The Madras Clinical Journal

Vol. XXVIII DECEMBER 1961 No. 6

CONTENTS

		Page
1.	Medical Aspects of Aneurysms ... — G. Victor ...	171
2.	The General Management of Fractures ... — R. Gopalan ...	187
3.	Abstracts and Excerpts	189
4.	News and Notes	194
5.	Association Notes	195
6.	Editorial Announcement ... ... Cover	3

FOR CIRCULATION AMONGST MEMBERS ONLY

The Madras Clinical Journal

JOURNAL OF THE MADRAS STATE BRANCH OF THE INDIAN MEDICAL ASSOCIATION
(WITH WHICH IS INCORPORATED THE "MISCELLANY")

Vol. XXVIII December 1961 No. 6

MEDICAL ASPECTS OF ANEURYSMS *

G. VICTOR, M. D.,
Professor of Medicine, Madura Medical College.

The human aorta could withstand an intra-lumenal pressure of 3000 mm Hg. An aneurysm is a permanent dilatation of an artery caused by destruction of its wall, resulting from localised weakness and stretching of the arterial wall. Aneurysms could be classified as follows:

I. OLD CLASSIFICATION:

1. True aneurysm. The sac is formed by the wall of the vessel.
   (a) Dilatation or fusiform aneurysm — Whole circumference is involved.
   (b) Dissecting — Blood extends between the coats.
   (c) Saccular — A cavity arising from a portion of the circumference, with the aperture commonly smaller than the greatest diameter of the cavity.
   (d) Cirsoid — Dilatation of an entire artery and its branches, found in small vessels.

2. False aneurysm (communicates with an artery, but the sac is formed by the surrounding tissues)—Haematoma from a wound or rupture of an artery.

3. Arteriovenous aneurysm—Direct communication between an artery and a vein exists.

4. Others — 'Traction' aneurysm arising at ductus arteriosus.

II NEW CLASSIFICATION:

(a) Congenital aneurysm — 1. Berry aneurysm (Miliary, Cerebral). 2. Cirsoid aneurysm.

(b) Traumatic aneurysm — Arteriovenous aneurysm.

(c) Aneurysms due to inflammatory cause — 1. Syphilis (Saccular aneurysm). 2. Bacterial endocarditis. 3. Periartertis nodosa (Mycotic aneurysm).

(d) Aneurysms due to degenerative lesions — 1. Atheroma (Fusiform aneurysm). 2. Mucoid degeneration of the media (Dissecting aneurysm).

* Paper read at the District Medical Association Meeting at Tanjore in July 1961.

(e) Other forms of aneurysms — 1. Venous aneurysms. 2. False aneurysms. 3. Aneurysm of the Sinus of Valsalva. 4. Cardiac aneurysm.

A saccular aneurysm is a pouching of the vessel at one point. This is the usual form of aneurysm. A fusiform aneurysm is a dilatation of a segment of the vessel, and is seen in the aorta and its large branches. The chief cause of cerebral aneurysm is a congenital defect in the wall of the Circle of Willis at the junction of the vascular ring with one of the incoming branches; in the course of 30 or 40 years, the thin wall bulges at this point to form an aneurysm about the size of a pea. When this ruptures, subarachnoid haemorrhage occurs. Mycotic aneurysm may result from streptococcus viridans inflammation of the endocardium and extension of the process into the underlying tissues with deep ulceration or perforation or aneurysm formation in the valve cusps or local ulceration and aneurysm of the aorta. This type of aneurysm is called a mycotic aneurysm. Miliary aneurysms develop on the arteries of the Circle of Willis, are usually of congenital origin, but some are the result of intimal atherosclerosis. Occasionally such aneurysms are found within the substance of the brain. Rupture of the aneurysm leads to subarachnoid or intracranial haemorrhage.

The term "dissecting aneurysm" is a misnomer, it is rather a dissecting hematoma with progressive splitting of the medial layer. According to Dr. Osker Klotz, syphilis protects the aorta agaiust the dissecting intramedial force. Thus syphilis is not aetiologically related to "dissecting aneurysm" and the lesions of chronic syphilis would prevent or limit aortic dissection.

An arteriovenous aneurysm is an abnormal communication between an artery and a vein, usually due to a simultaneous laceration of an adjoining artery and vein. The blood passes from the artery into the vein, and prduces a local distention of the vein which pulsates as forcibly as the artery. A congenital arteriovenous fistula is a direct "shunt" between an artery and a vein without the interposition of the capillaries. The blood passes forcibly into the vein, which becomes dilated (arteriovenous varix). The lesion is commonest in the leg, but may occur in the arm or in the scalp; in the latter position, it forms a mass of dilated vessels known as a cirsoid aneurysm.

A traumatic aneurysm is a false aneurysm, a hematoma, formed by laceration of the vessel wall. A false aneurysm is secondary to a traumatic lesion from sharp objects or missiles. It occurs chiefly in the limbs, neck, axilla, femoral triangle, Hunter's canal, popliteal space. It may also develop secondary to the rupture of a fusiform or saccular aneurysm. Blood leaks, liquefaction of the original thrombus occurs, and a fibrous sac forms. In cardiac aneurysm (left ventricular aneurysm), clinically there is unusual pulsation in the region of the apex beat where a left ventricular enlargement is improbable on other grounds. Differential diagnosis is a dilated left auricle, an intrapericardial haematoma, pericardial cyst, and cardiac tnmour.

AETIOLOGY OF ANEURYSMS:

A. 1. Syphilitic involvement of the arteries.
2. Arteriosclerotic involvement of the arteries.
3. Infectious arteritis - bacterial endocarditis, rheumatic fever.

4. Periarteritis nodosa.
5. Other types of necrotizing arteritis.
6. Congenital defects - weakness of arterial wall.
7. Trauma.

B. Age group: 40 to 55 years in syphilitics, children (rarely) with congenital syphilis.
Youth (most frequent) with traumatic and non-syphilitic infectious aneurysms.
Syphilitic aneurysms occur at least 10 years earlier than the arteriosclerotic variety.

C. Sex: Male : Female : : 6 to 10 : 1

D. Race: More common in the Negroes.

According to Scott, *syphilis* is the cause of 75% of all the aneurysms in patients under 50 years, 64% in Negroes; and when it is due to *arteriosclerosis*, all patients were over 50 years, and all were white. In a clinico-pathological study of 369 necropsy cases by Brindley and Stembridge, syphilis was found to be the aetiological agent in 54% of cases. Less common causes are tuberculosis, actinomycosis, non-specific arteritis and other types of septicaemia.

PATHOLOGY OF ANEURYSMS:

Sites of aneurysm: Ascending aorta, arch of aorta, descending aorta, abdominal aorta, large arteries of lower extremities, intra-abdominal arteries, arteries of upper extremities and neck, popliteal arteries, pulmonary artery, coronary arteries of the brain and heart.

Congenital aneurysm is a developmental anomaly in which greatly dilated arteriovenous communications form a large vascular tumour.

Dissecting aneurysm is caused by mucoid degeneration of the media. The dissection occurs down the centre of the medial coat, forming a false channel between the two layers. The lining of the sac is roughened owing to the endothelium giving way. Thrombosis occurs and layer upon layer of laminated clot is rammed down and becomes incorporated with the wall of the sac. Microscopic examination of the wall of the sac shows that it consists only of adventitia; the intima and media have disappeared. Adjoining parts of the wall show microscopic lesions of active syphilitic aortitis.

Aneurysm of the aorta: This is much more common than the other forms. A syphilitic aneurysm is more likely to be saccular and an atheromatous aneurysm to be fusiform. The "syphilitic aneurysm" decreases in frequency as one passes downwards. The site of election of the "atheromatous aneurysm" is the abdominal aorta below the origin of the renal arteries.

Syphilis produces mesaortitis with destruction of the elastic tissue. As the destruction is more marked in one place than another, a bulging occurs in the weakened area. Atheroma may weaken the aorta sufficiently to lead to the formation of an aneurysm.

CLINICAL FEATURES OF ANEURYSMS:

Fusiform aneurysm: Co-existent aortic incompetence, angina pectoris, pulsation in the suprasternal notch, dullness over and to the right of the manubrium sternum, loud aortic second sound.

Dissecting aneurysm: Sharp pain at onset. Dissecting aneurysm must be kept in mind in the differential

diagnosis of abdominal emergencies of puzzling aetiology. May produce abdominal pain as the outstanding symptom.

