsed between the publishing of the report and the acceptance of the report. In case a written objection comes from any Member, the accounts will really be finalised in due course. Thus the resolution was approved, unanimously.

Resolution No. 4.—"I move that an amount of Rs. 20 paid to the Auditors for auditing the accounts for the period 1-12-52 to 31-12-52 be passed" moved by Dr. Valiath, and seconded by Dr. Janardhanam. This Resolution was also passed unanimously.

The Auditor for the next year was appointed: "Resolved to appoint Y. Ramaswamayya, the present auditor to audit our accounts for the year 1953 and pay him the usual fees". Moved by the Secretary, Dr. Janardhanam, seconded and passed unanimously.

The next item—Election of Office Bearers.—Dr. Janardhanam explained that he called for nominations for the year 1953 on 23rd December, 1952. The nominations received till 10—1—53, were as follows:

Presidentship.—Dr. Y. S. Narayana Rao only. So he was elected unanimously. For the Vice-Presidents, Dr. K. Madhava Menon's nomination was the only one received for the Non-resident vacancy. Hence he gets elected unanimously. For the remaining seat for Vice-President, as there was no other nomination, our present Vice President, Dr. (Mrs). T. P. Raman continues.

For the 9 seats of Executive Committee Members, only 5 nominations were received, that of Dr. M. Narayana Pai, Dr. V. R. Thayumanaswami, Dr. P. S. Kumaravelu, Dr. K. P. Sarathy and Dr. T. Janardhanam, and 4 more seats have to be filled up. For the Executive Committee, the following present incumbents are eligible for election—Dr. C. Raghavachari, Dr. R. Subramaniam, Dr. R. Mahadevan, Dr. G. Valiath and Dr. R. S. Muthiah and Dr. Victor. Unless 2 of them withdraw, we have to run an election. Dr. Muthiah expressed that he was not anxious to continue. Dr. Raghavachari also expressed a similar wish but was requested to continue, by Dr. Sarathi. He said that he was prepared to withdraw in Dr. Raghavachari's favour. The President appealed to the Committee Members that we have been there for a number of years; it is better some of us withdraw and allow the younger blood to come in. So the withdrawal of Dr. Muthiah and Dr. Raghavachari was accepted and the remaining four elected unanimously.

Formation of Branches and Service Conditions.—The rules framed by the Executive Committee had already been circulated. Dr. Janardhanam said if the formation of branches is accepted by General Body, any changes that are recommended by the General Body could be incorporated in the rules circularised. He moved that the resolution of the Executive Committee be accepted to form 4 branches of the Association—One at Visakhapatnam, another at Guntur and the other at Coimbatore and the remaining one at Madura. He said that the main idea of forming the branches is to facilitate easy collection of the money and also the non-resident members can take active part in the management of the affairs of the Association by holding meetings in their branches periodically.

One of the Members of the Association wanted to know if there was really any necessity for forming branches - what are the advantages?

The Secretary of the Association replied that there would be a good number of extra activities; the people in the mofussil think that this Association has been organised at Madras, and that it is run for the benefit

of the Members at Madras, alone. Practically they are having no activities at all. Therefore, to remove this general impression from the minds of the mofussil Members, and to make them feel that this Association is not restricted to Members of the Association at Madras alone, these branches are absolutely necessary.

At this juncture, the newly elected President, Dr. Y. S. Narayana Rao entered the Hall in the midst of cheers and enthusiasm.

Then another Member, Dr. Dasanna, raised the question of partition of Madras Province, and said that in view of this it would be better to postpone the proposals. One other Member favoured the objection of Dr. Dasanna saying that there is lot of correspondence with the Government in the matter, and it is better to postpone the proposals.

The President said that when the Andhra State is formed we will reconsider the proposals.

The Secretary Dr. Janardhanam replied that if the Andhra Province is formed, one of the branches in the Andhra State will become the Head Office of the Association of the Andhra Province and that the parent Institution at Madras will be of some help if the service is to be bifurcated.

Then the Resolution was put to vote and carried with one Member only being against the main resolution.

Then it was proposed by a Member that 5 Members must be Resident Members and 4 seats can be filled by non-resident Members in the Executive Committee. Then Dr. Janardhanam said that the existing rules provide for this, but no nomination was received from the mofussil members.

Publication of Journal.—Dr. Janardhanam requested the Members to be prompt in paying their subscriptions, as it was one of the reasons why the Journal could not be published. As pointed out in the Annual report, we are not able to pay our arrears to the Printers. Regarding regular publication of Journals, we have already appealed as to what the Members must do, that is, they must procure advertisements for our Journal, send articles for publication and pay subscriptions in advance each year. This was the request of the Secretaries. If this is done, the next Journal can come out in the month of February. Dr. A. Ananthanarayana Iyer said that our Journal is being abstracted and we must endeavour to keep it going regularly. He earnestly requested the Members to contribute articles as our service consists of some of the cream of the Medical Profession. So he requested that each one of us should find it necessary to write articles and bring out the Journal successfully and regularly.

The Resolution brought forward by Dr. Valiath:

1. "We represent for the present that appointment of Deans after the present incumbents' terms are over, may be kept in abeyance till such time as we have sufficient number of teachers".

It was argued that the appointment of Deans to the Hospitals and Colleges involves the transfer of experienced and specialised teachers to purely administrative Posts. We are passing through a stage of very rapid advance in Medical Education in India and Medical Colleges are springing up in various parts. The University insists upon certain standards. The number of experienced teaching staff is very limited. It is also very difficult and practically impossible for us to get from outside India. Taking the instance of two Deans, we know Dr. Prasada Rao as Professor of Medicine and Dr. Raghavachari as a Surgical Teacher. Now we have lost both of them. They have become Deans. Clinical work in the Hospital and teaching of the students suffer. Now I feel that the trouble about the administration is mostly about money coming and money going. If something like an accounts officers, be appointed attached to the Hospitals and Colleges, then we can certainly and safely go back to our original system of having the superintendent of the hospital again. The teaching will not suffer and the experienced teachers need not be taken away from their specialities. We are at present passing through a critical stage as regards experienced teachers in Medical Colleges. So I put it before the House that we represent for the present that this Dean-ship, after the present incumbent is over, may be kept in abeyance till such time as we have sufficient number of teachers.

The above Resolution was unanimously approved by the Members of the Association.

The next resolution is "Resolved to request the Director of Medical Services, to represent to the Government to delete the words 'Recruited on or after 1st November 1928'". In a resolution already passed during December 1950 and forwarded to the Government. We thought some definite decision will come from our Government but so far we have not heard anything. It was also proposed to send a reminder to the Government.

The next Resolution proposed by Dr. S. P. Vedachalam runs as follows:

- 2 "The Members of the Medical Association request the Director of Medical Services to recommend to the Government and the Vice Chancellor of the Madras University not to enforce for some years that a Member of the service who has procured a

Prescribed Post Graduate qualification should complete at least four years after obtaining the qualification before he is promoted as a Professor in his speciality. The sudden enforcement of this rule has resulted in great inconvenience, monetary loss, disappointment and injustice to many of the Members in the service, especially the war service candidates who were during the years 1940—47 away from their regular special departments.

3. (b) This Meeting further resolves to request the Director of Medical Services to permit the Members of the Association to wait on a deputation on the Vice Chancellor of Madras University for sympathetic consideration of their above resolution".

There was also a similar resolution sent by Dr. Mary Philipose.

It was finally resolved to approach the Director of Medical Services to represent to the Government the severe hardship caused to some senior Members of the service, on the University insisting on 4 years of experience subsequent to the Post Graduate degree to qualify for a Professorship. "Here is a Circular from the Director of Medical Services, asking how many in our service are affected by the operation of this rule of the University. I think that some of us must go and explain to the Director of Medical Services to represent our position to the Secretary to Government."

Then, a Resolution proposed by Dr. Sarathy and seconded by Dr. D. V. Ramamurthy ran as follows:

4. "This Meeting of the Madras Medical Service Association strongly feels that the Members of the Non-clinical department were neither granted increased scales of pay nor permitted transfer to general line, nor allowed to have restricted general practice. As such the general body requests the Director of Medical Services to recommend to the Government the early grant of (1) increased scales of pay with effect from 1st January 1953; (2) In the alternative to withdraw the above said restrictions of of transfer to general line; (3) to withdraw the present ban on these Non-clinical officers to practice, so that they may have a chance to reinforce their present low pay."

The Resolution was unanimously approved.

Dr. T. Janardhanam, then brought forward the following 2 Resolutions:

5. "(1) This Association resolves to request the Government to extend the Madras House rent allowance Scheme to Members of the service employed in places where Accommodation

Controllers are appointed by the Government, as it is—generally felt that in such places, Officers are unable to procure suitable accommodation suited to their status unless a very high rent is paid". The resolution was seconded and unanimously passed.

Dr. Dasanna pointed out an instance at the Tuberculosis Sanatorium, Tambaram. At Tambaram, there is no accommodation Controller. There is no house there and 75 to 80 per cent of the officers live in Madras City. It was also stated that several requests were sent to the Government to consider Tuberculosis Sanatorium also as a part of the City area without any result.

6. Dr. Janardhanam moved "(2) That this Meeting of the Madras Medical Association requests the Government to consider favourably the grant of special children's allowance to Members of the service posted to Primary Centres or in any Mofussil centres in the district. An allowance of Rs. 25 per month for each child (above 5 years) of the Medical Officer be paid to enable the officer to provide proper educational and other facilities for his growing children away from the place of his duty where he is unable to get proper educational facilities".

In reply to a question, it was said that this would apply only to Medical Officers going to Rural villages where facilities of education would not be available for children.

Dr. Latif Khan remarked that it is not worth while to pass this Resolution, because the Government will think that the Medical Officers are always having an inappreciable view of things, and we will not get a favourable reply from the Government.

In reply to the above, the President said that whether the Government are amenable to our recommendations or not, we must be always pressing our claims. So he put the resolution before the House, and the Resolution was passed.

Dr. N. Vaidyanathan presented a Resolution seconded by Dr. K. P. Sarathy. It reads as follows:

7. "Resolved that the Association desired to bring to the notice of the Director of Medical Services the inconsistency of appointing a person with requisite qualification as lecturer while he is actually carrying on the duties of a Professor on the ground that he has not had 4 years experience after obtaining the Post Graduate qualification. It is not clear to the Association where the distinction is except in the emoluments drawn by the Officer

and in the denial to him of his legitimate rights. The Association requests that whenever such appointments are made the incumbent though called a lecturer should be promoted to the cadre of Civil Surgeons".

