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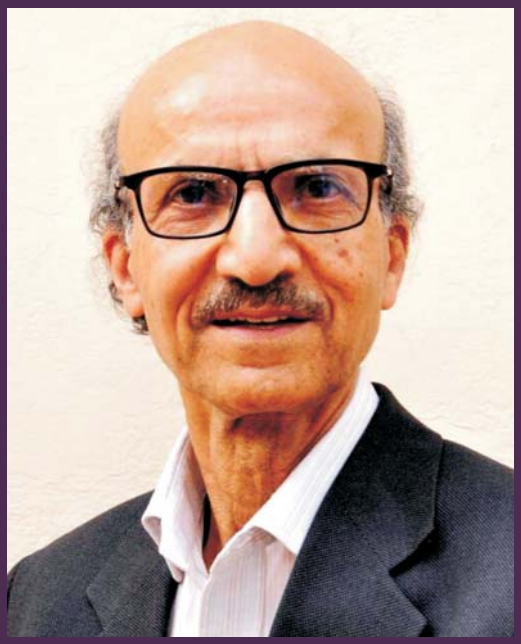
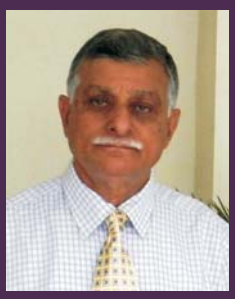
Stories from Dr. K.L.Chowdhury's 'My Medical Journey'





Compiled by : M.K.Raina

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Dr. K.L.Chowdhury's

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Contents

About Dr. K.L.Chowdhury :

Born in Srinagar, Kashmir in 1941, son of eminent criminal lawyer Shri J.L.Chowdhury, K.L.Chowdhury did his MBBS from Punjab University and MD from Delhi University. He did his fellowship in Neurology from London.

Dr. Chowdhury started his career as a faculty member in Medical College, Srinagar, as a clinician, teacher and researcher, rose to become a professor, and pioneered Neurology as a specialty in the Medical College.

In 1990 he moved to Jammu along with his community, and started charitable work by organizing the displaced doctors of KP Community and provided free medical care to thousands in the migrant camps. Thereafter he started Shriya Bhat Mission Hospital and Research Center which provides free multi-specialty consultation and treatment to the poor and indigent patients and conducts medical camps, surveys and research. He conducted pioneering work on the Health Trauma of the displaced populations and coined new syndromes like “Stress Diabetes”, “Psychological Syndromes of exiles”, “The 10-12 Syndrome”, “The metabolic syndrome in ‘migrant’ camp inmates” etc. and highlighted the adverse effects of stress of environmental and lifestyle changes on a displaced population. He held 123 Medical camps from 1990 to 2020 on different diseases in migrant camps and other areas of Jammu province where he provided free medical care. Even just before five days of his death he was providing the online consultation to the people.

Dr. Chowdhury was engaged in multifarious activities as a medical professional, social scientist, journalist, poet and writer. Besides, he was a political thinker who wrote “Why Homeland”. He also gave the concept of City State for Kashmiri Pandits in the Valley. He was a staunch believer of Homeland for KPs and was also the vice president of PK for 15 years. Besides, he was chairman of Global Kashmiri Pandit Diaspora and KMECT.

Besides being a medical doctor, Dr Chowdhury also earned name as a noted writer and journalist. His works won him several awards including 'Kashmiri of the Year' and ‘Rajiv Gandhi Shiromani award’ in 2007, 'The Smiriti Samman' in 2006, ‘Prem Nath Bhat Amateur Journalist Award’ in 2004, and ‘Best Book Award for Excellence in Literature’ in 2008.

Dr. Chowdhury breathed his last in USA on 31 October 2021. He was 80. He is survived by his wife Dr Leela Chowdhury and two daughters.

Dr. Chowdhury has the following books to his credit:

Of God, Men & Militants (2000)
A Thousand Petalled Garland and other poems (2003)

Enchanting World of Infants (2007)
Homeland after Eighteen Years (2011)
Faith & Frenzy (2012)
Why Don't You Convert and other stories (2015)
The Final Frontier (2017)
Room in our Hearts and other stories (2019)

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Dear Kundanji – about your New Adventure

(A brother remembers his sibling)

You love nature, exploration and adventure
I imagine you on a journey in several stages
First on a shikara gliding over the placid waters
Of a freshwater lake.
You see colourful hills in the distance
Further away are the high mountains
With glistering snow-clad peaks.
Next you are on a more sturdy boat
Navigating a fast-flowing river
Passing through forested terrain
You will negotiate steeps and bends
Swirling waters and dangerous rapids.
In time, you will reach the ocean.
A much longer voyage will begin
You are on a modern ship,
High-tech, well-endowed with equipment
For coastal and underwater adventures.
I imagine you diving in and exploring
Near reefs with multi-coloured corals
Teeming with marine life
In all its variety.
Back on the ship,
Among the passengers
You make many friends,
You already seem know some
Not clear how that is so
Yet, you take that in stride.
The captain accepts your offer
To be part of his medical team,
If and when need arises.
The ship will dock in the port after port
New passengers join in.
Once in a while you will notice
A face that seems familiar
As if from a different time

You walk across and say hello.
Little further recall
The best that can be done
Is to chat over cups of tea
As you might have done
At reunions with friends
At your own house
In time just gone by.
Many more experiences
Will come your way
In these voyages.
Of that, I am sure
Yet dear brother and friend
All that and more
Is beyond my imagination
Love and farewell.

Baiji (Robin)
Figtree, N.S.W., Australia
November 3, 2021

Stories from Dr.K.L.Chowdhury's 'My Medical Journey'.

How did it all start?

Dr. Chowdhury's letter dated 5 August 2002 to Härvan readers :

Dear Friends,

The editor of Härvan, Shri M K Raina (MKR) has asked me to contribute a regular health column for the journal starting with the second (September 2007) issue. This is a big calling. I have great affection for MKR and have no heart to decline his invitation. However, after giving it a serious thought I have come to the conclusion that if I accept this brief, I shall approach the subject rather differently. Yes, unconventionally. That is what I communicated to him.

The usual practice with write ups in the lay press on the subject of health and disease is to tackle the subject, more or less, in the manner it is described in text books of medicine - providing the definition, the causation, the presentation, the tests and the treatment etc. of a particular disease or a symptom - except to put it in a simple (layman's) language. Often the description is impersonal and boring; it burdens the reader with a lot of facts - controversial at times - that he/she could do without; it initiates in the sensitive readers an obsessive process of imagining the symptoms and signs and an apprehension that he/she may be a victim of the disease under discussion. Often, it leaves many questions unanswered or raises new questions for which there is no direct way to get answers from the writer. In short, more often than not, it stops quite short of the ideal of writing for lay public.

Another reason I intend to break this convention is the fact that, since I will be writing for an E-journal, it is not difficult in this age of information technology for the reader (web surfer) to glean information of this sort. Go to Google or some similar search engine, click the mouse and there you are! Even the latest that may not yet have appeared in the text books will be dished to you through so many web-links. Besides, a pedantic approach can become dull and boring, particularly when handling the sensitive and difficult subject of medicine. The practice of medicine is the best marriage of science and art that demands of the practitioner more than mere knowledge and experience - a personal touch, a lot of application and passion, and some measure of insight and intuition.