Saccular aneurysm : 1. *Aneurysm of the Sinuses of Valsalva :* Symptoms latent, angina ; those of co-existant aortic incompetence, if inferior vena cava is pressed upon, congestion and oedema below the diaphragm. Clinically, aortic regurgitation is an outstanding feature of the aortic sinus aneurysms. Next in importance is heart failure, often intractable.

2. *Aneurysm of the ascending arch :* Pain, cough, slight haemoptysis, expansile pulsating tumour to the right of the sternum, accentuated aortic second sound or diastolic murmur, systolic thrill and murmur over the sac.

3. *Aneurysm of the transverse arch :* Alterations of voice, bovine or brassy cough, dyspnoea, occasionally haemoptysis and dysphagia, suprasternal pulsation, laryngeal paralysis, anisocoria, inequality of pulse, Oliver's sign.

4. *Aneurysm of descending arch :* Symptoms latent until rupture occurs, pain referred to the abdomen, severe when erosion of vertebra and pressure on nerve roots occur, cough, dysphagia, occasionally transverse myelitis. Pulsating tumour in left interscapular area, systolic murmur, collapse of lung.

5. *Aneurysm of descending thoracic aorta :* Symptoms often latent, pain referred to the abdomen, severe after erosion of vertebra and pressure on nerve roots, cough, dysphagia, occasionally transverse myelitis.

Aneurysm of abdominal aorta : Pain often intense, radiates round the flanks or to the back, gastric symptoms, compression myelitis after erosion of the vertebra, epigastric pulsation, on palpation definite tumour with expansile pulsation, systolic murmur, distal pulse usually small.

Aneurysm of the abdominal aorta may involve the renal artery. Surgery provides for aortic resection and restoration of aortic continuity with a homograft. Anastamosis of the cut-end of the renal artery to a branch of the graft is done with preservation of the renal function.

Anuria due to aortic aneurysm is usually a terminal event. Gradual and painful expansion of the aneurysm may lead to a sudden reflex anuria as it compresses the ureter. Nephrostomy operation could result in an immediate return of the renal function.

Miliary aneurysms : Rupture of the aneurysm leads to subarachnoid or intracranial haemorrhage.

N. B.- In the series of Scott, pain was present in 84% of syphilitic aneurysms, while 80% of cases were asymptomatic when the aneurysm was due to arteriosclerosis.

COMPLICATIONS OF ANEURYSM :

1. *Rupture :* With aortic aneurysm a period of leakage often precedes frank rupture.

(a) External - to the right of the sternum.

(b) Trachea and bronchi - commonest sites, usually left bronchus.

(c) Pleura - especially descending aorta and arch, rapidly fatal.

(d) Lung substance.

(e) Oesophagus, pericardium, superior vena cava, pulmonary artery, auricle.

2. *Thrombosis :* Seen in peripheral aneurysm, particularly of the popliteal artery. When the aneurysm undergoes thrombosis, the clot usually spreads into the host artery, and these patients develop symptoms of peripheral ischemia, either intermittent claudication, rest pain or gangrene.

3. *Peripheral emboli :* Aneurysms often have a great deal of clot in their walls, portions of this may separate and lodge in vessels peripheral to the aneurysm.

4. *Enlargement with pressure on the nearby structures :* Bodies of adjacent vertebrae, recurrent laryngeal nerve, cervical sympathetic chain, phrenic nerves, and veins.

5. *Dissection :* Occurs in the aorta which is atheromatous, but the vessel may be surprisingly normal.

6. *Secondary cardiac involvement.*

DIAGNOSTIC METHODS IN A CASE OF ANEURYSM :

1. Fluoroscopy.

2. Radiography - P. A. view, straight lateral view, oblique view, barium swallow picture.

3. Serology.

4. Blood culture in patients with bacterial endocarditis.

5. Biopsy of an accessible nodule in cases of polyarteritis nodosa.

6. Arteriogram gives the exact location of the aneurysm as well as the position of the collateral vessels.

7. *"Respiratory phenomenon" - in cardiac aneurysm :* Fluoroscopic or radiographic examination of the heart alternately in forced inspiration and expiration is carried out. During forced inspiration, the amount of blood entering the heart from the systemic and pulmonary circulations is decreased. The lung, overdistended with air, presses upon the heart with the result that the cardiac shadow becomes smaller and the intracardiac pressure is increased. At the same time, a rise in the intra - pleural negative pressure exerts a sucking effect upon the aneurysmal sac which, having lost its tonicity, becomes distended and more prominent. During forced expiration, these are reversed. The lung retracts because of the outflow of air, a greater amount of blood enters the heart and it becomes larger, while the intracardiac pressure decreases. The aneurysmal sac collapses, disappearing completely and the left ventricular border loses its convexity and becomes flat. This respiration phenomenon is indicative of a cardiac aneurysm.

DIFFERENTIAL DIAGNOSIS OF ANEURYSMS :

A. *Aneurysm of the thoracic aorta :*

1. Syphilitic aortitis.
2. Intrathoracic tumours.
3. Aneurysms of pulmonary arteries.

B. *Aneurysm of arch of aorta :*

1. Mediastinal tumours — Thymoma, lymphosarcoma.
2. Lymphoma.
3. Tuberculous lymphadenitis.
4. Malignant metastasis.
5. Substernal thyroid.

C. *Aneurysm of the abdominal aorta :*

1. Patent ductus arteriosus with pulmonary valvular insufficiency.
2. P. D. A. with I. V. S. defect.

3. Coronary artery and right ventricular fistula.
4. Aortic regurgitation with I. V. S. defect (acquired or congenital).
5. Ruptured aneurysm of a sinus of Valsalva into the right ventricle.
6. Acquired aortic - pulmonary artery fistula with valvular insufficiency.
7. P. D. A. and aortic septal defect.
8. I. V. S. defect including Eisenmenger's complex.
9. Pulmonary arterio - venous aneurysm.
10. Arterio - venous fistula of the chest wall.
11. Bronchial collateral circulation.
12. Rupture of a normal sinus of Valsalva due to bacterial endocarditis.
13. Syphilis of the root of the aorta with aneurysm of the sinus of Valsalva.
14. Miscellaneous — Anomalous pulmonary venous drainage, A. S., A. R., congenital aneurysmal dilatation of the aorta with regurgitation, aortic aneurysm with rupture into pulmonary artery, substernal thyroid, coronary arterio-venous fistula.

D. *General :*

1. Nervousness.
2. Anaemia.
3. Hyperthyroidism.
4. Marked dilatation of the aorta in hypertension.
5. Dynamic pulsation of aorta.
6. Scoliosis and deformities displacing the heart and great vessels.
7. Pulsating pleurisy.

CASE RECORDS

CASE No. 1.

Name : Sunder Raj.

Age : 36 years.

Sex : Male.

Date of admission : 5—10—1960.

Date of death : 16—5—1961.

Complaint : Cough with expectoration and chest pain.

Duration - 7 months.

History of venereal disease - 15 years back.

Positive findings : Hoarseness of voice present. Coarse rales and crepitations heard in the right base.

Investigations :

B. P. Right arm - 90/70;
Left arm - 100/70.

Urine for albumin and sugar - Nil.

T. C. 1—9—1960 - 6200/cmm.
21—10—1960 - 4000/cmm.

Blood Khan - + +

X-ray chest - Aneurysm of the arch of the aorta with bronchiectatic changes in the right base.

19—10—'60. Vocal cords normal, no evidence of paralysis.

19—10—'60. 48 hours later, erythema test - 7 m. m. x 5 m. m. 21—10—'60 - fainter erythematous papule.

20—10—'60. Blood taken for TPIA & RPCF test.

27—10—'60. Treponima test : LFA control, RFA Treponima antigen.

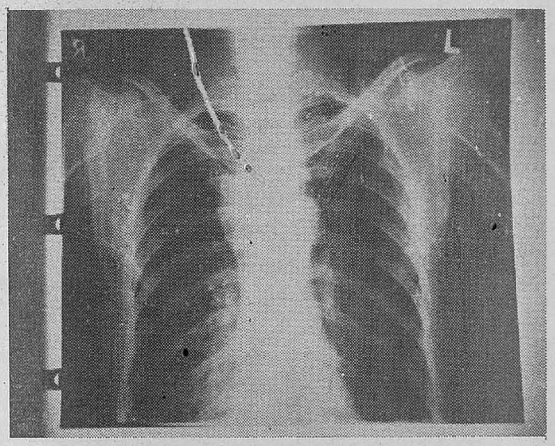


FIG. 1.
Case Ne. 1 – Sunder Raj – Skiagram chest
A. P. view.