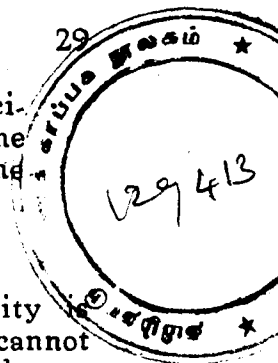
The above Resolution was also passed.

Dr. R. V. Rajam argued that the point of view of the University is that a person passes M.D., or M.S. and in another 2 years' time he cannot straightaway become a Professor. The idea is that the Professor has to get certain experience and certain independent standing in the subject. So we can call him a Lecturer. Qualification alone is not sufficient. Sufficient experience is also required. But this may be either before or after Post Graduate qualification. A person who has taken the M.D. or M.S. degree can be considered as a Lecturer but cannot become a Professor. Take the case of Dr. Hari Rao who was Civil Surgeon. The post was that of a Civil Surgeon, but he was not made a Professor. Take the case of Dr. Ramalingam. The post is that of Civil Surgeon. The Lecturer's pay starts from 310 whereas the Professor's pay starts from 500. Take the case of Dr. Ramalingam. He is qualified to become a Professor, but he is made a Lecturer. When the Congress Government came, they made this a little more complicatory. They said that all those who were especially in the Civil Assistants cadre, except the then existing incumbents who were Civil Surgeons and unfortunately, I came in the latter category. I was a Lecturer for the greater part of my service. So there is a little confusion with regard to it. It is not the University regulations of 4 years of teaching experience after Post Graduate qualification. Those Members of the service by the application of this new rule of the University are reduced to Lecturers, though they are doing the Professors' Job. They must be given the Civil Surgeons' pay.

Dr. A. Srinivasulu Naidu pointed out that the operation of this rule will be arbitrary in some cases and it is already causing hardship and I think this 4 years after qualification must be amended. This Association wanted a modification to the University regulation with regard to the existence of the 4 years after qualification. The present regulations of the Government are different from the University. He pointed out the case of Dr. Rama Rao, the former Professor of Anatomy. After a heated discussion, it was decided to represent the matter to the Director of Medical Services.

Then the next Resolution Presented by Dr. Dasanna was taken into consideration: The Resolution runs as follows:

8. "This Association resolves to request the Director of Medical Services to recommend to the Government to recognise the Government Tuberculosis Sanatorium, Tambaram, as an



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Institution, belonging to the City for purposes of Madras House rent allowance, as no residential quarters are provided for the Medical Officers and as such most of the Medical Officers belonging to that institution live in the City".

It was argued that we have represented many a time. The Government servants in the Coach Buildings Factory Chromepet are given House Rent Allowance under this rule, and when we pointed out this, they did not recognise it. This is a great hardship and feeling among the Assistant Surgeons is that the Government should provide quarters. This Resolution was accepted whole heartedly.

Dr. M. Krishnamurthy moved the following resolution:

9. "Resolved that in view of the present cost of living and of the low scales of pay of Officers holding Clinical posts in the service and the restricted scope for private practice at present available, the scales of pay may be revised to what applied in other Provinces, such as Lucknow, Uthar Pradesh, Bihar".

It was stated that the Resolution is self-explanatory; that we are paid very low here, in this Province. Take for instance, the scales of pay in Lucknow. The cost of living is very high at present. It is 3-1/2 times to what used to be in 1939.

"At present, the Madras Government bans the Members of the Medical Service alone to become the Members of certain Associations. That G. O. does not apply to other services; for example, you cannot be the President of Indian Medical Association, the Treasurer of Indian Medical Association for the simple cause you are a Government servant. You are not trusted by the Government. This happened when I was the Secretary of the Indian Radiological Association. Though the Indian Radiological Association protested vehemently, it was not given weight".

"Further the Madras Medical Service Members are not given any Travelling Allowance whenever they attend a Conference. But take for instance, the Assistant Engineer, the Indian Roads Congress. The Scheme is supported by the Government. If the Government think that Indian Road Congress alone benefit the Government, I do not understand any reason why they should not think that the Members of the Medical Service will also be benefited by attending such Meetings. Atleast a few Members of the service who will be recommended by the Director of Medical Services must be given the T. A. Formerly, the rule was that the paper should be accepted by the Director of Medical Services, but now that rule is removed; but if you read a paper, half the T. A. will be given to you".

Dr. Dasanna said that the President pointed out that two cheques were dishonoured by the Bank. "This is obviously due to lack of funds in the Bank and as you know the Association consists of very few Members. I do not know how many resolutions of this Association have been given weight to by the Government and I do not know any Assistant Surgeon who has been benefited by any resolution. This Association fights mostly for the Civil Surgeons, and however every Member of this Association should give a permanent letter to the Bank that the Bank can pay this Association their subscriptions regularly every year".

Then the next resolution was by Dr. Munuswamy concerning war service candidates:

10. "Those Members of the service who have done War Service have been denied the same privilege that were offered to non-war service candidates. In the case of non-war service candidates their temporary service before recruitment for regular service by the Madras Public Service Commission has been accepted for pay and pension. The same may be given to War Service Candidates also taking into consideration the period of War Service as temporary Civil Service by the War Service candidates".

In the above resolution, the word "War" was deleted and "Army" was recommended and instituted.

11. Dr. Munuswamy moved (2) as regards the start of pay for the War Service Candidates, Government orders have already been passed and communicated already individually to War Service Officers that one increment be sanctioned for 4 years and above of war service, with retrospective effect from the date of joining of these Officers in the Madras Medical Service. Many officers have already drawn this and some have not drawn. Many who have drawn are now asked to repay. The Director of Medical Services may kindly be requested to expedite the payments, of the accrued amounts of the officers without further delay by the Accountant General.

In the 2nd resolution also, the word "War" was deleted and the word "Army" was inserted.

The above two resolutions were also passed unanimously.

Then Dr. Narayanan Kutty Menon presented the following Resolution:

12. "This Association requests the Deans or Principals, to represent Director of Medical Services, to convert the Clinical Lecturers who are in Independent charge of departments into those of Clinical Professorship".

This resolution was seconded by Dr. Valiath.

It was argued that there was already a G. O. existing that the Cadre of Civil Surgeons be increased to that of supernumerary civil surgeons. It will be amended if a post is occupied by a Supernumerary Civil Surgeon.

So this resolution was also passed.

Finally, the President in his closing remarks said "Before bringing this very interesting and useful Meeting to a close, I would like to say one or two sentences. We had a very useful Session. We are going to have a very good dinner. The interest of the Association will be getting into the hands of Dr. Y. S. Narayana Rao. (Cheers). It will be the greatest pleasure to me to know that my successor is Dr. Y. S. Narayana Rao.

There was a time when people thought that it was run by Clinicians. There was a time when people thought that it was a true Civil Surgeons' Association, but today I am sure they will realise it is everybody's Association".

The vote of thanks was given by Dr. Valiath. He said "The Association has extended the activities and extended its Membership. This year we have practically more than 70 new Members. This Association is not restricted to Members in Madras alone, and as President just now expressed this Association is the Association of every member of the service. Though Dr. Ananthanarayana Iyer ceases to be the President, he still continues to be the Editor of our Journal. I am sure we can go to him for help and service. I have very great pleasure in welcoming Dr. Y. S. Narayana Rao as our new President. (Cheers). I hope our Association will grow very strong under his guidance.

[Ed.-Sec.—The above is a short hand report of the Proceedings of the annual meeting.]

Then the Meeting was adjourned for dinner.

After dinner Dr. Vasudeva Rao got up from his seat and delivered the following oration.

Dr. K. VASUDEVA RAO'S ORATION DELIVERED AT THE
ANNUAL GENERAL BODY MEETING HELD ON 24-1-1953.

Mr. President and Members of the Madras Medical Association.—I feel that a signal honour has been done to me by the Madras Medical Association, by asking me to give the annual oration. I am sincerely grateful to the members of the Association for this distinction. On a previous occasion, Sir A. L. Mudaliar gave a very lucid description of the early years of the Provincial Medical Service in Madras, and traced its progress through half a century or more. From the position of dressers, Hospital assistants, sub-assistants, the members of the Madras Medical Association are now occupying all the posts and are manning the State Medical Services.

Even before the advent of Independence to our country, the Indianisation of the Medical Services was begun by that sagacious and farsighted statesman, the late Rajah of Panagal. On an occasion like this, it is but proper that the members of the Madras Medical Association should remember this statesman and, express our gratefulness to him.

Till 1950, the head of the department was a member of the Indian Medical Service, thereafter, this post was also thrown open to the members of the Madras Medical Services, and Dr. David, a member of our service was appointed as the Surgeon-General, the last to be the head of the Medical Department under that designation. From the dawn of Independence the Provincial Services and the I. M. S. Services have been unified and all belong to one service. With the retirement of Dr. David the designation of the Head of the Medical Department has been changed from Surgeon-General to Director of Medical Services, and I had the honour of being the first Director of Medical Services in the Madras State.

From the administrative point of view, I feel that certain other reforms are essential for the expeditious and rapid development of the medical department.

Integration of the Medical and Public Departments.—It is wrong to look at the medical science from two angles of view. Prevention and cure should go hand in hand, and the ultimate aim of the medical science is to eradicate all diseases, and therefore, prevention form a very important part of a doctor's work. As it is, all the Health Officers are fully qualified doctors, who do not do any curative work but, confine themselves to the preventive aspect, which, in actual practice means a lot of administrative work. I see no reason why these qualified doctors who are working as Health Officers should not do the curative work and thus, put into use the knowledge they gained during their training. No one can deny the fact that India consists of a very large number of villages and the health of the nation cannot be raised unless, the villages receive as much attention as the cities and towns. No serious attempt has been made so far towards

improving the health of the rural population. It is true that during the last few years an attempt is being made in this direction by the establishment of Primary Health Centres, and more recently our popular Health Minister has been working hard on this problem and has evolved some method of rural Medical Relief by means of Mobile Dispensaries, to be started soon. It would be a very great advantage if the Health Officers can also be utilised for this purpose. The two departments can work very well, if, there is a common head for both. His or her designation may be the Director of Health Services. If the head for the time being is of the curative side, he may be given the senior most officer of the Health side as his Deputy. In the same way when the Health man is the chief, the Deputy may be of the curative side.

In addition to this both the departments have a large number of problems in common, and, an appreciable amount of time is wasted by the time one file passes from one Officer to the other. A curious fact was brought to my notice while I was in service. A certain paper took seven days to travel from the Office of the Principal of a Medical College to the Supt. of the attached Hospital. Excepting Madras, and Bombay all the other provinces have these departments integrated. Earlier this is done the better for the province and its health.