Yet another reason to do away with convention is the tendency for the lay public to take as gospel truth whatever is written about a subject by an expert, especially a reputed author or a person of renown in the field. We live in an era of the explosion of scientific knowledge. New facts come to light every day as old and 'established' beliefs

get dismantled. There is no place for dogma nor can anyone claim the 'final word' on a subject. Evidence-based medicine is the buzzword. As an example I will relate a recent advisory by FDA (Food and Drug Administration of USA) on common cold and cough remedies for kids below 2 years. It has been reported that many kids suffer from serious side effects from some ingredients of these over-the-counter mixtures like pseudo ephedrine and dextromethorphan especially if administered in wrong doses. Now, these so called established remedies are still being consumed by millions of kids round the globe, when, in fact, they may be working as mere placebos. While we endeavor to make the necessary evidence available, it devolves on the inquisitive reader to separate the grain from the chaff and not leave it all to the so called expert. He can do so by reasoning, by questioning, by pressing for more information and drawing inferences from the facts and figures presented.

How do I approach the Health Page then?

Well, my endeavor will be two-pronged - one to make it more interesting at the same time as it is informative and, two, to make it interactive.

Interesting, by doing away with the traditional pedagogic description of disease or symptom-complex and by being avant-garde. For example, I would like my readers to have a taste of case vignettes from my long experience as an internist - interesting cases, bizarre cases, missed diagnosis, personal triumphs (so called miracles) including the eventful exile experience of the last 17 years. This will lend it a personal touch and the stories will speak more.

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A prophet in his own house

[And so they took offense at him. But Jesus said to them, "A prophet is not without honor except in his hometown and in his own house." Matthew 13:57]

I was an intern in the summer of 1962. Internship in India is a period of practical training after completing five years of studies for the M.B., B.S. degree. It lasts 12 months and rotates in different disciplines - Medicine, Surgery, OBGY, Eye, ENT, and Community Medicine. I had finished my degree from Medical College Patiala and had sought special permission from my university to complete my internship in SMHS Hospital, affiliated to Medical College Srinagar. My posting was in medicine.

One Sunday morning mother called me to have a look at my grandfather. He complained of pain in the abdomen. I knew from my childhood that grandfather suffered from chronic bronchitis and duodenal ulcer. He had survived numerous episodes of black motion (ulcer bleed). Often he would dash me to the grocer for a packet of baking soda and wash a spoonful down his gullet with a glass of water whenever he suffered ulcer pains. That gave him instant relief. But this pain was different, he explained. It had started early at dawn and soda bicarb had given no relief. It was intermittent and crampy, mostly centered below the navel. He had passed urine but had not moved his bowels. There was no fever; pulse and BP were within range. I set about to feel the abdomen but grandfather had worn his pajama high above the navel level. I tried to loosen the knot to pull it down so I could have a proper look but he would not let me. Only after I reassured him that I would respect his privacy did he let loose the knot just enough for me to feel the abdomen. It felt soft to my palpation; there was no tenderness but he kept covering his groin with his hand. I pulled away his hand gently only to find a swelling under the pajama!

"This is nothing; it has been there for quite some time. It comes and goes and never gives trouble. You need not bother about it. It is my tummy that hurts."

The words of my surgical registrar rang in my ears, "Do not ever forget to lok at the hernia sites in any case of abdominal pain," and I jerked the trouser down, impatiently, almost irreverently. He was unhappy with me, angry at my audacity. I felt a tense, slightly tender, apple-sized swelling. It was an inguinal hernia. The cough impulse was missing and I tried in vain to reduce the swelling by pushing it gently back into the abdomen. It was certainly obstructed - a surgical emergency!

This was the first time since I graduated that I had been asked to examine a patient on my own, and it happened to be my grandfather. I had to be very sure about my clinical impression. I opened the text book of surgery to corroborate the findings.

By now father arrived on the scene - anxious and worried. I told him that the situation called for an emergency operation. Father looked askance, incredulous.

"What are you talking about? Surgery in this fragile old man! Can he take it; can he survive surgery with that lung problem of his? Can he tolerate anesthesia?" He shot questions one after the other, like the lawyer that he was, taking on a professional witness. I felt like being in the dock. Relevant questions no doubt. I had not even considered them. Like a typical trainee I had concerned myself only with the diagnosis and none of the other details that come with experience. And, strangely, I was not behaving or thinking like a grandson whose grandfather has taken ill, but as a doctor examining a patient and wanting to get at the bottom of the clinical situation.

"Are you not making a mistaken diagnosis? Have you seen cases like that before as a student?" father wanted to be certain.

I was silent, for I had seen hernias but never an obstructed one.

"Even if it is what you say, is there no other way." He looked at me, a mixture of the disbelief on a novice and compassion and faith that only a father is capable of. The rest of the family that had assembled looked on, again with a mixed sense of concern about the patriarch and empathy with me.

I said I was certain it was a hernia and that it was obstructed. But there was might be a small chance to avoid or delay surgery. I would attempt to reduce the hernia under sedation, though I was not sure about the procedure for I had never seen it being done during my student days. At best it would be a temporizing measure, at worst it would not work, I said.

Since it was a non-surgical intervention, it appealed to my father and my self-confidence helped generate some trust. Father was very understanding; he gave me a free hand. Not many would in that situation, but he trusted me, looking at my cool reassurance. He always believed in his children, and here was a great occasion to give that belief a chance.

I opened the text book of surgery again and studied the procedure carefully. I gave my grandpa a shot to sedate him and tried the reduction. He was shy, restrictive, un-cooperative, again trying to shield the area with his hands.

It is one thing to have learned all the theory and graduated with honours, quite another to translate that knowledge into the nitty-gritty of everyday practice of medicine. Exactly that is what happened. I started with deep trepidation - nervous, over-cautious and gauche - as I attempted the reduction while the whole family waited outside. The swelling would not budge. I tried a second time but the hernia was stuck. I stopped, for any further attempts could precipitate strangulation of the hernia.

And then, first time since morning, I sat down besides my grandfather and looked at his deep-set brown eyes, his sunken cheeks, and the loose wrinkled skin on his thin neck. He was like a baby – innocent, pure and helpless. He looked back all compassion

and affection, even as he was in obvious pain. And I loved him most that moment. He understood my predicament.

"Why do you worry; I am an old man and have lived my years. Whatever will be, will be? You did your best; I think it will settle down soon. Let me get some rest now."
"No, I will not let us take it lightly; we cannot sleep over it."

I came out and told my father that there was no way out except surgery. We must take him to the hospital. As if he had read my thoughts, father asked, "I know you are right, but would you like to have the opinion of a surgeon?"

Father suggested Dr. B M Bhan, an upcoming surgeon, a FRCS from England. He was an Assistant Professor of surgery in the Medical College. I did not know him personally, had not even heard about him.

My cousin and I hired a 'tonga' to fetch him. I introduced myself and explained the case. He agreed to come with us.

It is an event in the neighborhood when a doctor comes visiting a patient. While Dr Bhan took time to examine the patient, the neighbors started pouring in and inquiring. I was like a student again, waiting for the result - more concerned this moment with whether the surgeon agreed with me than about the gravity of my grandfather's illness. Dr. Bhan might have sensed my trepidation.

"Kundan is right; your Dad has an obstructed hernia. Reduction often fails in this situation. He will need surgery right away," he addressed my father, looking appreciatively at me.

This is a rare moment in the life of a greenhorn in the profession to be encouraged thus, especially in the presence of a huge assembly of relatives and neighbours. It is a moment of triumph. But now was also the time for action. Dr. Bhan said he could not perform surgery for it was not his day admitting day. Dr. Gulam Rasool, a senior surgeon, was on call that day, he informed us.