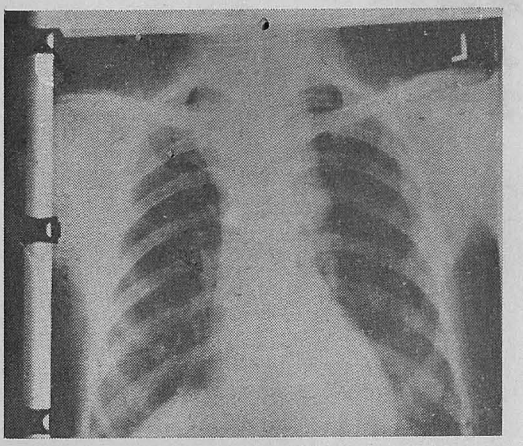


FIG. 2.
Case No. 2 – Thayammal – Skiagram chest
A. P. view.

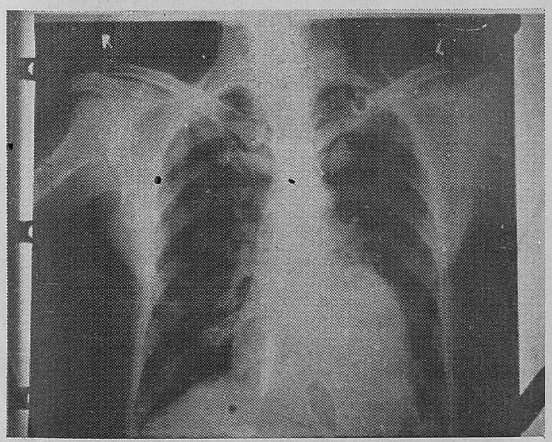


FIG. 3.
Case No. 3 – Ananda Iyer – Skiagram chest
A. P. view.

FIG. 4.
Case No. 3 – Ananda Iyer – Skiagram chest – Oblique view.

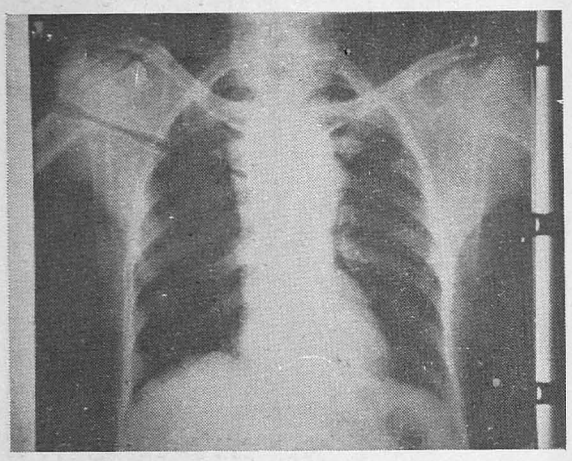


FIG. 5.
Case No. 4 – Srirengan – Skiagram chest A. P. view.

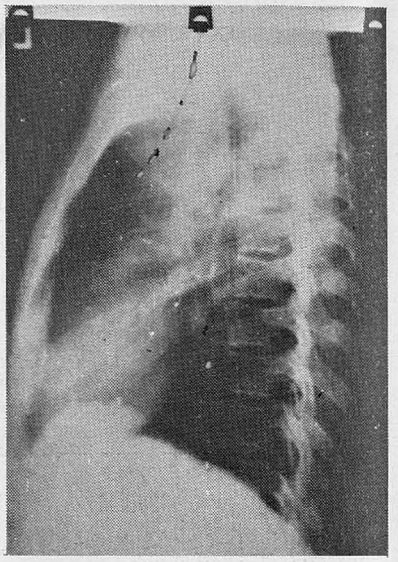


FIG. 6.
Case No. 4 – Srirengan – Skiagram chest – Oblique view.

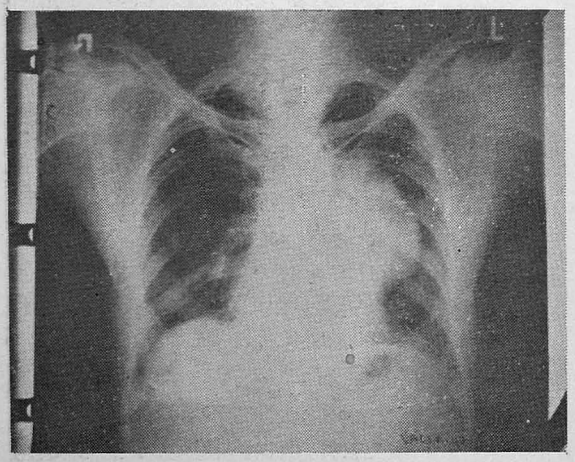


FIG. 7.
Case No. 5 – Vellaiyan Achari – Skiagram chest A. P. view.

FIG. 8.
Case No. 5 – Vellaiyan Achari Skiagram chest – Oblique view.

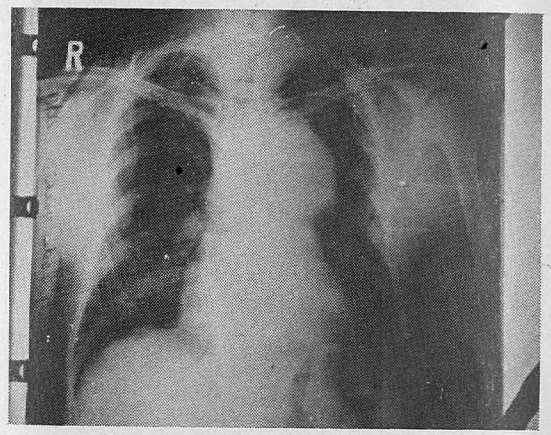


FIG. 9.
Case No. 6 – Chelliah Padayachi – Skiagram chest A. P. view.

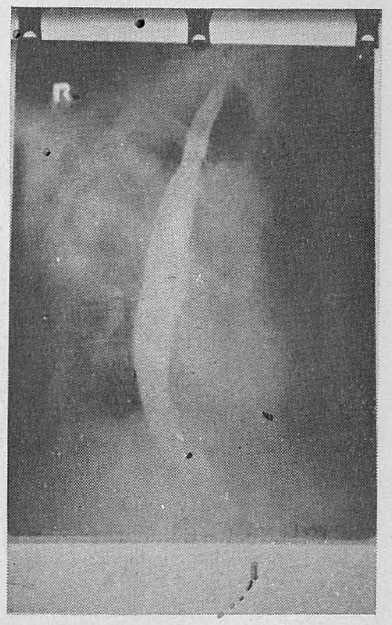


FIG. 10.
Case No. 6 – Chelliah Padayachi Barium Swallow.

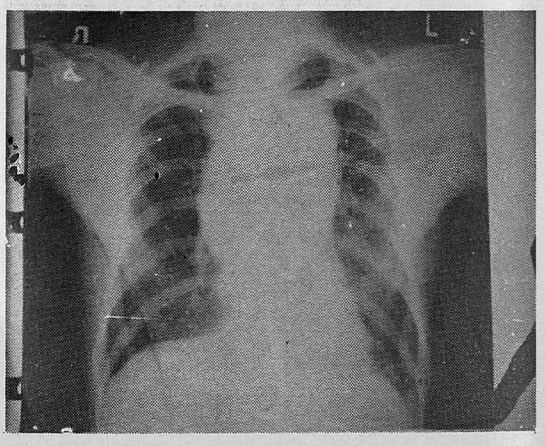


FIG. 11.
Case No. 8 – Nataraja Pillai – Skiagram chest A. P. view.

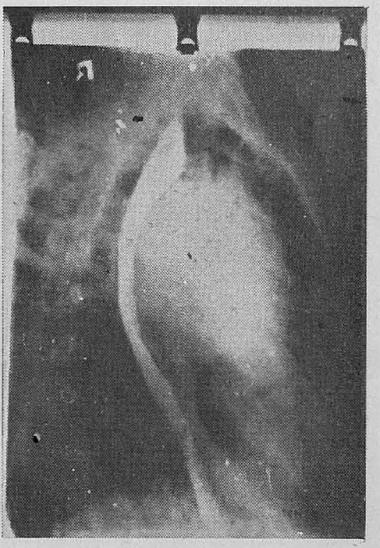


FIG. 12.
Case No. 8 – Nataraja Pillai Barium Swallow.