Director of health Services should also be the Secretary of the Health Dept.—

As it is the Secretary of the Health department is not a medical man. So far he has been a member of the Indian Civil Service and many of them have held the post with distinction and merit. The proposals of the heads of the Medical and Health departments have to be submitted to the Secretary who looks at them not from a professional point of view, but, from the point of view of an administrator, with the result that the urgency of any aspect is not realised, thus leading to the degradation and loss of efficiency in the department. I know the days when, many of the proposals of the D. M. S. came back in such mutilated state that it was difficult to recognise the original ones. After all the head of the department is the man on the spot who is expected to know what is best to the service and its development and therefore he should also be the person to pilot all his proposals through the Government. This combination of the head of the medical and health department and the Secretaryship of the Health department is now in existence in the state of Hyderabad, and from all accounts the combination is working well. Not that we have any misgivings about the efficiency of the I. C. S. Officers who are now manning these posts. They are doing the work most admirably. I strongly feel that the department will expand very rapidly, and progress better if the combination suggested above is effected.

D. M. S. and Deputy D. M. S.—Coming to the Services certain conventions have to be established. It is now recognised that the seniormost in the service is to be appointed as the D. M. S. provided there is nothing

against him, the second senior is appointed as the Dy. D. M. S. provided also that there is nothing against him. When the D. M. S. retires, the Dy. D. M. S. is promoted as the D. M. S. and the next senior officer is appointed as the Dy. D. M. S. provided his credentials are good. The senior officers may belong to the non-clinical departments. There is no denying the fact that in the discharge of the duties of the D. M. S. and the Dy. D. M. S. Hospital experience stands in very good stead and make them better administrators than otherwise. Many of the seniors in the clinical side have at one time or the other been Supts. of Hospitals and have studied the Hospital problems in all its phases. The Officers of the non-clinical department have not had this advantage, with the result that it works as a handicap.

My suggestion is that the officers of the non-clinical department also should be given the same opportunity as the officers of the clinical side. How is this done? I may be a dreamer and may dream of many impossible things. My own impression is that every big Hospital with a bed strength of 500 should have a whole time officer as the administrator, or Dean as at present known. Administration is an art by itself, and it does require the services of a whole time officer. There are some who still believe that the old system of having a senior officer appointed as the Superintendent or the Principal of the College, works as smoothly if not better than the present system of having a Dean. Another argument that has been advanced for the old system is that senior officers who are good in teaching are taken away and therefore it is not for the good of Medical Education. This argument in my opinion is not valid for the reasons that a similar contingency will arise when such people are appointed as Dy. D.M.S. or as D.M.S. It is gratifying to note that a large number of our young men are taking higher post graduate qualifications and equipping themselves for teaching.

I believe that to start with there should be Deans in the Medical Colleges and their attached Hospitals. I would suggest that the first five senior officers of the department should be selected, the seniormost will be the D.M.S. the next senior the Dy. and the next three seniors will be the Deans of the three Medical Colleges in any order, as, this order has no bearing. When the D.M.S. retires the Dy. becomes the D.M.S. and the senior of the Deans will take the Dy. D.M.S.'s place. The next senior officer in the department will be appointed as the Dean, in the place of the Dean who has been promoted as the Dy. D.M.S. This will ensure that by the time an officer is appointed as Dy. D.M.S. he has had a fair amount of experience of Hospital work. In working out the seniority for the Dean-ship, the officers of the non-clinical side also should be considered and they should also be posted as Deans when their turn comes.

There is always a snag with such arrangements. The senior medical officers are taken away from the Profession and are put on the administrative side. This is bound to happen until the Service people

attach importance to seniority. No one would like to be overlooked in his service. When an officer does not get a post which is his by seniority and good service, the officer does feel rather injured and takes it as a punishment. It may not be possible to come to a stage when the administrative posts may be in a separate cadre, and when a member of the clinical or the non-clinical side becomes the seniormost, he may be given the rank and the pay of the seniormost post and then shown as on other duties, namely his original post of teaching. This arrangement will work a slight amount of hardship to the senior members of the service. It comes to this, that these officers will have to give up their clinical side or teaching work for a larger number of years than when appointed as Dy. D.M.S. straight. In the interests of the efficiency of the service and its progress, the senior members have to sacrifice some of their privileges and when called upon, I am sure they will willingly do so.

Such a convention when established will increase the efficiency of the department and at the same time economise the expenditure.

Service itself.—Members of the Madras Medical Service must remember that they owe a duty to their posterity. A few odd things have come to my notice during my service and I am placing them before you for what they are worth.

Buildings.—Many of the buildings were built at a time when the needs of a Hospital were ill-understood, with the result they have become unsuitable for the present day needs. Even the Hospitals that were built 30 years back reveal the fact that the people who planned the buildings did not think of the future. Take for example the O. P. Department of the Vizagapatam Hospital. Many of the departments are over crowded and enough space is not available. I do not deny the fact that the ideal plan of today may be of no use tomorrow or may be out of date. Leaving that apart, it is the service people who have to plan with the future in view. It is always best to look ahead of at least 20 to 30 years, and make sufficient provision for any future expansion. If this were not possible it at least may be possible to see that the foundations of the buildings are such that an additional story can be put up on the existing buildings. I also realise the difficulties the members of the Medical Services are experiencing from the want of full co-operation from the P. W. D. Department. Personally it has been my good fortune to receive the greatest amount of co-operation from the P. W. D. and hence I have no complaints, but a good many D. M. O's. have been complaining about this.

While planning it must be kept in mind that certain buildings are essential before the Hospital can be made to function, viz., quarters for Nurses, quarters for R. M. O. and some of the menials. In the Hospital

built at Kozhikode, and Tirucharapalli, no provision has been made for these two class of people with the result that unsatisfactory temporary arrangements had to be made when the Hospitals were opened. The quarters provided for the Nurses in many places are inadequate and therefore any proposal for a new hospital, should always provide decent quarters for the nurses.

There is another aspect where the Service people should be vigilant, and that is with regard to space. While new Hospitals are being planned, please see that sufficient space is made available. This should be done at the first instance itself, otherwise the locality will become busy with the location of the Hospital and naturally the land will become costly, which will stand in the way of acquiring at some future date. Take for example the Hospital at Anantpur, or at Masula. Plenty of land is available at the back of these Hospitals but they are costly. I am aware of the difficulties that confront the D.M.O's. but the position would be explained in very great detail and if necessary in person, so that, the importance may be realised by the recommending authorities. When such proposals are sent to the Govt. fully explained, there would be, I should say, no difficulty in approving the same. The Officers should not be deterred if they fail in one or two attempts. They should persist in their proposals every year till the sanction of the Govt. is obtained.

O. P. Department.—In many of the Western Hospitals the O. P. is a very important section of the Hospital. Elaborate arrangements are provided for all investigations to be carried on and meticulous care is bestowed on the care of the O. P. cases, with the result that many of the cases are disposed off in the O. P. itself without being admitted in the Hospital for observation, and treatment. Senior members of the Medical and Surgical Staff attend the O. P. and do the work in addition to teaching work. During my last visit to the U. K. I was struck with the very good work they are doing and if possible I would like the following improvements to be made in the working of the O. P.

1. The senior members of the staff should attend the O. P. in the hospitals, attached to the teaching institutions in the city, and in Vizag this practice is prevailing, but in other hospitals in the districts, the D. M. O's. do not attend the O. P. One or two D. M. O's. sit occasionally in the O. P. The head of the District attending the O. P. will increase the reputation of the Hospital and at the same time keep the subordinates trim, both with regard to time and work, it means the quality and quantity of work will improve. Many cases that are being admitted into the Hospital can be disposed off here itself, thus, the strain on the inpatient admission can be greatly reduced.

2. Some of the sections may work in the afternoons. This arrangements will decrease the morning crowd and at the same time the staff can be better utilised. The O. P. works in the afternoons also, but the number of cases that attend in the afternoons is comparatively small.

3. There is no necessity to have separate medical and surgical side for the female side. What I would propose is that there should be one medical and surgical O.P. in the mornings, where both men and women patients can be examined. Separate O.P. run by the lady doctor may be opened in the afternoons for Maternity and gynec cases, keeping in view the importance of the anti-natal work. Very great importance is being attached to anti-natal work, which, I regret to say, is not receiving the attention it deserves. This has become a speciality in the West and I do hope that this important branch is rapidly developed in our Hospitals. If the O.P. Midwifery section works in the afternoon there will be enough space for it, and the lady doctors are able to spare more time for this work. In certain Hospitals, special clinics are not opened for the simple reason that enough space is not available in the O.P. Department for housing these clinics. My own impression is these special clinics can very well be conducted in the afternoons.

4. Every attempt should be made to be of assistance to the general Practitioner. The Private Practitioner has not all the equipment nor the time to make all the necessary investigations or, it may be he had not been able to make out what the disease is. In all such cases the Hospital should assist him as in the Western Hospitals. There it is a common sight to see the cases sent by the practitioners being seen by the doctor in charge and at the end of the O.P. hour, the sister in charge of the section, gives the doctor the required number of stamps for sending the reply for the letters received that day, wherein the findings of the Hospital doctor, the investigations done, the provisional diagnosis, and the line of treatment suggested are given for the benefit of the Practitioner. This is a very good procedure which tends to produce plenty of good will and co-operation between the staff of the Hospital and the Private Medical Practitioners, which is so essential for the smooth running of the institutions.

5. **Case Recording.**—We are very much out of date in this aspect. We are still sticking to the chit system, when all over the world card system has been introduced. The O. P. case cards contain a very large amount of useful information pertaining to the patient, for future reference. I wish this system is introduced in all the Hospitals.

Separate Hospitals for Men and Women.—In Kakinada, Kozhikode, Mangalore, and Salem separate Hospitals for men and women existed. In the new Hospitals that have been built in Kakinada and Salem, the two

sections are amalgamated, whereas in the two other districts of Calicut and Mangalore, no provision has been made in the new Hospitals for this amalgamation. In Mangalore provision has been made for the construction of both the Hospitals.

I doubt whether it is a right course to have this decentralisation. I can well understand the second Hospital is used solely for Maternity work. Instead of this all cases are admitted in this Hospital and no female patients are to be admitted in the main Hospital, but this means double work for the D.M.O. as well as duplication of some of the things as instruments, laboratory, etc., with the disadvantage of lacking the attention of the senior medical officer. The process of amalgamation that has taken place in Kakinada and Salem is to be encouraged, which will result in better working and efficiency of the Institutions. There should be no objections to have these institutions as Maternity Hospitals, but the medical and surgical cases should be admitted in one Hospital. This is my personal view.