The 'tonga' dropped the surgeon back home and another was hired in which we drove grandfather to the hospital. Having settled him in the ward, an ambulance was sent to Dr. Ghulam Rasool with the house surgeon's note detailing the salient features. I decided to go along in order to expedite the proceedings and to give my own impressions on the case to the surgeon. Dr. Gh. Rasool was a bespectacled stocky fellow, more like a pugilist than a surgeon. He went through the case sheet hurriedly and, without giving it a second thought, wrote down a note and handed it over to the ambulance driver, and motioned him to go, eyeing me just once as he started to turn back inside his house.

"Sir, won't you come and operate upon this patient?" I said with great humility.

"I will see him tomorrow; meanwhile I have written out the instructions." He had suggested conservative measures - nothing by mouth, intravenous fluids and pain killers.

Now I revealed that I was an intern and the patient my grandfather. I explained my fears that the hernia may strangulate if not operated upon in time. Tomorrow might be too late, I said. And would he not, for the sake of a fellow professional, come and have a look?

That made him angry. “Don’t teach me surgery, young man,” he barked, and so did his bulldog. I thought the canine was waiting for a signal to tear me to pieces but I was not to be moved. I stood there facing the surgeon and his dog, firm and undeterred.

“In that case I will report to the head of the department and request him to examine my grandfather,” I said. “I hope you have no objection.”

“I do not care whom you report,” he was really incensed now, “and what objection should I have, if someone else wants to take over this case?”

I wished to get away from there as soon as possible. How could I trust my grandfather with a person who seemed uncompassionate and unprofessional? This was a clear dereliction of duty. He did not like his Sunday disturbed. (We became friends many years later when I was a professor in my own right in the Medical College. He turned out to be an able administrator of the hospital – a position which was bestowed upon him after his retirement!)

I asked the ambulance driver to head for Dr. Khanna‘s residence. Dr. Khanna was the head of Surgery. I knew him for he had been my professor in Medical College Patiala and, after retirement last year, he had accepted the position of HOD in the Medical College here.

I introduced myself and he recalled at once that I had been his student. Lean and handsome, he was a contrast - genial, soft spoken, civilized. He made light of my disgust with his colleague, and wasted no time to board the ambulance on way to the hospital.

It was a proud moment for me to introduce my father to my illustrious professor. His tension eased the moment he realized that grandfather would now be in the best hands. Prof Khanna won over my grandfather with his quiet manners, his wide smile and his soft touch.

“It will take us half hour to set you on course,” he said reassuringly.

The patient was moved to the operation theatre and when I sought the permission of Dr. Khanna to watch the surgery, he took me off guard, “Of course, you will wash up and assist me in the surgery, won’t you?”

I did not dare to admit that I had never assisted an operation in my life and hardly watched any during my student days. I had yet to rotate my internship in surgery. But this was a matter of prestige besides the opportunity to prove myself.

It was such a smooth affair! Dr. Khanna spoke softly, almost inaudibly while operating, relating interesting anecdotes from his vast surgical experience, gently guiding me and the theatre assistant, never losing his temper at my clumsiness in

handling instruments and, literally, teaching by the hand. He made us all feel at such ease that I forgot this was my first operation; I forgot that the patient under the scalpel was my dear grandfather.

It was a clean job, accomplished in half hour as the surgeon had said. The patient came out of anesthesia and was moved to the ward soon after. The whole crowd was waiting outside to thank the surgeon, eyeing me with admiration. Or, that is what I thought.

Grandfather was home after a week in the hospital, going through an uneventful recovery. It was a grand homecoming, the neighbours and the relatives had assembled to receive him – and me!

"It was all because of you," everyone patted my back in appreciation.

Till that day I was Kundan but now I transformed into Doctor Kundanlal, and people started addressing me as 'Doctor Sahib'. I was no longer a green horn, but a physician in my own right who could be trusted. I had performed a twin 'miracle' of sorts - started charity from home by treating my own grandfather and diagnosed my first test case correctly and handled it well.

I became a prophet with honour in his own house!

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Baptism by fire ~ A case of Catatonic Stupor

It was a clear sunny spring day in 1968. We had finished the rounds of male patients in ward 3 and were coming out on the corridor, walking towards the female ward when a gentleman squeezed his way through the crowd of waiting attendants and rushed towards Dr. Ali Mohamad Jan (Dr. Jan). He started updating him on a patient who had been examined by Dr. Jan some days earlier, and was now persuading him for a home visit, to have a second look at his patient. Dr. Jan, asked him to repeat the medicines he had prescribed and with that characteristic gentle jerk of the neck towards right, a tick that suited him so well, dismissed the fellow as we entered ward 5.

Nearly an hour later when we came out of the ward we found the gentleman again, waiting eagerly, with a profoundly sheepish expression. Dr. Jan started climbing the stairs to his chamber with the man at his heels. Suddenly he called me aside, "Dr. Chowdhury, can you please go with this gentleman and examine his patient at lunch time? It is a case of brain tumour I examined a couple of days back. He is in coma and I don't think we can do much, but why don't you go and have a look, for his satisfaction?" Then he addressed the gentleman, "Dr. Chowdhury is a bright young doctor; he will examine your patient and report back to me."

This was the first time ever Dr. Jan asked me to see one of his private patients, an honour he would not easily bestow on any one. But, was this just passing the buck? What purpose my visit if the patient was in coma with an incurable brain tumour? What was my role except to go through the rituals of examining and putting my stamp on a death warrant issued by one who was considered the last word in medicine? Yes, a brain tumour with coma meant death those days. There were no diagnostic aids beyond a plain x-ray of the skull, while neurosurgery was in its infancy in India and non-existent in Kashmir. Naturally, I was not excited as I should have been if it were a different situation, say a patient who could be salvaged. I had just started my practice and was making no headway. And now here I was merely to endorse, what my boss had declared, an incurable situation. This appeared unappetizing, unchallenging, uninspiring.

The gentleman hired a Tonga and soon we were trotting along the Karan Nagar road towards Chotta Bazar, taking a left to Kanya Kadal. From there we drove towards Habba Kadal to a picturesque scene - a pleasantly warm sun in a clear blue sky, and people in pherons shopping from the numerous regular as well as pavement shops on either side of the road. The Vitasta was meandering along gently, unmindful of human activity on her shores, sending whiffs of gentle breeze as we crossed Habba Kadal and aimed towards Babapora, stopping right at the 'tail', as they would call the place down the end of a narrow and long sloppy road. I was led to the third floor of a small house, to a room with extension on to a wooden balcony called Dab in Kashmiri. It was a neat and

well-lighted room with pictures of gods and goddesses hanging from the walls, a couple of chairs, and a table with a few bottles of medicines and glasses on it.
The patient was lying on the floor, on a mattress, bolstered with cushions on either side in this. There was a crowd in the room. As I entered, some of them sitting around the patient moved aside to make place for me. I sat besides the patient and started examining him.

Here was a medium-sized, middle-aged man, laid on his back, unaware of the surroundings, unresponsive to any commands, unable to make any movement,. He was obviously in stupor. He was stiff in the body and limbs; pain stimuli did not evoke any response; the tendon reflexes were normal and the plantar response was flexor in both feet. Funduscopic examination of the eyes did not reveal any evidence of raised pressure in the brain. I could not think of any thing else except a brain tumour. The examination of other systems did not reveal any abnormality. I stood up, wrote my findings and told the attendants that they should continue the instructions by Dr. Jan for I had nothing more to add except that they should change the patient's posture frequently so he does not get bed sores, lying down in one position all the time.
We rode back to the hospital and straight to Dr Jan's room. I reported my findings and he was obviously pleased that I had done my job well and reinforced his diagnosis. The attendant left, rather dismayed and disappointed.