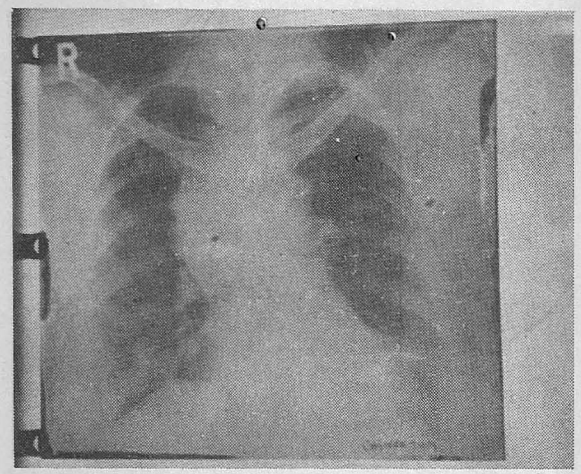


FIG. 13.
Case No. 9 – Chinnathai – Skiagram chest A. P. view.

FIG. 14.
Case No. 9 – Chinnathai – Skiagram chest – Oblique view.

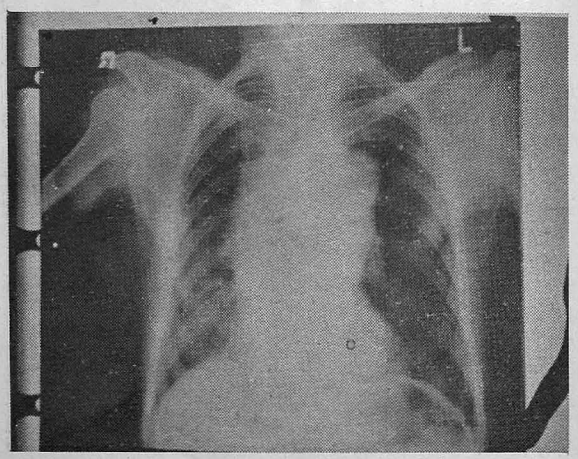


FIG. 15.
Case No. 10 – Subbiah – Skiagram chest A. P. view.

CASE No. 2.

Name : Thayammal.

Age : 40 years.

Sex : Female.

Date of admission : 24—2—1961.

Date of discharge : 3—3—1961.

Complaint : Breathlessness, cough with slight expectoration.

Duration - 3 months. Onset sudden, condition progressive.

Positive findings : Engorged veins over the neck and front of the chest (right side). No cyanosis, no clubbing. Pulmonary area : systolic and diastolic murmurs heard. Aortic area : same murmurs heard. Third left intercostal space : both murmurs are better heard. Pulse collapsing.

Investigations :

B. P. Upper : Right - 170/66;
Left - 170/68.
Lower : Right - 140/60;
Left - 150/68.

Urine for albumin and sugar - Nil.

T. C. 8600/cmm.

D. C. P_{64} L_{34} E_2

E. S. R. $\frac{1}{2}$ Hr. 50 ; 1 Hr. 80 mm.

Blood cholesterol : 200 mgms %

X-ray chest : Widening of mediastinum present. Hypertrophy of the left ventricle noticed.

28—2—1961. Bronchoscopy : Vocal end movements normal ; no obstruction at the level of larynx.

28—2—1961. Montoux test :

CASE No. 3.

Name : Ananda Iyer.

Age : 50 years.

Sex : Male.

Date of admission : 6—3—1961.

Date of discharge : 2—4—1961.

Complaint : Pain in the chest, back, and right arm.

Duration – 15 days. Cough – 1 year. No history of venereal disease.

Positive findings : No cyanosis, no clubbing; trachea in the midline; breath sounds vesicular.

Investigations :

Temperature off and on during hospitalization–100°–102·6° F.

B. P. 110/60 — 114/70
148/86 — 140/80

T. C. 11700/cmm.

D. C. P_{85} L_{14} E_1

Sputum negative for AFB.

Culture : Streptococci grown.

Blood Kahn - negative ;

VDRL - negative.

C. S. F. Glob. – negative
Kahn. – negative
P. R. – 30 mgm.
Cl. – 760 mgm.
Sugar – 77 mgm.

X-ray chest : Thoracic aortic uneurysm with erosion of the vertebra present.

Sputum for malignant cells : Fibrin, lymphocytes, polynuclear cells, histiocytes containing haemosiderin pigments also seen. No evidence of malignant cells.

CASE No. 4.

Name : Srirengan.

Age : 50 years.

Sex : Male.

Date of admission : 11—4—1961.

Date of discharge : 11—5—1961.

Complaint : Laboured breathing, dyspnoea on exertion.

Duration — 6 months. Cough with expectoration present.

Positive findings : Radial pulse on the right side not palpable.

Apex beat 1 inch within MCL ; heart sounds norml in all the valvular areas ; air entry slightly diminished over the left interscapular area and the left base; percussion note impaired over the same area; trachea markedly deviated to the right side.

Investigations :

B. P	?	180/60
	112/70	110/70

T. C. — 3000/cmm.

D. C. — $P_{64}\ L_{30}\ E_{6}$

Sputum for AFB –negative

Screening of chest: Widening of the mediastinal shadow; no pulsations seen.

X-ray chest: Enlargement of the right border of the superior mediastinum with slight displacement of the trachea to right and aortic knuckle outward.

Bronchoscopy: No evidenc of any pathology.

CASE No. 5.

Name : Vellaiyan Achari.

Age : 70 years.

Sex : Male.

Date of admission : 19—4—1961.

Date of discharge : 26—4—1961.

Complaint : Cough with expectoration, sensation of something present inside the chest. Duration - 2 years.

History of recent attacks of haemoptysis present; numbness over both lower limbs; creeping sensation over tips of fingers.

Positive findings : Broncho-vesicular breath sounds over the left infrascapular zone; diminished breath sounds over the same area; right pupil constricted.

Investigations :

B. P. 150/90 ; 150/90.

T. C. 8400/cmm.

D. C. $P_{60}\ L_{40}$

E. S. R. 1 Hr. 30; 2 Hrs. 50 mm.

Random blood sugar-170 mgm%

Fundus - Right eye no view. Left eye tendency for cripping, tesselated fundus in both eyes, vitrious opacities present. Tension 20 mm. Hg. Right eye cataract.

1. X-ray chest : Double shadow arising from the ascending thoracic aorta.
2. Barium swallow : No thinning of oesophagus.
3. X-ray spine : No evidence of bony erosion.

CASE No. 6.

Name : Chelliah Padayachi.

Age : 55 years.

Sex : Male.

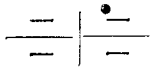
Date of admission : 23—4—1961.

Date of discharge : Still in hospital.

Complaint : Inability to walk, pain in the back ; later on, he could not walk at all ; duration - 4 months.

Positive findings : Pulse in both arms equal ; mitral area - systolic murmur present, not conducted ; Aortic second sound heard low.

C. N. S. : Cranial nerves normal, muscle power lost in both legs, tone slightly increased, wasting of right

calf present. Sensation - light touch impaired over the dorsum of both feet, pain impaired below costal margins. Thermal totally lost below 6th intercostal spaces, vibration lost below 6th intercostal space, joint sense lost in lower limbs. Reflexes - Plantars  ,  , Epigastric — — , pupils not reacting to light. Jerks - BJ, SJ + + + +, KJ, AJ + + +, + + +, ankle clonus +, spine - kyphosis over upper dorsal spine, visceral reflexes normal.

Investigations :

B. P. 106/50 - 112/58

Urine for albumin and sugar - negative.

Blood Kahn - negative.
VDRL - negative.

L. F. - Fluid clear and under tension (104 drops/min.)

Cells - 4/c. mm.

Globulin - +

Proteins - 90 mgm %

Chlorides - 680 mgm %

Sugar - 42 mgm %

X-ray chest : 1. Aneurysm of aorta (junction of transverse portion and descending part of arch). Transverse diameter of the heart increased.

2. Barium swallow : Slight kinking of the upper half of the oesophagus.

3. X-ray spine : Polycyclic erosion of the dorsal vertebra.

CASE No. 7.

Name : Malayappan.

Age : 55 years.

Sex : Male.

Date of admission : 5—5—1961,

Date of discharge : 13—5—1961.

Complaint : Pain in chest and upper limb, dry cough.

Duration - 3 months.

Positive findings : Brassy cough; pulse collapsing in character - right weaker than the left. Praecordial bulge present in the right second and third intercostal spaces; pulsation present in the same area; soft systolic murmur heard in aortic area. Aortic second sound accentuated. Pupils - no change in size or light reflex. Spine normal.

Investigations :

B. P. Rt. 126/80; Lt. 110 70.

T. C. 13100/cmm.

D. C. P_{80} L_{18} E_2

E. S. R. 22 mm/45 - m.

Blood Kahn - negative.