A similar situation has arisen in Vizag with the acquisition of the Gosha Hospital.

Domain of Pathology*

BY

Dr. D. JAGANNADHA REDDY,

Prof. of Medical Jurisprudence Andhra Medical College, Vizagapatnam.

"Not of what Beauty and Truth may mean,
But what concerns us more,
How knowing what they are,
We best for our own ends may use them."

—'Windfalls' by R. C. Trevelyan.

Disease existed long before man inhabited the earth. In the past-prehistoric and mediaeval period disease was viewed as a punishment of disobedience in man. Naturally treatment of disease comprised of either undertaking of a pilgrimage to the shrines (Canterbury tales of Chaucer) or by offerings made to the Almighty to beg for forgiveness. Even now such beliefs and practises exist in certain rural areas of our country and pointing of bone at the enemy to induce fear and disease is in vogue in the native tribes of Central Australia. Incidence of infectious fevers and Small pox are viewed as indications of anger inflicted on mankind by a particular deity. Faith in the curative effects of a talisman is not altogether extinct.

Medicine was not separated from magic and many magicians were regarded as doctors. Egyptian, Indian, Chinese and Greek medicine in the pre-Christian era was based on observation. Hippocrates (460-370 A. D.) was the most outstanding physician of those times whose record of clinical observations are even today treasured.

The rise of the Roman Empire gave birth to Dogmatists (Physiologists), Pneumatists, empirists, and eclecticists. For the first time Galen, (131-200 A. D.) whose dogmas reigned supreme all through the mediaeval ages, stressed the need of a knowledge of anatomy without which a physician is like an architect without a plan. His knowledge of human anatomy was inaccurate, being gathered from dissection of animals.

From 1100-1300 a period of retardation and monopoly of church setting in, medicine suffered. Prayer and fasting were advocated as cures and miracles of healing were witnessed in churches. Human body was

*Speech delivered to the Science Club, Visakapatnam on 3-8-'52.

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held as sacred and dissection was prohibited. Superstition siezed public minds. Arabic medicine resulted in the growth of chemistry and Pharmacology. By now medical schools were opened in Salerno, Bologna, Paris and Padua in Europe. Anatomica Publica was practised once a year on executed criminals and Mundinus (1275-1316) is said to have presided over these demonstrations and described stomach as spherical and that brain contained worms which we now know as Choroid Plexuses. Even then people believed in King's evil (Scrofula) and flocked to receive the Royal touch which was to alleviate the suffering.

The period of Renaissance 1400-1700 marked the growth of art, literature and also medicine. People were now receptive and unbiased toward innovations. Present accurate concepts of Anatomy were contributed by Andreas Vesalius (1514-64) who was envied both by his teacher and disciple and was forced to accept the lucrative post of physician to the Spanish monarch and died in tragic circumstances while returning from a pilgrimage.

So far no attempt was made to know the cause and the progress of the disease except for the fact that Syphilis is a contagious disease is inferred from the poems of Fracastorius (1483-1553). We are also told how William Harvey in 1618 commanded by James I did an autopsy on Thomas Barr who was alleged to be 153 years old at the time of death brought about by the impure London air and sudden high mode of life and rich diet to which he was not accustomed before in his country home. It was left for G. B. Morgagni (1682-1771) to study disease processes, their cause, how they start, their progress, termination and how the body reacts and adopts itself to damage and injury—all this we now call Pathology. Being Professor of medicine at Padua, he taught Anatomy, Pathology and medicine for fifty-six years. He emphasised for the first time how useful is a knowledge of pathology in the understanding of disease and its clinical application. He is regarded as the founder of Pathological anatomy. He was so much impressed with the study of Pathology in medicine that he wrote,

"Those who dissected or inspected many bodies.

Have at least learned to doubt

When others, who are ignorant of anatomy

And do not take trouble to attend to it are in no doubt at all."

This period was marked by a great rise of Physicians who studied the sick in the ward and disease in the autopsy room. Sir Richard Bright (1789-1858) and Thomas Addison (1795-1860) both Physicians at Guy's Hospital, London contributed much to Pathological anatomy in Nephritis,

Anaemia and Adrenal disease which are now known by their names. The former associated albuminuria and oedema with disease of kidneys for the first time. Indefatigable and sweet tempered Czech, Carl Rokitansky (1804-78) firmly established the importance of postmortem examination in the study of disease processes. He had to his credit of having conducted several thousands of necropsies. He rightly observed that Medicine and Surgery are built on the rock of Pathology. Rudolph Virchow (1821-1902) confirmed Rokitansky's observations and excelled him in the further study of diseased organs by the microscope which was invented by the Dutch grocer Leeuwenhoek (1632-1723.) Thus he was able to build up the cellular concept of Pathology meaning that in disease the cell was the first to be affected, millions of which form an organ.

Up till then only clinicopathological correlation was perfected but no thought was given to the cause of disease. Contemporary of Virchow, Louis Pasteur, the French chemist (1822-1895) set fire to the spontaneous germination theory and by experimental and clinical evidence proved bacterial causation of disease like anthrax and rabies for both of which he invented the antiserum and rabies vaccine respectively. He is recognised as the founder of modern bacteriology. He was a slave to his laboratory where he worked with monastic simplicity assisted by his devoted wife. His disciples and co-workers, Metchnikoff, a Russian, Robert Koch, the discoverer of cholera vibrio and tubercle bacillus (1890), Kitasato (Japanese) who discovered the Bacillus of Plague, Hansen a Norwegian, who described the causative organism of leprosy, William Welch (1892) discoverer of causative organisms of gas gangrene, are only a few of the many who added to the list of several pathogenic bacteria. The discovery and progress in electricity by Galvani, Volta and Ohm enabled the construction of D. C. I. microscope with whose help Schaudin in 1905 spotted the Treponema pallida of Syphilis. Loeffler described the virus of foot and mouth disease and the invention of Electron microscope in 1940 enabled the study of virus diseases. The expedition of Walter Reed (1851-1902) in search of the Yellow fever virus and its insect vector mosquito along with Carrol and Lazzar were epoch making discoveries and Lazzar and later Noguchi fell martyrs to it. In 1891 certain diseases caused by fungus were recognised. Ricket Taylor (1871-1910) who identified Rickettsia in typhus fever, died of typhus fever in Mexico while investigating the same problem. Robert Bruce (1855-1931) an army surgeon described the causative organism of Malta fever (now known as Brucellosis) and Trypanosomes. The discovery of plasmodium as the cause of malaria by Laveron in 1880 and later the insect vector by Ronald Koss in India in August 1897 and the causative organism of Kala-azar independently found by Donovan (1903) in Govt. General Hospital, Madras and Leishman (1900) elsewhere greatly helped in the recognition of these parasites in disease and treatment of them by chemotherapy.

The clear exposition of Antigen-Antibody reaction by Paul Ehrlich and Brodet enabled Serologists to utilise them in the detection of syphilis by Wassermann test (1906) Rickettsia viruses, Protozoa, and helminths by the wider applications of complement fixation test by employing respective specific antigens. The presence of antibodies in the blood of typhoid patients was utilised by George Widal in 1896 in the diagnosis of Enteric fevers and the test is familiarly now known by his name. The development of precipitin type of antibodies to protein or bacterial or other bombardment is made use of in Kahn test for syphilis and in the determination of protein specificity of human tissues for medico-legal purposes. Haemoagglutination in the form of cold agglutination to detect primary atypical pneumonia, Paul-Bunnell test to spot glandular fever and haemoagglutination inhibition test of Hirst in the recognition of Influenza are valuable diagnostic aids. Landsteiner, Moss and Jansky (1906) described blood groups which are now employed in transfusion services and in paternity tests. Virus neutralisation tests are employed with advantage.

Vaccines and antisera as therapeutic agents are often (specially the former) prepared in laboratories. The keen and continued observations of Sir Alexander Fleming of St. Mary's hospital, London, from 1929-1940 resulted in the discovery of antibiotic Penicillin. In less than a decade since then several other potent antibiotics like Streptomycin, Chloromycetin, aureomycin etc., were isolated by American scientists. Sensitivity tests of bacteria to antibiotics, the assay of antibiotics in body fluids etc. are part of a Pathologists duties.

Hoppe-Seyler (1825-1895), Emil Fischer (1852-1919), Hopkins, Falin, Haldane, Vanslyke and others took advantage of the rapid strides in chemistry - physical and organic, in qualitative and quantitative analysis of biological fluids like blood, urine, C. S. F. milk etc., in the normal and in disease. Biochemical tests carried out with the help of spectroscope photoelectric calorimeter, paper chromatography only to mention a few for the recognition of disease have added a substantial stature to Pathology. Biochemistry is the Achilles heel of the Pathologist. Radio-active isotopes phosphorus, iodine, sodium etc., have enabled the pathologist to understand the metabolism of fluids in the normal and in disease and the function of endocrine organs in normal and in disease, (Bio-physics).

Along with these the immense value of biopsy and cytological (Papanicolaou 1923) examinations in the diagnosis of tumours was established.

Thus you will appreciate how from the miniature and feeble infant stature of morbid anatomy fostered fondly by Morgagni nearly 250 years back, it has rapidly grown and assumed its present gigantic stature.

Owing to rapid expansion, subdivision into Bacteriology Biochemistry, morbid anatomy etc., is inevitable. Naturally you will all voice my sentiments in that the Pathologist occupies an enviable and pivotal position in any medical scheme and in modern hospitals. But he is wise not to take mean advantage of his position in that he always the first to own a mistake made in diagnosis for he is a student of disease and does not assume a judicial position as though his opinion is final and court of last appeal. He is prepared to admit his sins of omission and commission and sets an example for others to follow as he is in search of truth and if he has been mistaken, vanity does not seduce him to pursue the mistake. He strongly believes in the saying "I wrong the patient if I am in the wrong".