Two days later, the patient's attendant was again waiting in the corridor as we came out of the ward after completing the rounds. With folded hands, he implored Dr. Jan to examine the case himself just once again. Dr. Jan turned down his plea and asked me to go, have another look. The gentleman looked very skeptical but dared not tell him that he would not like his patient examined again by me, because it would not serve any purpose nor give them the satisfaction of consultation by the big man himself. There was a lot to choose between an unknown doctor and the doyen of medicine! Nor would I dare to say no to my boss.

It was a reluctant doctor going to see a patient in company of a reluctant attendant - a double jeopardy of sorts! The Tonga sped fast on the asphalt and I tried to open conversation with the attendant but found him rather reticent, even sarcastic. After all I was only a second fiddle to the treating physician, and I had given him no reason to have any confidence in me. This seemed to him another futile exercise.

I found the patient in the same position as I left him two days earlier. He was lying down facing the ceiling with eyes half open but vacant. He did not respond to any stimuli. The stiffness seemed to have grown worse. Other than these observations, a re-examination did not reveal anything new.

Yet, something was amiss; something told me this was not a case of brain tumour. There were no localizing signs; there was no evidence of a raised intracranial tension.

Was my vision clouded because I had started with a bias, a diagnosis by the tallest man of medicine in town? What was the missing link?

All this passed my mind quickly as I rose to occupy the chair nearby and a lady advanced a cup of tea towards me. Before I could decline, another lady moved near my feet. "Please do something to save him. Look at his two daughters; they are to be wed this fall. His son is still in teens. What will become of them if anything happens to him? Pray, work some miracle."

It was a tragic, touching spectacle. I looked around at the anxious attendants assembled there - pretty but careworn faces of the two maidens, the frightened wife, the saddened old mother and two fretful middle aged men, possibly brothers of the patient, looking on with helpless resignation. The boy must have been away in school.

Sipping tea, I started asking the history in details, probing for clues that would help. Some important facts emerged. This man had been behaving 'odd' for quite some weeks. He was withdrawn and apathetic for many days before he finally went into stupor. There was no headache, no vomiting, no weakness of any limb, no impairment of visual, auditory or other faculties, no gait disturbances, no problem with bladder and bowel. He was normally intelligent and working as a salesman till 3 weeks earlier.

"He has been in this state for a week now as if he were a living corpse, stiff, and immobile except for that quiet heave of the chest that tells us he still lives," said his agonized wife, as I sat on the chair, contemplating.

Yes, here was a man in stupor and yet there was neither anything in the history nor on examination to suggest a brain tumour. Nor was there a systemic disorder to explain his stuporose state.

"Has any such thing happened in the past?" I asked the attendants.

"Yes, nearly twenty years back, he had a similar condition for two days when he was in Patna. We did not see him then. By the time we were informed and traveled there, he was alright."

"What was he doing in Patna?"

"He was in the army but after that episode he was discharged from service. We were not given any other reason for his discharge."

"Has he remained healthy ever since?"

"More or less, till this thing befell."

Suddenly the cobwebs cleared as the details of the history of this patient poured in and clinched my suspicion that I was dealing with a case of Catatonic Stupor and not brain tumour. I had read about it during our short training in psychiatry in my graduation days, though I had never seen a case. Yet, I was almost certain about my diagnosis - from knowledge and intuition as much as from a logical sequence of events and examination. Suddenly the mournful ambience seemed to light up with the bright light

that entered from the open windows of the balcony. The supposedly dying person seemed coming to life again.

"We are not dealing with a brain tumour, but something else," I declared, animated, "Please do not worry; I am sure we will be able to help."

There was a surprised, but skeptical expression on the faces around me. Was I just trying to humour them or was I in earnest?

"Not a brain tumour? Then what does he suffer from?" The men craned their necks towards me.

"From Catatonic Stupor"

"What does that mean?"

"It means a type of mental disorder we call Schizophrenia. He has obviously suffered from it when he was in Patna and this now is a relapse. It was because of this disorder possibly he was discharged from the army; and now he was behaving odd and withdrawn before he went into this state. I will admit him tomorrow and meanwhile prescribe a different drug."

"But, what about Dr. Jan?" asked the attendant who had accompanied me, alluding to the name with great reverence, still incredulous that I had changed my opinion about tha patient and was challenging his Dr. Jan's diagnosis.

"I will discuss the case with him."

We started riding back to the hospital. The attendant turned friendly now and started asking questions on the way, now that I had become a harbinger of hope. I was throbbing with enthusiasm and wanted to be left alone to collect my thoughts. The streets were busy as usual with pedestrians and shoppers, stray cows and mongrels, cycles and Tongas. Life in the valley was simple, replete with these wonderful images of animals and people going about their business as the mighty mountains stood guard and the river a grand testimony to the civilization that grew on her shores and reflected in her face. And here I was, just at the threshold of a professional career, wondering what future had in store and excited about my first encounter with a problem case.

I had started my brief stint in the Medical College as a house physician in Medicine in the year 1962 with Col. Saligram Kaul, followed by 3 months each in Surgery and OBGYN and a short stint of 2 months as Casualty Medical Officer and another 2 months as Medical Officer, Pahalgam (the only rural duty of my career). From there, I had proceeded to Delhi for my MD, and returned in 1967, to join back as Medical Registrar, now with the legendry Dr. Jan, Professor of Medicine. Col. Kaul, the Principal of the Medical College, had brought with him his administrative and disciplinary skills from the army while Dr. Jan was a civilian doctor, with his fingers firm on the pulse of the Kashmiris. The former was an academician of repute, the latter a living legend, an astute clinician and an icon. I was lucky to have worked with these stalwarts. And here I was now, a novice in the medical profession, a whiz kid just cutting his teeth and about to

confront a veteran, a David about to face the Goliath of medicine to inform him that he had misdiagnosed a case. How would I stand up to this baptism by fire?

I went straight to Dr. Jan's chamber directing the patient's attendant to stay outside. Dr. Jan was finishing his lunch on roast chicken and toast.

"What?"

"Sir, I feel he does not have a brain tumour?" looking him straight in the eye.

"What does he have, then?" he asked in his characteristic soft voice, unexcited, and surprisingly unsurprised.

"Sir, I feel he is suffering from Catatonic Stupor."

"Dementia Praecox, you mean? How can that be; I believe he must be in his fifties? Rather too old to suffer from it, don't you think?"

"He is around 48, but there is a history when he was young. He suffered a similar episode about 20 years back and was discharged from the army. There have been other subtle symptoms of schizophrenia. Besides, if it were a brain tumor that gave him stupor, he should have some symptoms and signs of raised intracranial pressure, some localizing signs."

"What did you tell them?"

"I asked them to bring the patient for admission tomorrow. Meanwhile I have prescribed chlorpromazine (largactil). I feel we need to call Dr. Khushoo as well from the Mental Hospital to have a look and give him electroshocks."

"They will make such a crowd in the hospital with so many attendants," he moaned.

"But he needs hospitalization for proper treatment. We can send him later to the Mental Hospital. I will see to it that we do not let in more than one attendant."