X-ray chest : Aneurysm - arch of aorta first portion.

CASE No. 8.

Name : Natarajan Pillai.

Age : 43 years.

Sex : Male.

Date of admission : 12—5—1961.

Date of discharge : 2—6—1961.

Complaint : Dry cough and breathlessness - since one year. Change in voice and haemoptysis for the last 15 days.

Positive findings : Patient dyspnoeic; clubbing of fingers; slight bulge around angle of Louis; no murmurs heard over praecordium. Radial pulse on the left side feebler than on the right. Prominent veins in the left anterior chest wall and left arm present.

Investigations :

Temperature on admission : 100·2° F.

B. P. 104/70 ; 94/70.

Blood Kahn : + +

Screening - Widening of aortic arch, pulsating mass.

X-ray chest - Diffuse enlargement of the arch of the aorta. Barium swallow shows marked kinking of the oesophagus in its upper half.

CASE No. 9.

Name : Chinnathai.

Age : 40 years.

Sex : Female.

Date of admission : 16—5—1961.

Date of discharge : 12—6—1961.

Complaint : Cough since 1 week. Patient was in the hospital 4 years ago and was diagnosed as " mediastinal syndrome " and given deep x-ray therapy.

Positive findings : No clubbing of fingers, trachea not deviated ; diminished air entry over the left chest ; crepitations heard over both sides of the chest, heart sounds normal.

Investigations :

Temperature on admission : 99°F.

B. P. - Rt. 124/74; Lt. 114/60.

Urine - No albumin, no sugar.

Blood Kahn - Negative.

X-ray chest - Widening of the superior mediastinal shadow.

Barium swallow : Kinking in the middle one-third.

Screening report : Widening of the superior mediastinum with more convex bulging on the right border-shows slight pulsation on either border. LAO position :— Marked widening of the ascending aorta. Movements of the domes of the diaphragm appeared normal. Appearance in favour of aneurysm of the ascending part of arch of the aorta and? innominate artery.

CASE No. 10.

Name : Subbiah.

Age : 50 years.

Sex : Male.

Date of admission : 16—5—1961.

Date of discharge : 30—5—1961.

Complaint : Pain in the chest, cough with expectoration, breathlessness on exertion. Duration - 3 months.

Positive findings : Clubbing of fingers ; superficial vessels in the left side of the front of the chest prominent ; radial pulse feebly felt on right side, pupils, carotid pulse, equal on both sides. Diminished air entry over left base.

Investigations :

B. P. Right 90/72 ; Left 81/72.

Blood Kahn : + +

Screening of the chest: Pulsating mass in the superior mediastinum in front.

X-ray chest : Marked widening of the superior mediastinal shadow with deviation of trachea to right, prominent aortic knuckle, aorta itself appears normal. No bony lesion in the dorsal spine.

Acknowledgement : I thank the Superintendent, Government Erskine Hospital, Madura, for kind permission to publish the case records.

REFERENCES

1. Brindley, P, Stembridge, V. A. - American Jl. of Path. Vol. 32, pp. 67, 1956.
2. Burchell, H. B. - "Circulation" Vol. 12, pp. 1068, 1955.
3. Ellis, F. H, Helden, R. A, Hines, E. A. - The Annals of Surgery, Vol. 142, pp. 992, 1955.
4. Enselberg, C. D. - The Annals of Int. Med. Vol. 44, pp. 1163, 1956.
5. Jellinek, E. H. - Lancet, 1956, pp. 922.
6. Puderbach, W. J. - Amer. Jl. Surgery, Vol. 87, pp. 887, 1954.
7. Rob, C. G. - The Annals of the Royal College of Surgeons of England. Vol. 14, pp. 35, 1954.
8. Rob, C. G., Eastcott, H. H. E. - Brit. Med. Jl. Feb. 1955.
9. Sayman, M. I. - Radiology. Vol. 67, pp. 242, 1956.
10. Shnider, B. I., Cotsonas, N. J. - The Amer. Jl. of Med. Vol. 16, pp. 246, 1954.

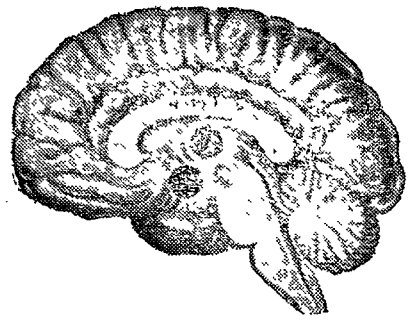
In the old days, if you developed, say, a small rash on one of your legs, you showed it to your doctor and he would say: "That's nothing to worry about. Get yourself a small tin of zinc ointment and it'll clear up in a day or two". So you went to a chemist and bought a 2 d. tin, and at the end of three days, when your rash had gone, you used the rest to lubricate the wheelbarrow or the latch of the garden shed.

Nowadays you sit for forty to eighty minutes in a germladen waiting room packed with people. When you eventually get to the doctor you show him your rash.

"Ha!" he says. "A fungus infection. We'll try you with some of this. It is sometimes very effective." You take the prescription to the chemist and pay him 1 s. and he tells you: "This is the very latest from America and costs the taxpayer 25 s. a tube". At the end of a week your rash is still the same; so you go back to the doctor, sit fifty-five minutes in his crowded germladen waiting room and show it to him again. "Hm!" he says. "We'll try you with this". He scribbles another prescription, muttering as he does so: "This is sometimes very effective indeed".

You pay another 1 s. to the chemist, who tells you: This is absolutely the latest from America and costs the tax-payer 35 s.".

At the end of three days the rash has broken out on the other leg and the back of your neck. You also have a cold in the head which you feel sure you caught in the doctor's waiting room. However, you go and see him again. "Ah!" he says, peering interestedly at the outbreak on the back of your neck. "You must be allergic to the stuff. A lot of people are you know". He smiles as if he thinks that ought to amuse you and scribbles another prescription. "We'll try you with this. It's very soothing". You grab the prescription and hurry out before he has time to tell you that it is sometimes very effective. You take it to the chemist, pay him another 1 s.; and ask him nervously what it is. "Zinc ointment", he says, "Quite harmless. I always recommend it for skin complaints. (A Running Commentary by Peripatetic Correspondents: Lancet, April, 16, 1960).



PROZINE*

meprobamate and promazine hydrochloride, Wyeth

CONTROLS BOTH ANXIETY AND PSYCHOMOTOR AGITATION THROUGH DUAL ACTION

PROZINE controls anxiety and tension as well as psychomotor agitation. This multiple effect enables the physician to exert more complete control over the emotionally disturbed patient.

PROZINE is indicated in patients with primary emotional disturbance, in patients with emotional disturbance unrelated to their organic disease, and in patients emotionally disturbed by primary organic disease.

In your everyday practice, **PROZINE** helps control moderate to severe emotional disturbance mainfested by apprehension and agitation or associated with:

- **nausea and vomiting**
- **insomnia**
- **depression (with anxiety)**
- **premenstrual tension**
- **alcoholism**
- **menopausal symptoms**

SUPPLIED: *Bottles of 20 tablets. Each tablet contains 0.2 Gm. meprobamate and 25 mg. promazine hydrochloride.*

Comprehensive literature is available

Wyeth

JOHN WYETH & BROTHER LIMITED
(Incorporated in England with Limited Liability)
Steelcrete House, Dinshaw Wacha Road, Bombay 1.

* Trade Mark

THE GENERAL MANAGEMENT OF FRACTURES

R. GOPALAN, B. A., M. B., B. S., Medical Officer,
Dharangadhara Chemical Works, Ltd., Sahupuram, Tirunelveli District.

It is not the purpose of my talk this evening to expostulate to you in detail the management of individual fractures in particular parts of the body. Any good text book on fractures will give you the information in a more precise and presentable way. Nor is it my purpose to tell you something new or novel in the methods of the management of fractures in general. My only idea in choosing this subject is to bring back to you certain well-known principles in the general management of fractures, which being too well known and too simple, have gone out of our minds.

The first and foremost principle in the management of fractures is to consider a fracture as a surgical emergency and to devote as much care and attention as you will to any other surgical emergency like an acute appendicitis or a gastric perforation. More often than not, we see that factures are seen as the last item of the day's programme and when fractures are admittd after hospital hours, they lie neglected, uncared for, till the next day. This sort of a complacent attitude sometimes spells disaster. A fracture must be immediately attended to. The reduction of fractures immediately after the incident is easy, because manipulations are quiet easy before pronounced muscle spasm has set in. The dictum that, " if you have seen a case of fracture before sunset, see that the fracture is set, before the sun sets " is a good dictum that can be followed in most of the cases. Even otherwise, where immediate interference is not necessary or is definitely interdicted, it is better to have the case examined immediately, so that a plan of action may be decided.