You may ask me of what use is the growth of Pathology to mankind. Public health laboratories are organised all over the world where clinical pathology is practised. These laboratories aim at an early recognition of disease, and assessment of cure by serial tests done at varied intervals. The first laboratory of this sort was started in 1888 in U.S. and by 1914 Laboratory services were provided to the physician and people in every state at a nominal cost. In India diagnostic laboratory facilities are only available in teaching institutions and at a few privately managed laboratories where the charges are unnecessarily prohibitive and inflated. Clinical pathologists now practice laboratory medicine. This includes observations and measurements of certain physical, physiological and chemical phenomena for the purpose of diagnosis or treatment and correlation of results so obtained. For this technologists (often women) who are sometimes PH.Ds. are employed. They are worthy collaborators and are treated with much respect. Any unfriendliness and jealousy creeping in between the medical and non-medical employees is unfortunate and unnecessary. The doctors should work as a team in harmony with them. Clinical pathology can very well be compared to a penny in the slot machine, specimens are received at one counter and reports despatched through another. Its use is well and widely known that even politicians and priests demand its inclusion in medicine.

It is comforting to observe the rapid growth of post graduate medical education in our country, on the lines of U.S.A. and Britain. A course of instruction in medical, surgical, obstetric and gynaecological anatomy, physiology and pathology (in gross and microscopic) are better included for the benefit of the post graduate. There is a feeling of animosity between the clinician and pathologist as a result of certain preconceived misconceptions, which act as impediments to mutual professional consultations in the interests of the patient. There is no aristocracy in Science and no superiority is attached to any particular scientific work for there is as much routine in the ward as in the laboratory.

A word on research is not out of place here. Pathology is unique in that it creates a variety of problems to think over and scope for expansion and development is great. We must admit that many of us are lazy and put them off to lack of time to devote on research projects. But when we realise that the Laboratory is the educational heart of the hospital and that the pathologist is a rugged individual and a potent force in his hospital staff organisation, we will strive hard to make our influence felt in shaping professional policy in the hospital. This enlightened profession of pathologists has received no patronage either from the state or Public and so has not taken the desired shape in our country. The seniors amongst us should set an example for the recruitment of young talent to this branch of laboratory science. It requires missionary zeal and aggressiveness to convert young prospects to take to Pathology to which Morgagni, Rokitsky, Virchow, Bright Addison, Pasteur and Koch only to mention a few gave the initial lead.

Proceedings of Madras General Hospital Clinical Society*

Lt.-Col. V. R. Thayumanaswami's Unit:

A CASE OF FRACTURE DISLOCATION OF THE RIGHT TALUS AND ADDUCTION FRACTURE DISLOCATION OF THE LEFT ANKLE.

Patient Raman, aged 40, fell into a pit 3 months ago. Since then he had pain and swelling in the region of both the ankles. He came to this hospital on 10th August 1949 being unable to bear any weight on the right leg and pain in the left ankle on standing. On examination, there was a swelling in the region of the right ankle with movements completely limited and with no localised point of tenderness. Left ankle movements were normal; but tenderness was present over the base of the medial malleolus.

X-ray.—(1) Left ankle: Fracture of base of medial malleolus.

(2) Right ankle: Fracture of neck of Talus with posterior displacement of the posterior fragment.

This case was presented for discussion regarding the best line of treatment.

(1) Should arthrodesis of the right ankle be done?

(2) Can the foot be left alone in the hope that arthrodesis would in any case occur, or

(3) Can an astraglectomy be done.

There was an interesting discussion on the above points. Dr. V. R. Thayumanaswami clearly demonstrated the mechanism of fracture dislocation of talus by specimens.

Dr. V. R. Thayumanaswami's Unit:

A CASE OF OSTEOLASTOMA—UPPER END OF LEFT HUMERUS.

Patient Narayanakutty, aged 21, came to the hospital on 16th July 1949 with a tumour in the region of the left shoulder, complaining of aching pain, of one year's duration. Five months prior to the appearance of the tumour, the patient had an injury on admission, the tumour was of the size of an unhusked coconut, in the region of the left shoulder, occupying the area of the lateral part of the chest wall, the upper third of the arm and the supraclavicular region. The skin over the tumour was stretched, shiny and bluish in places. The tumour was warm, lobulated, cystic over the greater part and not pulsatile. The tumour could be sharply delimited from the shaft of the humerus. All movements of the shoulder were normal. There was slight oedema over the tumour.

* Editorial Secretary will gladly receive similar proceedings and activities of our mofussil members for publication in the journal.

X-ray.—Of the left shoulder showed expansion of the upper end of the humerus, sharply delimited from the rest of the shaft. The cortical covering could not be made out. The Articular cartilage of the head was intact. A few trabecular markings could be seen.

(2) Of the chest: No evidence of secondaries.

Treatment.—3—8—49: Under general anaesthesia, interscapulo-thoracic amputation was done by Dr. V. R. Thayumanaswami. The patient was given 750 c.c. of blood and one pint of saline. The patient had an uneventful recovery.

Lt.-Col V. R. Thayumanaswami's Unit:

A CASE OF OLD FRACTURE STYLOID PROCESS OF FIBULA AND MEDIAL CONDYLE OF THE TIBIA WITH NERVE INVOLVEMENT.

Hameed Saheb, age 24, was admitted with a history of having been struck by the bumper of a car on the right knee.

The patient had a foot drop on the right side. Movements of the ankle joint were restricted. There was anaesthesia over the dorsum of the right foot, the heel and over the lower third of the leg in front and laterally as far back as the tendo-achilles.

X-rays—showed avulsion of the styloid process of the fibula rt. with fracture of medial condyle of the Tibia Rt.

Discussion.—This case was presented because it did not conform to the usual type of 'Bumper Fracture' where there was a valgus strain on the knee. In this case the injury had caused a varus strain. There had been at first an avulsion of the styloid process of the fibula. The continuation of the strain caused fracture of the medial condyle of the tibia. Because of the varus strain there has been stretching of the lateral popliteal nerve. This accounts for the foot drop and anaesthesia over the distribution of the musculo-cutaneous nerve of the leg. The anaesthesia over the lateral aspect of the foot is explained by involvement of the sural communicating nerve which arises from the Lateral Popliteal.

Dr. C. P. V. Menon's Unit:

A CASE OF MULTIPLE MYELOMA.

Patient, Easwaran, male, 42 years, was admitted for weakness and cough of six months' duration. The trouble started in November 1941 with pain in the left hip. The pain increased gradually and he began to limp and could not squat. In April, 1942, he noticed a small lump over the back of the left hip which progressively increased in size. On admission in 1941, there was a hard painful lump over the ileum just below the posterior superior iliac spine.

X-ray.—Myeloma left iliac bone. All other bones normal.

Biopsy.—Plasmacytoma.

On 16-5-1942 the tumour was removed as best as possible after which he had two courses of deep X-ray. The bone became dense and the cavity began to fill up. Patient was practically symptom-free. The case was reported in the Indian Journal of Surgery in 1943 as a case of plasmacytoma.

He rejoined duty and did his work until February 1948 when he was again admitted for a painful swelling over the left mastoid region. He was operated and this tumour also resembled plasmacytoma. He was given another course of deep X-ray therapy. 8 months later, he had severe pain and tenderness over the 11th dorsal vertebra. X-ray revealed that the body of T 11 was affected by the same type of tumour. He was advised to lie in a plaster shell. A few months later, he developed pain in the chest. X-rays revealed infiltration in the manubrium sterni and ribs.

At the time of presenting the case, the patient was having morphia for the pain and he was rapidly going downhill.

This is a case of Multiple Myeloma and not plasma-cytoma.

Dr. C. P. Visvanatha Menon's Unit:

A CASE OF SEMINOMA OF THE UNDESCENDED TESTES (LEFT SIDE) AND BILATERAL RENAL CALCULI.

Patient Seshaiyah, male, aged 20 years, was admitted on 16th May 1949 for swelling of the lower abdomen of six months' duration.

Sometimes ago, the patient had pain during micturition shooting towards the tip of the penis. There was no haematuria.

He noticed a small swelling of the lower abdomen 6 months ago and this swelling slowly increased to the present size.

Local Condition.—There was a smooth ovoid swelling about 5" by 3" occupying the hypogastric and right iliac regions. Firm, freely movable inside the peritoneal cavity. There was no tenderness on fluctuation. The mass was dull on percussion. Rectal examination revealed no abnormality. No masses were felt in the epigastric or umbilical regions. Both testes were absent in the scrotum. Penis was developed normally. A Biopsy of the tumour was done under local anaesthesia.

Biopsy Report.—"Seminoma of the undescended testes left side. Undeveloped uterus present". Blood urea: 40 mgms. B.P. 120/90. Plain X. R. Bilateral renal calculi. I. V. Pyelogram: Poor excretion on both sides. Urine: Acid, 1005, no albumin, no sugar. Hb.: 60%.

Urea clearance test:		1st hour.	2nd hour
Urine urea	...	302.4 mgms.	402.8 mgms.
Percentage of standard clearance	...	14.4	22.7

3-6-1949.—Under high spinal, the abdomen was opened by a right paramedian sub-umbilical incision. The left testes was found enlarged to the size of a small unhusked cocoanut, cystic in places and highly vascular, and (Marked dilated veins present on the surface) attached to the mesorchium which was extending across the pelvis like a broad ligament and getting attached to a small structure resembling the shape of the uterus. The other testes was normal in size, soft in consistency (resembling an ovary).

The vas were found to be softer than normal and converging on the median line, resembling Fallopian tubes and uterus. Gubernacula on both sides were identified escaping out of the abdomen through the internal abdominal ring. The Epididymis was not distinguishable on the left side-on the right side it was normal. The gubernacula and the testicular vessels were divided between clamps and the layers of the mesorchium dissected off from the median ridge formed by the converging vasa differentia. The vas were divided between clamps and both testes removed along with the mesorchium. The Peritoneum was closed at the root of the mesorchium. The right ureter was found dilated and the right pelvis contained one stone. Abdomen closed in layers.

Dr. C. P. V. Menon's Unit:

A CASE OF LYMPHADENOID GOITRE.

Patient Arokyamma, from Malabar, 65 years old, was admitted on 26th September 1949 in the General Hospital, Madras, with a swelling on her neck of six months duration. It began as a small, firm nodule over the left side of her neck and progressed medially. She came to the hospital for the neck swelling and slight hoarseness of voice. There was a sausage shaped swelling of the thyroid, more marked on the left side. The left lobe was hard and the skin was tense but not fixed to the tumour. The whole tumour was firmly adherent to the underlying structures. The trachea was deflected to the right side. There were no signs of excessive vascularity, thyrotoxicity or any local pressure symptoms.

It was diagnosed as a case of malignant thyroid and she was operated upon on 5th October 1949 under endo tracheal anaesthesia. The tumour on the left side was pale, firm and was firmly adherent to the ribbon muscles; sternomastoid and carotid sheath. There were finger like strands from the tumour tissue getting attached to all the neighbouring structures. The jugular vein was firmly adherent to the tumour mass. Wedge-shaped pieces of the tumour mass were removed from either side of the thyroid, more from the left side. The patient made an uneventful recovery. Biopsy showed lymphadenoid goitre.