"Well, if you have asked them, it is alright."

I took leave from my professor and came out. The waiting attendant wanted to go in and convince himself that the big man had agreed with me. I took him in and, before he could say anything, Dr. Jan told him to do as I directed.

Next day brought a big surprise. I would not believe my eyes when I saw two attendants helping the patient walk towards me in the outpatients. He was conscious but confused. I conducted a quick examination. He was slow in responding to questions, and quite incoherent; his cognitive functions were still haywire; there was mild stiffness now; his sensory, motor and reflex examination was normal as before. I directed him to ward 3. We conducted a detailed interview next day and got more facts about the history which confirmed the diagnosis of Schizophrenia. We called the psychiatrist. He agreed with our impression about the patient. Electroconvulsive therapy was started and the patient recovered within a week and was discharged.

Schizophrenia is a chronic mental health disorder that results in altered behaviors, thinking and perceptions that don't correspond with real events. Early signs and symptoms of schizophrenia - such as social withdrawal, unusual behaviors, anxiety and

decline in daily functional abilities - may begin gradually before the primary symptoms of schizophrenia, known collectively as psychosis, are manifested. But disease onset may also be acute with the sudden appearance of psychosis.

Catatonic schizophrenia is a subtype of schizophrenia. People with catatonic schizophrenia display extreme inactivity or activity that's disconnected from their environment or encounters with other people (catatonic behavior). These episodes can last for only minutes or up to hours and days. Men with catatonic schizophrenia usually experience their initial catatonic episode in their teens or 20s.

Catatonic Stupor is characterized by a loss of all animation, and motionless, rigid, unchanging positions. People in a catatonic stupor will become sometimes mute and stare into space, remaining still for hours or days. Trying to awaken a patient out of a catatonic stupor is virtually useless. Usually he or she will not acknowledge their surroundings, and will not respond to stimuli.

The patient continued to see me for several years. The psychiatric condition remained under control. He never relapsed into catatonia again but suffered from hypertension, obesity and chronic bronchitis and finally died of a stroke.

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DASH

(Dietary Approaches to Stop Hypertension)

"I wish more and more that health were studied half as much as disease is .....why not inquire what foods people eat, what habits of body and mind they cultivate ... "

(Sarah N. Cleghorn)

Year 1966: When I joined Medical College, Srinagar as a faculty member the commonest emergencies we had to tackle were 'Strokes'. Stroke is the result of bleeding from, or blockage in, the arteries supplying different areas of brain. Bleeding (hemorrhagic stroke) leads to compression and destruction of neighboring brain tissue while blockage (ischemic stroke) leads to death of an area supplied by the blocked artery by cutting off the vital blood flow. In both cases there can be devastating consequences – paralysis, loss of sensation and function, blindness, deafness, in-coordination, impaired intellect, loss of consciousness, etc. A third of stroke patients die, another third are permanently handicapped and only a third may return to normal life. Why so many strokes in Kashmiris then?

Well, nearly all of these patients suffered from high blood pressure (Hypertension).This condition results in high impact injury to the vessel wall. Hypertension initiates erosion of the blood vessel wall and the deposition of fats (cholesterol, lipids), platelets etc. leading to a segmental narrowing and ultimate blockage. High shearing forces can also burst the vessel wall leading to bleeding (haemorrhage).

We found that high blood pressure was rampant in the Kashmiri population, both Muslims and Hindus. Many of these unfortunate victims of stroke were unaware of their high blood pressure till they landed with this catastrophic event, because hypertension may not cause any symptoms, whatsoever, while it is damaging the target organs – the blood vessels, heart, eyes and kidneys.

Why was hypertension so common in Kashmiris? While we know that hypertension is multi-factorial, and ethnicity (and genes) play a big role, we also know that excess salt consumption is one very important causative factor. Salt seemed to be the main culprit in our people. We conducted a large population study and found out that Kashmiris consumed nearly 3 times the salt of an average Indian. The major source was the salt tea (sheer chai) but food too was highly salted, and pickled. Down the years till, along with three hundred and fifty thousand Hindus (Pandits) I was forced into exile in 1989-90, hypertension and its dire consequences continued to take a big toll of Kashmiris.

Year 2006: Hypertension continues to haunt us in exile too. In fact, during the last 17 years, along with diabetes, hypertension has assumed epidemic proportions. To find

the actual statistics we at Shriya Bhat Mission Hospital and Research Center (SBMH) organized a Multipurpose Medical Camp at Purkhoo (a refugee camp, in the outskirts of Jammu, housing Kashmiri Pandits). Amongst other objectives one was to find out the prevalence of high blood pressure (Hypertension) in the adult inmates. The highlights were as follows:

Total subjects examined =150 (Male 48% Female 52%)

Age: The age ranged from 20 to 67 years

Age in Years	Percent suffering from Hypertension
20-30	6%
31-40	14%
41-50	31%
51-60	30%
>60	29%

45% of all subjects were suffering from high BP, of which only 25 % knew about their hypertension and the remaining 20 % were new cases

Pre- hypertension	11%
Stage 1	16 %
Stage 2	18 %

It is shocking that even after 40 years nothing seems to have changed or changed for the worse. Not only is high blood pressure rampant in the Pandit exiles but nearly half of them are ignorant of their condition and the other half possibly do not care.

Why do we continue to suffer from this insidious and dangerous affliction even as there is a high level of awareness about hypertension?

One, since old habits die hard, we have not changed our habits and life style. The rural folk, even after 17 years of forced urbanization, have not shed their salt cravings.

Two, life style has further degenerated with sedentary habits and the unabashed adoption of new, elaborate and complicated menus on weddings, birthday celebrations, house warming ceremonies etc. and the overall consumption of salt has increased manifold as also of beverages, fats and sweets.

Three, urbanization and the travails of exile, especially the breaking up of families, frequent displacements, highly stressful corporate and factory jobs and a great increase in travel, all conspire to set the tempo for raised blood pressure.

The stress factor has emerged as a major player in accelerating this condition with the result that I find an increasing number of young students and working adults with hypertension. Many of them have run the gamut of tests and come up with other complicating factors including high lipid, blood sugar and uric acid levels, all a reflection

of the changing life style. When you combine high blood pressure with this emerging Metabolic Syndrome and the other scourge of modernity, diabetes, what you have is a deadly mix rampaging and ravaging your systems before you know it.

There is a lot of ignorance even in the medical fraternity about the normal (healthy) range of blood pressure and the approach to treatment. It is not all their fault for the guidelines keep changing as more and more evidence keeps flowing in from large population studies.

Let us look at the BP levels for adults.

	Systolic	Diastolic
Normal	90-120	60-80
Pre-hypertension	120–139	80–89
Hypertension	above 140	above 90

Blood pressure can be unhealthy even if it stays only slightly above the normal level of less than 120/80 mmHg. The more the blood pressure the greater the health risk.

There is a wide array of drugs with which to fight high blood pressure. Even the layperson can enumerate many of them because drug cocktails are in fashion, but to prescribe the right drug or the right drug combination requires an in-depth knowledge of the drugs and a full clinical and biochemical detail of the individual patient. There is no hit and trial thing here but a well informed, well thought out plan in each case.

And yet, drugs are but only a part of the approach to a patient of hypertension. Equally important is:

- To endeavor to lead a quiet, peaceful, tranquil life, and to fight stress through meditation, yoga and other recreational activities like reading, writing, music, games and vacations.
- To be physically active on most days of the week and to maintain a healthy weight.
- If you drink alcoholic beverages, to do so in moderation.
- If you are prescribed medication, to take it as directed and not to stop the treatment once the blood pressure is under control. Remember, once hypertension always hypertension except in certain situations.
- To follow a healthy eating plan.