The next principle is to have a thorough examination of the patient with special reference to the fracture. I will not be far from true when I say that sometimes fractures are seen only in the the skiagrams and instructions are given to the assistants as how best to deal with them. The patient is never seen and is left severely alone in the back ground. Most of the cases of fractures are due to accidents and as such a thorough examination of the patient for evidence of other injuries is called for besides a detailed examination of the fracture in question, as regards its exact method of production, the type of injury and complications, if any. It has been well-said that in all cases of accidents every part of the injured member must be examined and every member of the injured part.

The third principle is in the treatment of fractures. The fundamental aspects in the principle of treatment of fractures have not changed since the dawn of orthopaedic surgery and they are not likely to change for ever. Reduction of the fracture, immobilisation of the part and maintenance of the function of the limb have been the mainstays in the treatment of fractures and all our recent knowledge has not altered these fundamental concepts. Methods in the reduction of fractures have

changed, ideas about immobilisation – how much to immobilise and for how long, have changed but not the fundamental principles behind them. At one time, fractures were so meticulously reduced that more emphasis was placed on the exact apposition of the fragments. Today, with our precise knowledge of the physiology of the union of fractures, we do not very much worry about those things as long as we are assured that the fracture will unite and that there will be no deformity or limitation of function of the limb. Similarly at one time, it was thought that PURE, prolonged, uninterrupted, rigid, extensive immobilisation has to be done for proper union. With better knowledge and understanding of the principles of immobolisation, we have discarded some of the older notions regarding immobilisation and laid emphasis on the maintenance of function as the guiding principle to govern us in the extent of immobilisation that has to be made. If after prolonged, uninterrupted, rigid and extensive immobilisation of a limb, first class union of the fracture has been possible, but the function of the limb is impaired, it is not worth the trouble. As the late Dr. C. R. Krishnaswami used to say, "what if the world is gained, if the soul is lost ?"

Thus the age-old principles in the management of fractures, which have stood the test of time have got to be followed in all cases. The fact that they are too simple and familiar should not deter us from following them. The price that we may have to pay for neglect of these rudiments may be incalculable. Verily has it been said that the bones are not filled with red marrow, but black ingratitude.

The man limped into a doctor's office and asked the nurse for an early appointment.

"What's your trouble ?" asked the nurse.

"I have got these terrible pains in my back," moaned the patient. "My ears ache, my stomach hurts all the time and I keep getting these stabbing headaches".

"Goodness," said the nurse admiringly, "you must be awfully healthy to stand all that pain". (J.A.M.A., The bright side).

ABSTRACTS AND EXCERPTS

FILARIA SURVEY OF PONDICHERRY SETTLEMENT:

Nair, C. P. Indian Journal of Malariology, 1960—233-52.

This paper records the findings of a filariasis survey carried out in March 1957 in Pondicherry Settlement, one of the four settlements comprising the State of Pondicherry, which was transferred from the French to Indian rule in 1955. The settlement contains an urban population of about 60,000 and a rural population of 1,50,000.

House-to-house visits were made in randomly selected parts of the settlement between 8 P. M. and 1 A. M. and all the inmates of the houses were examined. Blood films of approximately 20 cmm. were collected and clinical lesions were recorded. Adult mosquitoes were collected in the morning and at night from houses and cattle sheds, and breeding places were sought. Blood smears were also collected from domestic animals during the day. The results are presented in 15 tables, data for males and females being given separately.

Wucheria bancrofti was the only species of filaria found. No area was free from infection, but the microfilaria rate, and, with few exceptions, the average microfilaria count per positive film, was lower in the rural areas than in the town for both sexes. No infections were found in 15 infants examined and the youngest infected child was 2 years old. For both males and females, there was a progressive rise in microfilaria rate to peaks of 7·8% and 7·9% respectively in the 11–20 year age-group, after which only minor fluctuations occurred. The mean microfilaria count followed much the same pattern with peaks of 25·7 and 24·7 in the 11–20 year age-group.

Disease manifestations are also given in detail for both sexes. The youngest affected child was 4 years old, and the incidence rose steadily with age. A higher overall incidence in males was largely due to hydrocele, and males in the town had a lower disease rate than those in an adjacent rural area.

14 species of mosquitoes were collected, but infection was found only in Culex fatigans, which had a filarial infection rate of 8 96% and an infective larva rate of 1·4% in 435 dissected from all areas. Breeding places were stagnant drains, badly constructed septic tanks, sullage drains and soakage pits.

Out of 158 animals examined, one bull was found to be harbouring microfilariae.

(Tropical Diseases Bulletin)

* * * *

DOMICILIARY TREATMENT OF PULMONARY TUBERCULOSIS:

In 1956, the Tuberculosis Chemotherapy Centre, Madras undertook a controlled comparison of home and sanatorium treatment of pulmonary tuberculosis for 12 months, all patients receiving isoniazid plus PAS. The

main conclusion drawn at the end of this period was that 'the results of domiciliary chemotherapy as carried out in this study, approach sufficiently closely the results of sanatorium treatment to suggest that it is appropriate to treat the majority of patients at home'. A follow-up of these patients is now reported by S. Devadatta and his colleagues (Bull. Wld, Hlth. Org, 1961. *24*, 149). Of the 130 patients who had attained 'bacteriological quiescence at one year, 126 were allocated at random to treatment at home for a second year with isoniazid alone or with a placebo (calcium gluconate). The daily dosage of isoniazid was 200 mg. for patients weighing 100 pounds or more, 175 mg. for patients weighing 80 to 99 pounds and 150 mg. for patients weighing less than 80 pounds. The daily dosage of calcium gluconate was 500 mg. At two years, 60 of the 61 patients in the isoniazid series who still had bacteriologically quiescent disease were allocated at random for a third year to insoniazid in the same dosage (30 patients) or to the placebo (30 patients). The patients in the calcium series continued on calcium gluconate in the third year, unless their disease was no longer bacteriologically quiescent. At two years, the main comparisons for the second and third years were between : (a) 61 calcium and 65 isoniazid patients ; (b) 57 home and 69 sanatorium patients ; (c) 42 patients with residual cavitation at one year and and 84 patients without cavitation at one year. A comparison for the third year is made between 30 patients who have received two years of chemotherapy and 30 who received it for three years. At the end of the third year, there was relatively little difference between the progress of the patients in the various sub groups : six (10%) of 61 patients who received one year of chemotherapy relapsed bacteriologically, as compared with three (5%) of 65 who received two or three years of chemotherapy ; three (5%) of 57 patients treated at home in the first year relapsed as compared with six (9%) of 69 treated in sanatoria. In all, nine (7·1%) of the 126 patients relapsed in the second and third years, eight (6·3%) relapsing in the second year. None of the 60 patients in the comparison of two years and three years of chemotherapy relapsed, although one in the 3 year series produced an isolated positive culture at 36 months.'

It is concluded that in the second and third years there was relatively little difference between the patients whose disease attained quiescence following a year's treatment with the same combination of drugs in sanatoria. Secondly, there was no evidence that the second or third year of treatment with isoniazid alone gave better results than a year of chemotherapy followed by careful observation of the patient and further chemotherapy if a relapse occurred. Thirdly, patients with residual cavitation at one year had slightly higher relapse rates than those without residual cavitation. 'Taken in conjunction with earlier studies, the present study confirms the value of properly planned domiciliary chemotherapy for one year even in the most adverse environment and dietary circumstances'.

— *WHO News Bulletin—The Practitioner Vol. 187 August 1961.*

— *See also "The Madras Experiment" Editorial. The Lancet September 2, 1961.*

TREATMENT OF TROPICAL EOSINOPHILIA WITH DIETHYLCARBAMAZINE :

Single oral dose therapy : A preliminary report of 30 cases. The authors summarize the literature suggesting that tropical eosinophilia is caused by a filarial infection and that the treatment of choice is with diethylcarbamazine. They had treated 2 series of patients with this drug : 21 with oral dosage of 8-10 mgm. per kgm. body weight daily in 3 divided doses for 7 days, and 20 with 2 injections of 6-8 mgm. per kgm. They have now treated 30 patients with a one dose regime of 15-16 mgm. per kgm. (i. e. usually 900 mgm).

The criteria for selection were : (1) absolute eosinophile count of over 3,000 per cmm; (2) suggestive symptomatology - cough, expectoration, nocturnal exacerbation of cough, and signs in the lungs; (3) exclusion of other conditions; (4) ability to attend for follow-up.