At present the patient is having deep x-ray therapy and the tumour has considerably diminished in size.

The case is being presented here because of the initial difficulty in diagnosing lymphadenoid goitre from malignancy. Clinically and even during operation, the tumour, was considered to be malignant. Only biopsy gave the correct diagnosis.

Dr. C. P. V. Menon's Unit:

HUMBE'S OPERATION FOR A CASE OF HYPOSPADIAS.

Patient Ganğa Reddy, male, aged 18 years, was admitted on 16th July 1949 for difficulty in passing urine since birth.

Condition on admission.—The external urethral opening is situated over the middle of the ventral aspect of the penis. The prepuce is like a hood over the glans. The penis is slightly deformed due to fibrosis. He had no other congenital defect.

Suprapubic cystostomy was done as a preliminary step.

On 16th July 1949 the patient was operated upon under spinal anaesthesia. The distal portion of urethra was isolated for about 2" and tip excised. The corpus cavernosum which was bent and fibrotic was slit longitudinally. A tube graft of whole skin was taken from thigh, rolled over a catheter and fixed to it by rubber solution. The distal portion of the urethra was reconstructed with this tube graft.

Dr. C. P. V. Menon's Unit:

MAIRE'S OPERATION FOR RECURRENT INGUINAL HERNIA (LEFT).

Patient Doraiswamy, aged 37 years, was admitted for a swelling in the left inguinal region of 2 years' duration. He was found to have a recurrent left inguinal hernia. He had been operated twice for the same condition. The abdominal muscles were found to be strong but the hernia had recurred. Patient has no predisposing causes of hernia. The internal ring admitted 3 fingers.

On 22-7-1949 he was operated under spinal anaesthesia. It was a case of sliding hernia Maire's procedure of repair of the hernia was done by using a whole thickness skin graft from the thigh. He was given chemotherapy post-operatively. The wound healed by first intention.

Maire's operation was done for two other cases during the last two months and in both the cases the wounds have healed satisfactorily.

Lt.-Col. C. K. Padmanabha Menon's Unit:

TWO CASES OF SUB-PHRENIC ABSCESES.

These two cases are presented because of the comparative rarity of left sub-phrenic abscesses and the difficulty in their diagnosis.

Case No. 1.—(Chronic sub-phrenic abscess—secondary to amoebic liver abscess).

Patient Krishna Hebbar, 49 years was admitted for a tumour in the epigastric region of six months duration. The tumour had been rapidly growing in size causing slight discomfort and a dull pain in the epigastrium. There was no history of dysentery.

On examination, there was a tumour occupying the epigastric the left hypochondriac and a part of the umbilical regions. It was ovoid in shape about 8 inches by 6 inches in diameter with a smooth surface, and indefinite margins. Transmitted pulsation was present. The tumour did not move with respiration and was dull on percussion; the dullness was continuous with liver dullness. The tumour was slightly tender. The liver and the spleen were not palpable. There was no free fluid in the abdomen.

The patient was anaemic. The barium meal picture showed the stomach pushed down to the left, but otherwise normal.

In view of the above findings, a provisional diagnosis of a retro-peritoneal tumour was made and an exploratory laparotomy was done. An inflammatory mass was seen between the left lobe of the liver above and the stomach and the transverse colon below, covered anteriorly by the upturned greater omentum. The swelling was fluctuant. A needle was passed and thick creamy chocolate-coloured pus was aspirated. The opening in the abscess was enlarged, and the creamy pus was mopped up on further exploration, the pus was seen coming from an opening from the inferior surface of the left lobe of the liver. The abscess cavity was drained by a rubber tube.

Post-operatively the patient was put on emetine.

Examination of the pus however did not show any amoebae.

This is an example of a chronic sub-diaphragmatic abscess which had an insidious onset unlike an average case of amoebic liver abscess leaking into the peritoneal cavity, usually producing acute abdominal symptoms. In tropics where amoebiasis is so common, it is worthwhile remembering a chronic sub-phrenic abscess as a possibility in the upper abdominal conditions.

Case No. 2.—(Acute sub-phrenic abscess - ? Primary).

Patient Kuppaswami, 70 years, was admitted for pain in the abdomen of 4 days duration and inability to pass motion and flatus with vomiting and distention of the abdomen of two days' duration.

There was a history of a burning pain in the epigastrium, which used to be relieved on taking food.

On physical examination, the abdomen was distended with a few dilated veins coursing over the upper abdomen. The upper abdomen was not freely moving with respirations. Apart from slight rigidity of the epigastric region, the rest of the abdomen was rather lax. There was tenderness (diffuse) over the epigastric and the umbilical regions. A diffuse tumour like mass was felt in the umbilical region. Intestinal peristalsis could be heard.

Blood urea.—27 mgms. W. B. C. 15,600. X-ray of the abdomen showed gas in the left hypochondriac region.

A provisional diagnosis of sub-acute intestinal obstruction was made and the patient was treated by gastric intubation and continuous aspiration. He was also given intravenous glucose saline, protein hydrolysate and intravenous sulphadiazine and penicillin. In two days the distention was very much less, and he was able to retain fluids and pass motion by himself. However, there was a diffuse swelling occupying the left hypochondriac the epigastric and the umbilical regions, which was very tender. Next day, the patient developed hiccough.

A diagnosis of sub-phrenic abscess left anterior inferior space was made and the abdomen was opened by a left subcostal incision. A thin watery foul-smelling (B. coli) pus with gas escaped. About 2 pints of this pus was sucked out. On further exploration, dense plastic adhesions were found between the stomach below and posteriorly and the left lobe of the liver above and the lesser omentum posteriorly. The abscess cavity was drained by corrugated rubber drain.

The patient made an uneventful recovery.

A few observations.—This is an instance of an acute sub-phrenic abscess masquerading as a case of acute intestinal obstruction. Though there was gas in the left hypochondriac region, its importance as a diagnostic feature is of no value on the left side because in this situation we always find gas in the fundus of the stomach, unless of course, it is proved by barium meal to be extragastric. In this case the barium meal pictures were done subsequently and they did not show any evidence of gastric ulcer or carcinoma. Therefore it is suggested that this might be one of the primary types of sub-phrenic abscess.

Lt-Col. D. Subramania Ayyar Unit:

A CASE OF MARION'S DISEASE. (Congenital bladder neck obstruction)

Ellappa Gounder was admitted on 25th April 1949 with a complaint of scanty micturition, pain in the loins, distension of the abdomen and swelling of the feet of 20 days duration.

He was in this hospital 9 months ago with a history of pain in the abdomen one hour after food and vomiting now and again of 3 years duration. His condition was diagnosed as duodenal ulcer. That time his upper abdomen was distended and a Ba enema was done to exclude megacolon. Ba meal confirmed the diagnosis of duodenal ulcer. His abdomen was opened and an active ulcer was found in the first part of the duodenum. Both the kidneys were much enlarged and polycystic. Gastro-jejunostomy with pyloric occlusion was done. He had an uneventful convalescence.

On readmission, 9 months later, he again had vague complaint of pain in the abdomen with distension. There was oedema of the ankles. During his previous stay in the hospital an I. V. pyelogram had been done and had showed a large bladder. Since the patient was complaining of difficulty in passing urine, a catheter was passed which passed in with some difficulty at the end. Urine - Sp. Gr. 1008 with trace of albumin. Blood urea was 61 mgm%.

A cystogram was done to rule out diverticula of the bladder since on catheterization large quantities of residual urine were got. The bladder was much larger than usual. No diverticulum was visualised. Bilateral hydroureters were seen. A diagnosis of bladder neck obstruction was made. The bladder was exposed through a sub-umbilical incision. It was opened into: The walls were hypertrophied and trabeculated with many minute saccules; the bladder neck was tonic and contracted. The posterior lip was brought up by the stay sutures and a wedge-shaped area resected in between from the posterior lip; A self-retaining catheter was passed through the urethra and left in position and the bladder was closed. The catheter was removed after 14 days, after doing cystogram. The patient was able to pass urine normally. The bladder was completely emptying and healed. Cystogram showed reduced capacity of the bladder.

X-ray showed spinal bifida 5th lumbar vertebra.

This might have had something to do with the bladder neck tonicity.

Lt-Col. Sangham Lal's Unit:

A CASE OF MALIGNANT MELANOMA OF THE LEFT MIDDLE TOE.

Nanjappa Gounder, aged 50 was admitted for a tumour in the inguinal region secondary to a malignant melanoma of the left middle toe of 8 months duration. The patient was treated by disarticulation of the left middle toe with the removal of a 3" strip of deep fascia from the middle toe to the inguinal region and by block dissection of the inguinal and the external Iliac group of glands.

Dr. M. N. Prabhu's Unit:

A CASE OF OTOGENOUS SEPSIS PRESENTING UNUSUAL NERVOUS SYMPTOMS.

Jagadeesan, aged 15, was referred to the E.N.T. Department from the Medical Side. He was admitted on 3—9—1949 for blindness of the left eye and weakness of the left side of the body, of 20 days duration. He also has been having discharge from the ear for the last 4 years.

Previous illness.—20 days ago after an injury of left thumb which was of no significance, patient got severe headache, giddiness vomiting and temperature. These symptoms went down in 3 days. Since then he has not been well.

(1) Papilloedema 3 D. (2) Left ext. Rectus paly and Ptosis lt. eye. (3) Weakness of left masseter with loss of sensation of left side of face. (4) Left facial palsy. (5) Taste of anti—2/3 lost (left). (6) Horizontal Nystagmus both eyes. (7) Mixed deafness, lt. ear. (8) Left vocal cords—abduction limited. (9) Asymmetry of the palate. (10) Hypotonia of muscles on left half of body. (11) Gait—Broad based with tendency to fall on left side. (12) The reflexes were normal. (13) Sensations normal.

Ear Condition.—There was perforation of the attic in the lt. ear with granulomatous and white cholesteatomatous scales. The mastoid was tender. X-ray mastoid-cellular mastoid with erosion of sinus plate. Mastoid was tender. L. P.—50 mgm. protein, no globulin.

Treatment.—Cortical mastoidectomy was done with exposure of the lateral sinus and the posterior cranial fossa. The attic and antrum were not disturbed. The middle cranial fossa was exposed as patient showed signs of anosmia. The wound was partially closed. He was given post-operative chemotherapy: and made an uneventful recovery. The tonsils were removed later.