In a path breaking study Scientists supported by the National Heart, Lung, and Blood Institute (NHLBI) showed that blood pressures were reduced with an eating plan that is low in saturated fat, cholesterol, and total fat and that emphasizes fruits, vegetables, and fat-free or low-fat milk and milk products. This eating plan, known the DASH (Dietary Approaches to Stop Hypertension) eating plan also includes whole grain products, fish, poultry, and nuts. It is low in lean red meat, sweets, added sugars, and

sugar-containing beverages and rich in potassium, magnesium, and calcium, as well as protein and fiber.

In the layman's language DASH means low salt, high fiber diet rich in fruits, green leafy vegetables, legumes, lentils, beans and pulses, tomatoes, mushrooms, nuts, seeds, and grains (brown rice, whole wheat bread),lean meat, fish and poultry, yogurt cultured from fat free milk.

Start by cutting salt in half. Use spices and green chilies instead of salt. In cooking and at the table, flavor foods with herbs, spices, lemon, lime, vinegar, or salt-free seasoning blends.

The DASH eating plan along with other lifestyle changes can help you prevent and control blood pressure. If the blood pressure is not too high, you may be able to control it entirely by changing your eating habits, losing weight if you are overweight, getting regular physical activity, stop smoking and cutting down on alcohol. The DASH eating plan also has other benefits, such as lowering LDL ("bad") cholesterol, which, further reduces the risk for getting heart disease and strokes.

The ebb and flow of blood

Like water in a river
I need to flow at an easy pace,
with an easy pressure.
At pressures too low
the tributaries dry up
and deprive land of sustenance.
At pressures higher
the shores slowly erode and overflow.
And with sudden surges
the dams burst to cause the deluge.

Like life itself, and for life to go on,
I need to flow at an easy pace,
at an equitable pressure,
to provide the vital energy to every cell,
and every system of the body.
Pray, do not rouse me,
do not provoke my flow
through indulgences and excesses,
through a rush of temper or nerves.

Moderation is the watchword in medicine
as in all things of life.

(Poem by K.L.Chowdhury)

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Medical Sleuthing

(Tracing the source of an epidemic of Virus Hepatitis)

Winter is not the usual season for waterborne disease in the Indian plains. Sporadic cases occur round the year, though. Epidemics of diarrhea, cholera, hepatitis etc are common in summer and rainy seasons. But when I took the monthly stock of patients in my clinic and counted 33 cases of jaundice from viral hepatitis in January and another 39 in February of 1998, I knew something was wrong with the water supply. Contaminated water or food supplies have been implicated in major outbreaks of Viral Hepatitis especially the consumption of faecally contaminated drinking water.

I wrote a letter to the editor of a daily newspaper and expressed my apprehensions about a breaking epidemic of hepatitis and pointed my finger of suspicion at the Public Health Engineering (PHE) department which provides water to Jammu.

Jammu, like many other towns in India, has the dubious distinction of the most dangerous layout of water pipes that provide the precious fluid to nearly a million mouths. In most of the neighborhoods, the pipes run along or inside the drains and gutters that line the lanes and streets, concealed in the muck that flows in them. Most of the supply lines are leaking somewhere so you have a heartbreaking scene of sheets of water running on the streets when water is pumped in the pipes once a day or less often, for about an hour. More water leaks from the breaks and unions or from the holes people bore in the pipes to tap water at unauthorized sites, than flows into the buildings and houses. The water tanks in which people store water are most often not fitted with the ball valve to stop the water once they fill up, further compounding the loss. It is painful to watch water running on the streets and into the drains in a criminal waste, when millions in our country have to trudge long distances for a bucket of this scarce resource. I call it the great water robbery.

Once pumping stops, a negative pressure develops in the pipes and sucks in the effluent from the streets, lanes, drains, gutters and cesspools through the leaks, faulty joints and ill-fitting unions. The sucked material is a source of all types of bacteria, fungi, viruses and other toxic contaminants that thrive in the streets and drains. Every time water is pumped again in the pipes the previously sucked-in material is washed into the recipient's houses contaminated by this rich culture of disease-producing vermin and toxic waste. .

My letter to the newspaper made no impact. Patients of hepatitis continued to pour in an unending stream. March brought a whopping number of 145 cases and there was now no doubt that an epidemic was on. I made detailed notes of the patient age, sex, addresses, clinical picture, complications, liver function derangements, progression, recovery and sequealae.

The patients who came to me were mostly the Kashmiri refugees, euphemistically called ‘migrants’. They lived a cramped life as tenants and very few had their own dwellings. The patients were mostly from New Plots, Sarwal, Rehari, and contiguous localities. There were clusters in some areas and some families where many members had contracted the virus. It was a picture of a local epidemic, confined to this small sector. They were of all ages and both sexes. It had to be either Hepatitis A or E, both water borne diseases. Since young adults aged 15-40 years were hit maximum, it looked like Hepatitis E rather than A which is mostly an infection of children; but confirmation was necessary.

Testing for viral studies and their markers was not available in Jammu till then. I could send samples to Delhi but the cost was prohibitive. Asking indigent ‘migrant’ patients to spend a few thousand rupees for the test would be cruel especially when it was more of epidemiological and academic interest than of as a substantial tool in the treatment of an individual patient. The illness was mild in most cases, and recovery uneventful. Fortunately there were few complications.

Both Hepatitis A and E are mild illnesses and mortality is much lower than Hepatitis B and C which are spread by a different route and do not present as epidemics except in institutions. Hepatitis E is bad on pregnant patients in whom high infant and maternal mortality has been reported. However, there were only 4 pregnant women till the end of February and fortunately there was no mortality. I still believed the cases to be E rather than A.

I dashed another letter to the newspaper, breaking the news of a full-fledged epidemic, outlining the geographic contours, the density, and the severity. I castigated the PHE for inaction since my last warning. Early in the morning of the letter’s publication, I received a distress phone call from the Chief Engineer PHE.

He was sore that I had written the letter and not spoken to him directly about it. I did not know him personally, I replied, nor was I expected to remind him of his job. His department had ignored my warning. The cost of their negligence was colossal in terms of human suffering. If the first letter was ignored, I was not sure they would not snub me for interfering in their departmental work. A newspaper was, in my opinion, the best medium to inform people, who were my main concern. In any case, what steps was he going to take now that the epidemic was on?

The Chief Engineer was apologetic. He said he would do everything to help and wanted to know what could be done to halt the epidemic. I replied that I suspected a major contamination of one or more reservoirs that supply water to the affected localities. We had to trace the source and that would entail a detailed inspection of the water reservoirs including a survey of the main feeder pipes, and the supply lines to the affected areas. The sealing of all the leaks everywhere in the town was obligatory. But tracing the local epidemic was urgent.

This was a tall order for a department notorious for indiscipline, disobedience and a culture of strikes and shutdowns in its cadres. But there was no escape. The chief requested me to guide his staff in tracing the epidemic and decided to send his deputy along with a team to discuss with me about the steps to stem the tide.