Twenty five of these patients were followed up for at least 3 weeks. All of these obtained clinical relief. While about half began to obtain relief within 12 hours, others took a week, and complete relief was not often obtained in less than this period. The eosinophile count did not decrease coincidentally with the clinical improvement, and the authors remark that if complete relief is obtained in under a week, the eosinophile count and the ESR do not drop and may even increase. They contrast their 100% symptomatic success with their previous results, 76% with the 7 day oral dosage and 80% with the instramuscular dosage.

They noted very few toxic effects. Vomiting occurred in 5 patients, abdominal pain in 1 and giddiness in 1. Four had an exacerbation of symptoms after 12 - 20 hours which cleared without any additional treatment.

— *Bhargava, H. S., Choubey, B. S. & Chouhan, S. S. J. Ass. Physicians India,* **9**, *222 - 229 (1961)*

* * * *

COMMUNITYWIDE USE OF ORAL POLIOVIRUS VACCINE (EFFECTIVENESS OF THE CINCINNATI PROGRAM :

(Sabin, A. B., Mechaels, R. H., Spigland, I., Pelon, W., Rhim, J. S. and Wehr, R. E.).

During the spring of 1960, type I oral, attenuated poliovirus vaccine was given within a short period of time to 181,784 persons in Cincinnati and adjacent Hamilton County : 67,634 preschool children ; 1,11,127 school children ; and 3,023 adults. Most of the preschool children, some of the adults, and a small number of schoolage children also received the type III vaccine at the end of May, and the type II vaccine at the end of June. The vast majority of the school children received the other 2 types of vaccine in November, 1960, and January 1961. There were no untoward reactions

to the vaccine, and with the exception of one imported case in September, there were no cases of poliomyelitis during the entire year in the entire area with a total population of 9,42,000.

A serologic survey carried out prior to the oral vaccine program indicated the presence of large numbers of very young children without poliovirus antibodies among the unvaccinated in the lower income families, and also among those who have had 3 doses of Salk vaccine in the higher income families. Among the parents of the preschool children in the higher income families, 46% of the fathers and 25% of the mothers had not received even a single dose of Salk vaccine. After ingestion of each of the 3 types of oral vaccine at monthly intervals, 100% of the preschool children, who were without antibody, developed antibody to all 3 types, and a marked booster effect was also obtained in Salk-vaccinated children from the higher income families with various preexisting levels of antibody.

Virologic studies on rectal swabs obtained from about 3,200 children at various times before and after the oral vaccine program indicated : (1) a very low incidence of other enteric viruses at the end of April even among the children from the poorest homes ; (2) rather extensive spread of polioviruses to the unvaccinated, susceptible persons both within the family and outside ; and (3) a rapid disappearance of polioviruses from the community within a few months after the oral vaccine program.

The results obtained in Cincinnati in 1960, as well as those being reported from central and eastern European countries where community-wide programs of oral vaccination were carried out in 1960, indicate that in oral poliomyelitis vaccine we now have a simple tool with which the complete elimination of poliomyelitis from the United States is proposed.

— *Amer. J. Dis. Child. 101 : 546-567 (May 1961).*

* * * *

MORE NEW PENICILLINS :

In the issue of the British Medical Journal for July 22, there appeared four papers describing some of the properties of a new semisynthetic penicillin with a wider spectrum of activity, covering many gram-negative as well as most gram-positive bacteria. Three of the papers are from the Beecham Research Laboratories whose workers first announced the preparation of 6–amino-penicillanic acid and some of the first new penicillins synthesized from it, and indicated that one of this type and many others were to be anticipated. This latest one is labeled chemically 6 (D – (–) a – aminophenylacetamido) penicillanic acid (or more simply D-alpha aminobenzyl penicillin) and has been given the trade name Penbritin.

A large number of recently isolated bacterial strains from several hospitals were tested in vitro. The activity against most gram-negative bacilli was found to be similar to that of tetracycline and chloramphenicol

except that it was slightly more active against salmonella species and *Haemophilius influenzae.* It is less active than penicillin G against most gram-positive organisms. However, it is as susceptible as penicillin G to penicillinase produced by staphylococci and by several other species, and such penicillinase producers are equally resistant to both of these penicillins. Its activity is somewhat greater at acid than at alkaline pH and it is not markedly affected by serum. Resistance to the new penicillin seems to develop stepwise, — but increases of 25-to 100-fold occurred in 5 transfers in the 3 examples given.

Penbritin appeared to be well absorbed after oral administration. In human volunteers the drug was well absorbed when taken on a fasting stomach; peak levels were achieved in one or two hours, demonstrable amounts were present at 6 hours, and about 30% of a given dose was recovered in the urine within 6 to 8 hours. It appears to be concentrated in urine and bile.

Stewart and his co-workers, at Queen Mary's Hospital in Carshalton interpreted their in vitro findings as indicating that Penbritin has bactericidal action comparable to that of penicillin G upon pyogenic cocci and a wide range of coccal and bacillary pathogens. In oral doses of 50–100 mg. per kilogram per day, they showed that it maintains bactericidal levels in plasma for 4 hours or more and is rapidly excreted in very high concentrations in the urine. Only a small number of cases were treated; of these 8 children with severe urinary infections due to coliform organisms or streptococci or both and 6 with other infections responded rapidly to treatment, whereas 6 carriers of *Salmonella typhimurium* and 2 of *Escherichia coli* serotypes were not cleared of infection. Among 28 patients who were treated for 5 days or more, the only toxic effects observed were transient rashes in 3. They felt that further clinical trials were warranted. Considerably more data in well studied cases will be needed before the therapeutic potentialities of this new penicillin can be delineated. Meanwhile, the medical profession can expect a large number of other semisynthetic penicillins, which are now undergoing clinical trial or being readied for such trials, to be made available in the near future.

— *Editorial, The New Eng. J. of Medicine Aug. 24, 1961.*

NEWS AND NOTES

THE VOLUNTARY HEALTH SERVICES, MADRAS

On the 8th October, 1961, the Prime Minister of India laid the corner stone of the V. H. S. Medical Centre under the auspices of the Voluntary Health Services, Madras. Though primarily the aims of this organisation appear to be similar to the prepayment medical care plans of some of the states in the U. S. A., in its essentials, it differs radically from them and appears to be eminently suited for the special conditions prevailing in our State.

The motto of this organisation is, " We serve the doctor who serves you " and the general practitioner is the pivot through whom the society serves its members. " There will be no direct access to the society's special services except through the general practitioner who may be the office doctor or the family doctor or both ".

This organisation should be congratulated on its having secured the services of a good number of specialists for their expert committee who have agreed to serve the members of the society for a nominal fee.

The citizens of Madras are fortunate in that this society will be the pioneer in the field of rendering medical aid on a voluntary prepayment basis. It should be the aim of this society to extend the scheme on a zonal basis throughout the state of Madras either directly by having branch organisations in other districts or by sponsoring similar societies in other areas.

* * * * *

" At the extraodinary meeting of the Madras Medical Council held on 13th November, 1961, Dr. P. Natesan has been elected as President for the Council and Dr. A. S. Ramakrishnan as its Vice-President. Drs. M. Natarajan, C. Nathamuni and D. V. Venkappa have been elected as members of the Executive Committee at that meeting ".

NOTIFICATION.

MADRAS MEDICAL COUNCIL—THE MADRAS MEDICAL REGISTER FOR 1961.

" The Madras Medical Register for 1961 is under preparation. Registered Medical Practitioners under the Madras Medical Registration Act – 1914 are requested to intimate their present addresses to make necessary corrections in the Register. They are also requested to intimate the full name, register numbers and addresses of any practitioners appearing in the register for 1960 who, to their personal knowledge, are dead ".

111, Mount Road,
Madras - 6.

REGISTRAR,
Madras Medical Council.

ASSOCIATION NOTES

BRANCH NOTES

Chingleput Branch:

At the annual meeting of the branch held on 9—9—1961, the following office-bearers have been elected for the year 1961—'62.

President: Dr. E. R. Menon, M. B., B. S.

Vice-President: Dr. P. K. Varughese, L. M. & S.

Honorary Secretary & Treasurer: Dr. A. Sundararaja Rao, L. M. P.

Madurai Branch:

The monthly meeting of the Madurai Medical Association was held on Saturday, the 21st October, 1961, under the Presidentship of Dr. Abdul Sattar, L. O., Maduri.