The E.N.T. Surgeon was of the opinion that the otogenic infection had caused a labyrinth fistula and had involved the nerves in relation to petrous portion of the left temporal bone.

Dr. R. Subramaniam's Unit:

A CASE OF COMBINED DEGENERATION OF SPINAL CORD WITH SYPHILIS OF THE CENTRAL NERVOUS SYSTEM.

Venkataraman, aged 30, was admitted on 26th July 1949 for inability to walk of one year's duration.

The complaint started about a year ago with pain in both the calf muscles subsequent to a long march. Gradually he developed a feeling of constriction around the waist (Girdle pains). Later, he developed inability to walk even short distances, gradually becoming bedridden. Four months ago he developed urinary symptoms-retention with overflow - along with loss of sensation over both the lower extremities. This was followed by precipitancy of micturition. The bowels were regular. Cranial nerves were all found to be normal. There was temporal pallor of both the optic discs.

There was wasting of the small muscles of both the hands and also the distal half of the forearm with weakness. The lower limbs showed spastic weakness with exaggerated reflexes. All sensations were lost upto the level of the anterior superior iliac spine.

Laboratory Investigations and reports.—Urine: Specific gravity 1020; Alkaline; no albumin; no sugar. Blood: R.B.C. 2.07 millions/C.mm. Hb. 42%; Volume Index 1.35. Packed cell volume - 26. Sternal puncture - Megaloblastic reaction of bone marrow. F. T. M. - Absence of free Hcl. and low total acidity. Histamine test meal done, result awaited. Lipoidal myelography - no evidence of spinal block. Blood for W. R. and Kahn - Both positive.

C. S. F.—Lange's Test - Negative, 0.1 c.c.	negative	} 27th July.
0.5 c.c.	negative	
Lange's Test - Negative, 0.1 c.c.	Anti-	} 9th August.
0.5 c.c.	complimentary	

Dr. R. Subramaniam's Unit:

A CASE OF WALLENBERG'S SYNDROME.

Patient Venkataswamy, male, aged 48 years, was admitted on 12th July 1949 for (1) weakness over the right half of the body, (2) intense headache on the right side of the head and (3) inability to walk freely all of one week's duration.

History of present illness.—The present complaint started one week prior to admission (12-7-1949) as an intense pricking pain over the right forehead accompanied by dizziness in the morning. An hour later when the patient attempted to walk, he fell down and developed loss of sensation over the left side of the body. He had some ayurvedic treatment which relieved his symptoms partially. Gradually he noticed some improvement over the affected side (i.e. left). Three days before the admission, the patient developed burning sensation over the right half of the face. The patient was a well-nourished individual of 50 years.

Central nervous system.—(1) Intellectual functions and speech were normal.

(2) Cranial nerves.—(a) Left pupil, larger than the right. (b) Left palatal weakness. (c) Horizontal nystagmus present.

Spinal nerves.—Motor power was diminished in all the four limbs, markedly on the left side, where there was impaired co-ordination. Loss of tone and diminished reflexes - but with no sensory toes. A few days after admission the above signs cleared, but the patient found that he had developed weakness on the right side. On examination there was flaccid weakness on the right side with impaired reflexes and co-ordination. In addition there was loss of temperature and pain sensation over the left half of the body. Because of (a) History of attack of dizziness followed by a fall. (b) History of loss of sensation on the left side of the body and pricking sensation on the right half of the face. (c) the signs of left sided involvement followed by right-sided involvement of the tracts in the lower brain stem region.

A diagnosis of thrombosis of a blood vessel first on the right and then on the left side of the brain stem, was made.

The patient recovered gradually.

Dr. P. Ratnaswami's Unit:

A CASE OF DIABETES WITH BILATERAL RADIAL NERVE PALSY.

Patient by name D'Souza, aged 28 years, was admitted on 5th June 1949 with the following complaints; General debility, Polyuria and mild diarrhoea of 3 months' duration.

The patient was treated for diabetes at Bombay 3 years ago with insulin injections. He continued to take insulin injections for about a year after which he discontinued.

The present complaint started 3 months ago with mild diarrhoea slight evening rise of temperature and night sweat.

The patient was ill-nourished, emaciated and slightly anaemic.

The abdomen was scaphoid and irregular masses were seen on the right side extending from the right iliac fossa to the hypogastric region. The abdomen felt doughy.

Other nervous system.—On admission except for the general weakness, the patient did not complain in particular about sensory or motor changes. He had also noticed that he was unable to lift ordinary weights with his left hand as easily as with his right hand.

Since 20 days there had been a gradual weakness of his left wrist joint leading to a wrist drop. A few days later, a gradual onset of wrist drop in the right hand also was noticed.

Examination of the nervous system showed no abnormality except weakness of the extensor groups of muscles of both the upper extremities.

The electrical reaction of muscles showed very weak reaction of the flexor and extensor muscles of the forearm the left more than the right. The patient was treated with splints to prevent wrist drops in addition to the treatment for his diabetic condition and tuberculosis of the abdomen.

Dr. P. Ratnaswami's Unit:

A CASE OF INFECTIVE POLYNEURITIS.

Patient Munuswami, aged 80 was admitted for inability to walk and sleeplessness of 1½ months duration.

History of present illness.—After 3 days fever, he noticed he was not able to use his legs and arms. During the fever he was not unconscious. Later he noticed he could walk with the help of a stick. He had incontinence of urine at that time. The bowels were regular. On examination there was Bilateral facial weakness with loss of taste. There was also some minimal sensory impairment of all sensation. The motor system showed weakness of muscles with increased tone and exaggerated reflexes. The plantars were flexor on both sides.

Investigations.—Urine: 1015, no albumin, no sugar. Blood: W.B.C. 8,600 P. 76; L. 23; E. 1.

22/8. L.P. done, fluid clear, not under tension Quickentdt's positive.

Bacteriology: Cells—Lymphocytes 13. Proteins 160 m̄gm. Globulin + + Chlorides 500 m̄gm. Sugar 103.1.

25/8. C.S.F. .1 c.c. } Postive strong.
.5 c.c. }

26/8. Blood Kahn—positive.

Dr. B. H. Padmanabha Pai's Unit:

A CASE OF DOUBLE ATHETOSIS OR HEREDITARY ATAXIA.

Patient Kannan, aged 12 years, was admitted on 15—9—1949 for difficulty in walking and alteration in speech, both of one year's duration and of insidious onset. There was no history of fever preceding or accompanying the complaint. The patient had no diplopia nor defect in vision nor any sensory disturbances.

There was no history of similar or allied complaint in the family. The patient's birth was normal, as also the various milestones in his development until the present complaint started a year ago.

Condition on admission.—There was a constant grimacing of the face. The tongue was big and showed coarse involuntary movements.

Central nervous system.—Intelligence, memory, etc. were found to be below par. There was a tendency to break into a laugh at the least provocation. The speech was slow and childish.

Cranial nerves.—Defective movement of eyeballs lateral-wards and downwards was seen. Both optic discs were normal.

There were slow, athetotic movements of both the upper extremities at fairly long intervals accompanied by Grimacing movements of the face. Slight hypertonicity of the musculature in the lower limbs was noted. Motor power was diminished uniformly all over. Co-ordination was normal.

Investigations.—(1) Blood W.R. and Kahn—normal. (2) C.S.F. clear, not under tension. Proteins 160 m̄gms%. Globulin present. Sugar 84 m̄gm%. Chlorides 550 m̄gms. W. R. Lan̄ge's test.

Dr. B. H. Padmanabha Pai's Unit:

A CASE OF BRACHIAL PARAPLEGIA FOLLOWING STAB INJURY NECK.

Name: Anthony Muth, age; 29 years.

Complaint.—(1) Inability to use the right lower extremity for the past 1½ years.

(2) " right upper extremity for the past 9 months.

(3) " the left lower extremity for the past 10 days.

Previous illness.—10 years ago, the patient had a sore on the penis for which he was given 10 injections (both I.V. and I.M.) after which he discontinued the treatment. He was stabbed in the neck just posterior to the middle of the right sternoma-toid about 10 years ago. He underwent treatment in Colombo Hospital. Since that time he has not been able to move his neck freely.

The present complaint started insidiously, as a slight weakness in the right leg which speedily increased. About 9 months ago, the patient got a pain in right side of neck and right shoulder and from the next day onwards he could not use his right upper extremity freely; the limb gradually became very stiff. For the past 10 days the patient felt rather unsteady in the left lower extremity also. There was involuntary movement of the right hand while yawning. There was a certain amount of hesitancy during micturition.

The patient was keeping his right hand flexed at the elbow and internally rotated. The movements of the neck were restricted to some extent especially these of flexion. There was tenderness over the scar in the right side of neck. Clinically nothing abnormal was noticed in the spines.

Power was very poor in the right upper and lower extremities. The muscles were separtic.

All sensations were present.

Superficial	Rt.	Lt.
Epigastric	—	—
Abdominal	—	—
Cremaster	—	—
Plantar	—	—
Deep		
B.J.	+++	++
T.J.	+++	++
S.J.	+++	++
K.J.	+++	++
A.J.	+++	++
Clonus		
Patellar	+	—
Ankle	+	—
Visceral		
Hesitancy of micturition		

Investigations.—1. L P. was done and the C. S. F. was clear, It was not under tension. There was no xanthochromia. Proteins: 240 m̄gms No cells. Globulin present W R.—Chlorides 700 m̄gms. Sugar: Below 20 m̄gms.

2. X-ray cervical vertebrae: A. P.—The tip of a knife blade measuring approximately 2½" in length was seen embedded in the soft tissues of the neck commencing from the side C4 vertebrae and running obliquely upwards and to the left and appearing to terminate at the level of the upper border of C2 vertebrae. There appeared to be fracture and impaction of C2, C3 and C4, vertebrae Lateral views: The blade was seen side on ½" broad 2" long. Passing upwards and backwards the broken base was lying on the side of C4 and the tip terminated at the root of C3 spinous process which was broken at this point.

3. X-ray cervical vertebrae after Lipiodol myelography: Sub-total subarachnoid block. 24 hours picture showed a medium sized speck of iodized oil at the bottom of the spinal canal. Retention of the lipiodol was still present about the block. The patient was operated upon and the blade was removed. The follow up showed improvement in the neurological condition.

Dr. B. H. Padmanabha Pai's Unit:

A CASE OF MYOPATHY-LEYDEN MOEBIAS TYPE.

Name: Narayanan, Age: 28 years, Sex: Male. Complaint: Inability to walk properly; difficulty in getting up from a squatting position; pain in both legs. Duration: 5 years, Family history: Patient's father and mother died when he was young. He has a younger sister who is healthy and is not suffering from any similar disability.