A team of five PHE officials reported in my residence same evening, headed by the SE. When I asked them if they could draw a rough sketch of the reservoirs supplied water to the localities under our scanner, they were not sure. When one of them said he would come prepared with the sketch next day, I produced my own from my pocket. I was ready with a rough sketch of the sources of water supply to the affected areas. This was provided to me earlier by a patient whom I phoned soon after the CE rang off in the morning. I knew he was a PHE official and he was glad to supply me the information. The team members were shocked and shamed. However, I put them at ease and outlined my plan:

- Draw a detailed sketch of the reservoirs and their areas of distribution after looking at the localities under the impact of the epidemic.
- Determine the type of hepatitis - A or E. The tests are costly and not available in Jammu. The patients cannot afford the tests so the department has to bear the cost.
- Scavenge all the reservoirs under the scanner.
- Plug all leaks, rents and holes in the distribution pipes, not only in the affected localities but whole of Jammu.
- Intensify surveillance against water poachers.
- Inform public through posters, pamphlets and news papers in order to create awareness about the epidemic.
- Outline the preventive measures against the infection like personal hygiene and the consumption of boiled water for drinking till the epidemic has died down.
- Ensure supply of properly treated water through leak-proof pipes.

The team left with assurances to me that they would plunge into action next morning. They said they would send samples of blood from my patients by courier service for testing to be carried out in Delhi and the department would bear the cost. They would prominently advertise in the paper on a regular basis till the epidemic died down.

The next week brought a stream of patients from the same areas. I waited for the team to collect the samples from the patients to be sent to Delhi but no one reported. I sent the samples by courier service on my own hoping PHE would reimburse later. The reports on viral markers confirmed my suspicion that we were dealing with hepatitis E. I had about ten reports on patients from different areas and there was no point pursuing with more testing once all of them proved to be Hepatitis E.

I sent two more letters in the paper with all the instructions especially to the residents of the areas affected. However, there were no advertisements from the PHE and on my evening walks I did not find any evidence that the leaks had been plugged in

our area which, however, was not affected. I asked some patients and was informed that some workmen were closing the leaks at places.

I phoned the SE and he said they were on the job; they were plugging all the leaks in the area under scrutiny. He agreed that there were a few major leaks in some feeder pipes that supplied the affected arrears, two of them were passing through filthy drains. They were going for a total overhaul. He hoped the epidemic would soon be contained.

But cases continued to pour in from New Plots and Sarwal which had the maximum density of the cases. Even if all the leaks were plugged it would take 4-8 weeks for the epidemic to die down, that being the incubation period of the disease.

But there was a problem. If it were just the leaks in the feeder pipes passing through drains there should have been a parallel increase in other waterborne diseases in the affected places. But that was not so; there was no increase in typhoid, dysentery, diarrhea etc. The increase was only in Jaundice and now we knew it was the hepatitis E virus. There had to be a single source of this virus from somewhere, most likely a reservoir. I phoned the SE again and insisted that he direct his team to look into the reservoirs that supplied the areas affected. Leaks in two feeder pipes of two localities could not explain the large areas involved nor the exclusive occurrence of only one water-borne disease. They must go to the reservoirs, inspect them, get samples for cultures and get them cleaned.

The SE reported back after a week and said they had looked into all the reservoirs supplying the localities and found nothing worthwhile; in any case they had got the cleaned.

The epidemic died down over the next 6 weeks. It could not have been just the result of my instructions to the patients and the letters in the news papers or the sealing of leaking points. There had to be a major contamination from the source of supply, I was sure of that. In any case it was a great relief to see the back of the virus.

My curiosity could not be satiated by that report by the SE that they had found nothing. I knew there was a skeleton in the cupboard. And I waited for my chance to find out.

Months later, another one of the PHE officials from the Team came to consult me for his mother. I complained that it was heart-breaking to find the water flowing over the streets whenever it was being supplied to our neighborhood, in spite of the epidemic a few months earlier. It was sad that PHE had failed to ensure a proper leak- free supply. He looked at me almost in reverence.

"Sir, you came as a messiah to the people and saved our department from a terrible disgrace. You were right in pointing us to the reservoir, but we looked there last. That is why it took so long. We lost priorities and started randomly checking the leaking points rather than going according to the plan you laid out for us. We found a dead monkey in the reservoir which you had marked for us on the very first day we came to your home

as a team. The reservoir was stinking and the monkey carcass rotten beyond recognition. How could the department acknowledge this gross negligence?"

There is no doubt the monkey was infected with hepatitis E virus and possibly drowned itself while trying to drink water from there. Primates like dogs, monkeys and rodents are known to harbor the virus. In fact, in a study conducted to examine whether Indian monkeys are infected with hepatitis E virus (HEV), serum samples from wild rhesus and langur monkeys were screened for anti-HEV IgG antibodies. The positivity rates were 36.7% and 19.1% respectively which goes to show how widespread the disease is in monkeys. No doubt the present epidemic was a result of the monkey which had found its watery grave in the reservoir.

My first case of heat stroke

Jammu 7th June 1991

I started the day at 5 AM with a futile wait for water. Every time I went to the backyard to find out if the water was running in the supply line, every time the tap eyed me with sympathy. I thought I heard it give a dry laugh or two but not a drop of the precious fluid we took so much for granted back home in Kashmir. We were left with just a bucket of water from yesterday. I spared that for drinking, not knowing if and when we would receive today's 40-minute supply that is pumped in the water pipes at 5-30 every morning. I washed my face and decided to forgo the shave and bath.

It was a busy morning with patients, most of them suffering from fevers, skin diseases, heat exhaustion, dehydration, anxiety, apathy and depression. Lunch had no attraction for we kept worrying about water but the tap remained dry as ever. Barley had I rested on my bed for a mid-day nap, when the door bell rang. It was 2-30PM. I went outside in my shots, my torso bare. It was burning hot, the temperature in mid forties. There were two men requesting me for a home visit.

I do not go for visits, I told them, and going out in this heat was, in any case, out of question. They begged of me. Their mother was in deep coma, they were new to the town, and they did not know where to go. There lodgings were not far off; it would take a few minutes in car.

Reluctantly, I slipped into bush-shirt and trousers and sat in the car which had turned into an oven from the ruthless sun, parked in the open. The steering was hot like live coal and singed my hands and I ran inside the house to wet my handkerchief with which to cover the steering. The melting tar macadam had turned into paste and the road spewed venomous vapors as we drove past closed shops through a ghost town, from where the denizens had fled from the terror of heat, like rats into their holes.

Nearly a mile away I was asked to stop near the back door of a one-storey ramshackle house that led into a dark, dingy room closed from all sides - no window, no ventilator, just three blank walls and the door through which we entered. It must have been a stable or a store room that was rented out to this family. The room was unbearably hot and suffocating. The temperature inside must have been much higher than the ambient temperature outside and living here seemed suicidal. There were a few utensils, cups and glasses and a gas cylinder in one corner which served as the kitchen; beddings, trunks, boxes, bric-a-brac in the other corner; some books strewn in the third, probably belonging to a student. This was clearly a multipurpose dwelling for a large family. In the middle, on the cement floor, on a tattered bed cover was sprawled a

human figure surrounded by two ladies and a couple of young men. They made room for me to examine her.

She was a middle-aged woman, lying limp and unconscious, breathing shallow and fast, froth drying at the corners of her mouth leaving crests on her cheeks. Her pulse was rapid 110 per minute and the blood pressure 105/68. She was hot and dry; her armpit temperature was a whopping107 degrees Fahrenheit!