Dr. Augustus Asirvadham, B.A., M.B., B.S., F. R. C. S., Surgeon, Erskine Hospital, Madurai, Professor of Surgery, Madurai Medical College, Madurai, gave an interesting lecture on "Some of the recent trends in Surgery".

Nagapattinam Branch:

1. A clinical meeting of the I. M. A., Nagapattinam was held on 3—9—1961, Dr. A. Thiagarajan. M. B., B. S., presiding. Dr. N. K. Iswaran, M. B., B. S., Senior Medical Officer, Government Hospital, Nagapattinam delivered a lecture on "Diarrhoeas".

2. A clinical meeting of the association was held on 1—10—1961 at the Government Hospital, Nagapattinam. Dr. Easwaran presided and also spoke on 'Eruptive Fevers'.

Nagercoil Branch:

Annual Meeting

The business meeting of the branch began at 5 p. m. on 30—9—1961 under the Chairmanship of Dr. Muthukaruppa Pillai, the Vice-President. The following office-bearers were elected for the year 1961—'62.

President:	Dr. N. Sitaraman.
Vice-President:	Dr. Fletcher.
Honorary Treasurer:	Dr. Muthukaruppa Pillai.
Honorary Secretary:	Dr. A. D. Ramamurthy.

The professional meeting of the branch began at 6-30 p. m. Dr. C. Nathamuni Naidu, President elect of the I.M.A., Madras State Branch for the year 1961—'62 was elected to the chair. Dr. Pai, M.R.C.P., Physician, Medical College, Trivandrum gave a talk on 'Chestpain'. This was followed by Dr. Ambadai, Skin Specialist, Medical College, Trivandrum, who spoke on 'Some Common Skin Diseases'. Then Dr. Christudas gave a talk on 'Diarrhoea in Infants'.

Nilgiris Branch:

The monthly meeting of the association began at 3. p. m. on 11th November, 1961 with Dr. P. V. Kurian, President in the chair. There was a discussion on anaemias. Dr. V. Mahadevan, M. B., B. S., briefly discussed the etiology of anaemias in the estates. Then Dr. D. S. Chandrasekhar, B. SC., M. B., B. S., discussed various laboratory aspects in dealing with anaemias. Dr. Miss Anasuya briefly touched on anaemia in pregnancy. The president wound up the discussion with his views on all aspects of anaemias.

Pudukkottai Branch:

The annual meeting of the association was held on 5—11—1961 at 4-30 p. m. in the Town General Hospital, Pudukkottah. Dr. C. R. Tiruvengadam, presided, Dr. A. Govindarajan, B. A., M. B., B. S., D. O., Eye Specialist, Town General Hospital, Pudukkottah, gave an interesting and elaborate lecture on 'Common Eye Diseases' in general practice.

Dr. Ramaswamy, M. B., B. S., Ph. D., Associate Professor of Anatomy, Stanley Medical College, gave a talk on his recent continental tour which was very interesting. Then the following office-bearers were elected for the year:

President: Dr. C. R. Tiruvengadam, M. B , B. S.

Vice-President: Dr. R. Reghunathan. L. M. & S.

Secretary & Treasurer: Dr. N. Thiagarajan, D. M. & S., D. T. M.

Ramanathapuram Branch:

1. The monthly meeting of Ramanad branch I. M. A. was held on Sunday the 1st October, 1961 at 5 p. m. at 'Kamak Hall' of Sivakasi Hindu Nadars' Victoria High School, Sivakasi. Dr. S. Raju Ayyar, L. M. P., of Srivilliputtur presided over the function. Dr. A. A. Asirvadham, B. A., M. S., F. R. C. S. (Eng.), Professor of Surgery, Madurai Medical College and Surgeon, Govt. Erskine Hospital, Madurai gave a very interesting lecture on 'Peripheral Vascular Disorders'.

2. The monthly meeting of the Ramnad branch I. M. A. was held on Sunday the 12th November, 1961 at 5 p. m. at the Municipal Office Meeting Hall, Srivilliputtur. Dr. S. Raju Ayyar presided. Dr. T. V. Venkatesan, M. B., B. S., F. D. S., (Lond),, F. C. C. P. (U. S. A.), of Erskine Hospital, Madurai gave a very interesting lecture on 'The Use and Abuse of Corticosteroid Therapy'.

Salem Branch:

1. There was a meeting of the branch on 9th September, 1961, Dr. Jayaramachandran of Namakkal presiding. Dr. G. Victor, M. D., Principal and Professor of Medicine, Madurai Medical College addressed the members on "Cerebro-Vascular Accidents".

2. On 22nd October, 1961 Dr. Jayaramachandran of Namakkal presiding, a meeting was held when Dr. Narasingha Rao, M.B.,B.S., F.R.F.P.S., Uro-Genital Surgeon, who has just returned after a long stay in the States

and United Kingdom addressed the members on 'Recent Advances in Urology'. He spoke on transplantation of kidney, artificial kidney and other recent advances.

South Arcot Branch:

The annual meeting of the branch was held in the Municipal High School Hall, Cuddalore N. T. at 4 p. m. on Saturday the 30th September, 1961. The following office bearers were elected for the year 1961–'62:

President: Dr. K. Rangasamy, Chidambaram.
Vice-President: Dr. Sankararaman, Cuddalore O. T.,
Honorary Secretaries: 1. Dr. S. Boovarahamoorthy, M. B., B. S.,
2. Dr. A. R. Reddy, M.B.B.S., D.L.O., (Lond)
Treasurer: Dr. S. Boovarahamoorthy.

Thanjavur Branch:

The silver jubilee celebrations of the association was celebrated on the 15th October, 1961. The proceedings began at 10-30 a. m. with an invocation song by Kumaris Mythili and Lakshmi. Dr. N. R. Subramaniam, M. B., B. S., then delivered his presidential adress. The report for the year 1960/61 and the messages of greetings received from all over the state were read by the Hony. Secretary. Dr. S. N. Ganapathy, M. B., B. S., District Medical Officer, Thanjavur and Dr. S. Balasubramanian, M. S., Dean of the Stanley Medical College then addressed the gathering, exhorting medical men to join the Association in large numbers. Dr. G. A. Atmaram Rau, M. S., Surgeon, General Hospital and Professor of Surgery, Madras Medical College then spoke on, 'Acute Abdomen'.

The general body meeting was held after lunch when the following office bearers were elected:

President: Dr. P. A. K. Nair, D. M. S., T. D. D., Z. C. V. D., (Vienna)
Vice-President: Dr. P. Narayana Rao, L. M. S.
Hony. Secretary & Treasurer: Dr. S. Narayanan, L. M. P.

The meeting passed a resolution protesting against the formation of a cadre of 'Semi Doctors'.

Dr. K. V. Thiruvenkadam, B. Sc., M. D., of the Stanley Medical College then addressed the gathering on 'Cancer of the Lung'.

Dr. Vishnu Sarma, M. A. (Cantab) M. D. (Cantab), B. Chir. M. R. C. S. (Eng) L. R. C. P. (Lond) D. G. O. (Madras), spoke on 'Gynaecological & Obstetrical Emergencies in General Practice'.

Tiruchy Branch:

1. A monthly meeting of the association was held on Saturday, the 16th September, 1961 in the medical association premises, Tiruchy. Dr. P. V. Sundaram, the President was in the chair.

A resolution congratulating Dr. T. V. Srinivasan on his election as the senior Vice-President of the Madras State Branch I. M. A. for the year 1961–'62 was moved from the chair and passed unanimously.

Dr. P. K. Kalyanaraman, M. B., B. S., Honorary Physician, Government Head-quarters Hospital, Coimbatore, gave a talk on 'Myocardial Infarction and the General Practitioner'. The lecturer gave an excellent talk on the subject which was followed by a lengthy discussion.

2. A monthly meeting of the association was held on Saturday the 7th October, 1961 in the association premises. Dr. T. V. Ranganathan, the Vice-President took the Chair.

Dr. V. Srinivasan, M. B., B. S., D. T. M. & H., Honorary Professor of Therapeutics, Madurai Medical College and Honorary Physician, Erskine Hospital, Madurai, gave a talk on 'Nephritis with special reference to its management'. After the lecture, there was the usual discussion in which many members took part.

A patient was informed by his psychiatrist that he could consider himself cured of his delusion that he was Napolean.

"Oh, Wonderful"! cried the happy man. "Where's the phone? I must call Josephine and tell her the great news!"

* * *

The surgeon was discussing a forthcoming operation with a wealthy patient. "Would you prefer a local anæsthetic?" he inquired.

"I can afford the best," replied the patient. "Get something imported."