History of present illness.—The present illness came on insidiously after the patient had a fall from a height of about 5 feet. He did not sustain any injuries then but had aches in his legs from that time. Since then there has been increasing weakness in his lower extremities as evidenced by his finding it difficult now to get up from a squatting position.

On examination the patient was fairly well-nourished. The tongue showed no fibrillary twitchings.

Cranial nerves.—There was no evidence of involvement of any of the cranial nerves.

Motor system.—There was marked wasting of the glutei of both sides as also the thigh and calf muscles. The wasting is more marked on the right side. There was no apparent wasting of the muscles of the upper extremities or the trunk muscles. No fibrillations were seen.

Power was weak in all the groups of muscles of the lower extremities. Power in the plantar flexors and extensors appeared to be better comparatively. No involuntary movements were detected. Co-ordination was normal.

Sensory system.—All sensations were normal.

Reflexes: Superficial—

Abdominals	...	Present and normal.
Cremaster	...	Present.
Plantar	...	Flexor on both sides.

Deep — all present and normal in the other upper extremities. Absent in the lower extremities. No clonus. Rombergism — Not present. Gait — Waddling in character with circumduction of rt. leg.

The other systems were normal. Because of the primary disability in the muscles a diagnosis of myopathy was made.

Lt-Col. C. K. Prasada Rao's Unit:

A CASE OF MYASTHENIA GRAVIS.

Patient Varadarajan, aged 38 was admitted with the following complaints: (1) Dimness of vision, (2) Difficulty in keeping the eyes open, (3) weakness of the lower extremities of 4 months duration (4) difficulty in mastication.

There was no previous history of venereal infection.

The present complaint started with epiphora in the right eye. He developed 'Dacryocystitis' and was operated upon. Gradually the patient developed drooping of the right eyelid and dimness of vision. While walking, he noticed that his lower limbs 'gave way' after he had progressed some distance. He also found that he could not keep his head straight for long as after some times there is drooping forward of his head. Soon his speech became slowed due to the tongue rolling in the mouth. While masticating, he found difficulty in keeping the jaws moving. There was slight difficulty in deglutition at about the end of his meal. He had no headache but felt giddy. He had to strain for micturition. Examination of the central nervous system revealed nothing abnormal except ptosis of the right eyelid and limitation of the external ocular movements.

Examination of the other systems revealed nothing abnormal.

The following investigations were done.

Investigations.—Blood pressure: 135/90. W.B.C. 4,600; D.C.P. 48; L. 33, E. 17, M. 2, R.B.C. 4.8 mil/c mm. Hb. 80%. Bl. calcium 9.5 mg%. Serum phosphorus: 2.8 mg%. Serum acid phosphatase: .9 units B.M.R.—29%. Blood sent for W.R. and Kahn. L.P Fluid clear — not under tension. Proteins — 80 mgm. Globulin — nil, Chlorides — 720 mgm%. Sugar: 58.9 mgm%. No cells. Funds Normal. Field of vision — normal. Muscle biopsy: urine creatin 89 mgm%. Blood creatin 2.6 mgm. X-ray chest: No mediastinal shadow: X-ray skull: Normal.

Jollys myasthenic reaction — repeated faradic stimulation of voluntary muscles.

The diagnosis of Myasthenia gravis was made for the following reasons:

The undue fatigue of the voluntary muscles after exercise, their return to nearly normal after rest, the absence of muscular atrophy, the failure on neurological examination to demonstrate evidence of structural changes either in the Central Nervous System or the peripheral nerves have enabled us to diagnose this condition.

The fatigue of the muscles concerned with extra-ocular movements—has added further weight to our diagnosis. The muscle biopsy showed 'lymphorages' and the amount of creatine in the urine showed an increase—89 mgm%.

The diagnosis was clinched by the administration of Prostigmine and the dramatic disappearance of the fatigue. About 15 or 20 minutes after the administration of amount of prostigmine, the ptosis cleared and the patient could walk.

Dr. S. T. Achar's Unit:

A CASE OF FACIAL PALSY WITH ATROPHY OF THENAR MUSCLES
(Right Side and Absence of Right Pinna from Birth)

Yogambal, female child, aged 4 years, was admitted on 4th August 1949 for a complaint of diarrhoea.

Past history.—History of measles 3 months ago. During the examination it was found that the patient had a right facial palsy of the lower motor type. The right pinna was completely absent. In addition there was wasting and paralysis of the right upper limb, most marked in the thenar muscles.

The case was presented for the clinical interest in the combination of symptoms.

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King Institute, Guindy.
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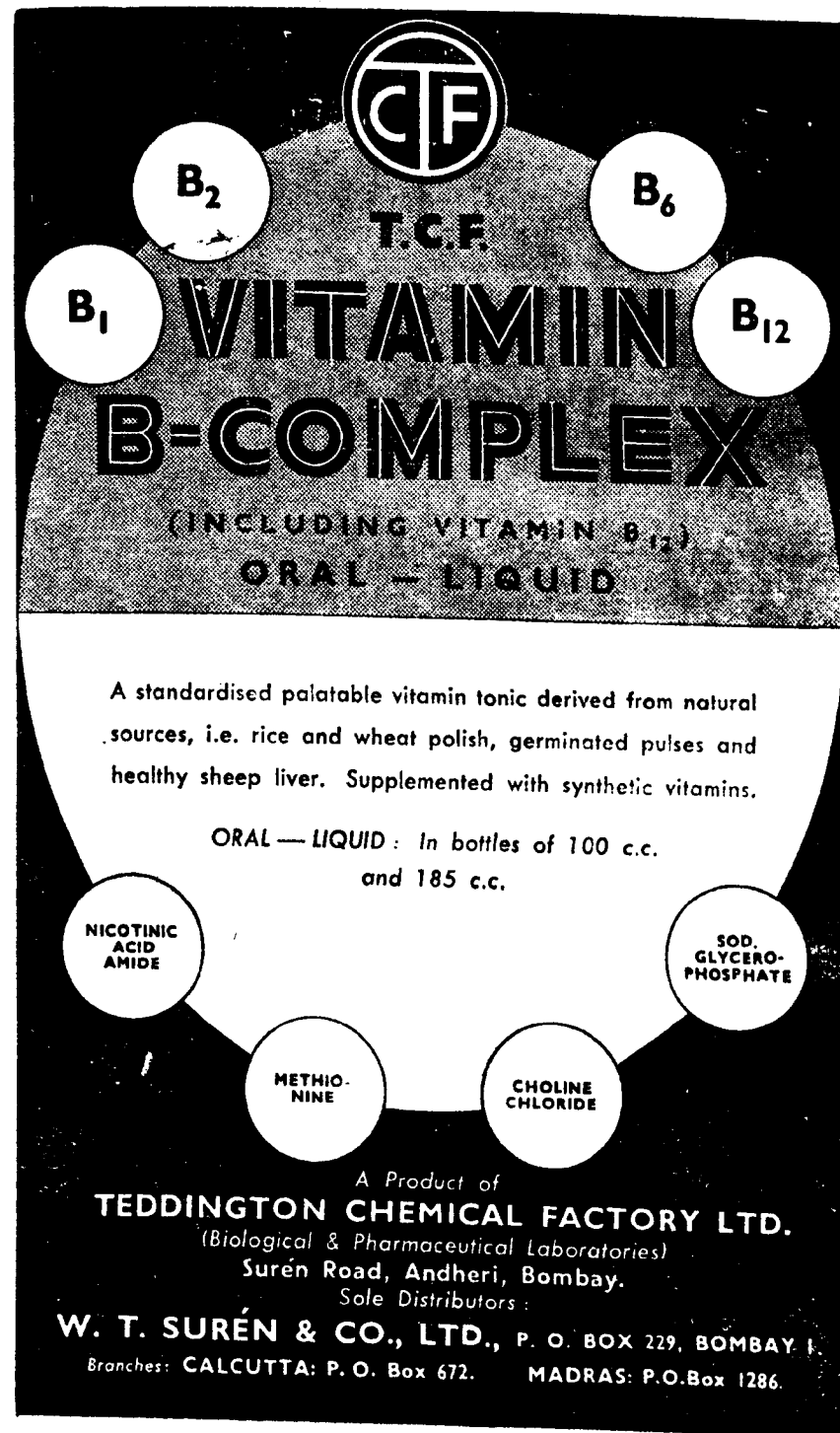
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The advertisement features a central circular design with a dark background. At the top center is a circular logo containing the letters 'CTF'. Below this logo, the text 'T.C.F.' is printed. The main title 'VITAMIN B-COMPLEX' is prominently displayed in large, bold, sans-serif capital letters. Directly beneath the title, in smaller capital letters, is '(INCLUDING VITAMIN B₁₂)' followed by 'ORAL - LIQUID'. Surrounding the central text are several white circles, each containing a vitamin label: 'B₂' (top left), 'B₆' (top right), 'B₁' (middle left), 'B₁₂' (middle right), 'NICOTINIC ACID AMIDE' (bottom left), 'METHIO-NINE' (bottom center-left), 'CHOLINE CHLORIDE' (bottom center-right), and 'SOD. GLYCERO-PHOSPHATE' (bottom right). Below the central text area, a paragraph describes the product as a standardised palatable vitamin tonic derived from natural sources like rice, wheat polish, germinated pulses, and healthy sheep liver, supplemented with synthetic vitamins. It also specifies the 'ORAL - LIQUID' form in bottles of 100 c.c. and 185 c.c. At the bottom, it identifies the manufacturer as 'TEDDINGTON CHEMICAL FACTORY LTD.' (Biological & Pharmaceutical Laboratories) located at 'Surén Road, Andheri, Bombay.' and lists the sole distributors as 'W. T. SURÉN & CO., LTD., P. O. BOX 229, BOMBAY.' with branches in 'CALCUTTA: P. O. Box 672.' and 'MADRAS: P.O.Box 1286.'

CTF
T.C.F.

VITAMIN B-COMPLEX
(INCLUDING VITAMIN B₁₂)
ORAL - LIQUID

A standardised palatable vitamin tonic derived from natural sources, i.e. rice and wheat polish, germinated pulses and healthy sheep liver. Supplemented with synthetic vitamins.

ORAL — LIQUID: In bottles of 100 c.c. and 185 c.c.

NICOTINIC ACID AMIDE

METHIO-NINE

CHOLINE CHLORIDE

SOD. GLYCERO-PHOSPHATE

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(Biological & Pharmaceutical Laboratories)
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