The attendants told me that she had gone out to submit her photograph and ration card of Kashmir to the relief counter in order to complete her documentation for registration as a 'migrant'. She had to wait for 2-3 hours for her turn. There was a long queue in the open, the sun beating on their heads. When she returned, she was feeling exhausted, dizzy and drowsy. She drank a glass of water but soon lapsed into coma.

This was my first case of heat stroke in my 29-year experience as a doctor. Would come across an occasional case of heat exhaustion in Kashmir during summer months but heat stroke was unknown. Yet, there was no doubt about the diagnosis; it was an open and shut case, so to speak:

A middle-aged woman
going out in the hot summer sun
without water to drink
waiting long hours in the open
and returning to a dungeon
hotter than an oven.

It was an invitation to disaster. In fact disaster had struck. The lady had been in coma for three hours. Her attendants did not know where to go. They were new to the city. Their neighbours discouraged them from taking the patient to the hospital. There was no doctor around. Someone informed them that I was in town for the last 5 months and they rushed to me.

There was no time to lose. Every minute of delay would send her nearer to the cremation ground. Taking her to the hospital was no use. It would waste another couple of hours getting there, checking in, shifting to the ward and starting the treatment for which there was no special arrangement.

I looked around and saw a bucket of water nearby. "Give me a towel or a sheet of cloth," I said, and dashed towards the bucket, "this lady needs cold sponging at once." But before I could lift the bucket near the patient a young woman, possibly her daughter-in-law, sitting nearby, seized hold of it and dragged it back. She was alarmed but apologetic. "Doctor Sahib, this is all the water we have for the family to drink for the day. We will die without water if we spend this last bucket sponging her."

"Can we get ice somewhere?" I asked.

"Yes, there is a shop just outside," someone amongst the crowd ran out and returned with a slab of ice soon after.

I asked them to break it into small pieces. The patient was stripped off her dress except for her underwear. Each of the attendants was given a piece of ice and directed to rub it into the skin. Four of them took charge of the four limbs and I took charge of the torso. We rubbed and rubbed. The ice slabs in our hands melted fast and evaporated, almost vanishing on the burning body of the unconscious patient. She remained amazingly dry and hot as before even as another ice slab was brought in.

I could not see a fan anywhere. Flies buzzed around the patient like vultures on a corpse, sticking at times on my face and arms; cockroaches darted from different directions; an odd mosquito stung my bare arms and the air was rife with fumes and fulminations of man and beast.

"Can we move her to a cooler room, a room with some ventilation? I asked.

"We arrived in Jammu only a couple of months back. We have scoured the whole city. Every nook and corner has been rented out. This is the best accommodation we could get after a long search."

Could they arrange a fan?

"I will try and see if the landlord loans one," one of the men ran out of the room and returned with the landlord. He seemed visibly annoyed for having been disturbed at this unearthly hour when the sun beats people unconscious. He wondered why the tenants were making such a big fuss just because a lady had swooned due to heat.

"They are not making fuss, sir. Can't you see this lady is dying? If you have a spare fan kindly loan it to them and we will be grateful." I said it rather tersely and he not only mellowed down but also went away to return with a table fan which, however, gave out more noise than air. I discarded it soon after for it was standing in the way.

The rubbing went on for half an hour but the temperature refused to come down. I could not stay there all the time. I asked them to buy a Ryles tube (stomach tube) and introduced it into her stomach to feed her chilled water in order to provide internal cooling. I passed on this function to one of the men and departed, asking them to report after 2 hours.

I drove back only to find water running away from the tap we had left open in the morning. Running away literally, for here was the life fluid we were thirsting for since morning, the fluid that sustains life and provides the boon of washing, cleaning, bathing. The lady I had examined was dying because she had not had enough of it to drink and because there was no water to sponge her. I rushed inside to wake up my wife and daughter from their midday siesta and we all gathered the buckets and pots and pans and filled them with water, carting some to the coolers, and the two pitchers for the patients. We were tenants in the ground floor. My landlord upstairs was also stirred into wakefulness by the cling and clang of the buckets and utensils and wondered why I had

not called him down earlier to collect water rather than having it all to myself. His family members trooped down with pitchers, buckets and started filling them, pushing us in the rear while we strove hard to get some more. It was a dingdong battle for water. And soon the tap started gurgling and spluttering and gassing and finally stopped dry in 20 minutes. Water must have runoff for 10 or 15 minutes before I saw the taps running – a precious waste indeed.

By that time it was 4 PM and I sank in my bed, feeling wretched and shaken to the core from the experience, and revulsion for existence. Was this going to be our destiny – to be driven from paradise, to live a beastly existence and to die unheard and unsung in a dungeon from stinging sun and dehydration? But there was to be no respite today, not even time to brood and cry as patients started pouring in for my evening clinic. Water was selling five rupees a bucket during the day. We came to know that because of gross fluctuations in the voltage the PHE pumps had broken down and they could not lift the water in the morning. That is a usual story and our electric appliances had burnt down due to voltage surge only last week.

At 6 PM the son of the heat stroke victim reported that her temperature had come down to 103 but she was still unconscious. They were pushing chilled water and fruit juices through the stomach tube. At 8 PM they returned again. The temperature had come down to 102 but she was still comatose. I asked them to keep sponging her to maintain the temperature at 101-102 and report back in the morning.

9th July:

The attendants did not turn up again. I presumed the lady was dead. Today I saw her picture in the obituary column of the news paper.

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Heat stroke killed more than a thousand Kashmiri Pandits in the first two years of exile. It continues to take precious lives even as people who were totally ignorant about the harsh weather conditions of Jammu, have now partly acclimatized to the new environment.

Some tips for the prevention of Heat Stroke:

- Drink lots of chilled water, lemon juice, lassi (butter milk).
- Eat fresh fruit like cucumber, water melon, musk melon etc.
- Serve food cold where possible.
- Wear white or light colored dresses - loose and sleeveless or half-sleeve shirts, and shots.

- Take frequent cold showers. In case water is short in supply, sprinkle a little every time into your arm pits and on the limbs.
- Do not go out in the sun. Avoid going out during the noon and afternoon. Use an umbrella if you have to go out.
- Remove all carpets and rugs and let the floors of your rooms bare.
- Use coolers and, if possible, ACs. If you must use fans, run them at lower speed during the hot dry months of May-June and faster during humid rainy season.
- Half-close the windows at daytime during a hot spell, and pull the curtains down till the sun sets, to prevent hot air coming in from outside.
- Stay in the ground floor or basement during summer. Do not go out for games or long walks or runs when the sun is up. Prefer a morning walk to an evening one.
- Aged and sick people, diabetics, alcoholics, heart patients, renal and hepatic failure patients etc. are more vulnerable to heat stroke; Patients taking medications which decrease sweating and precipitate heat related situations - All these categories should plan their summer sojourn in a hot place with care.

Heat

O wind
Rend open the heat
Cut apart the heat
Rend it to tatters

Cut the heat
Plough through it
Turning it
On either side of your path

- Hilda Doolittle

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The patient and the legend

Nineteen sixty-seven was my first year as faculty in Medical College, Srinagar. I was Assistant Professor and Dr Ali Mohammad Jan, famously known as Ali Jan, a legend in life as in death, was the head of our unit. .

It was a Tuesday, our outpatient day. The outpatient building was an annexe to SMHS Hospital and rather cramped, for it also housed the patient registration, the laboratory, and the X-ray screening rooms. There was one large room for interns and residents and a smaller one for consultants. Dr Ali Jan and I shared the smaller room, a cloth screen between us.

As far as I can trace my ancestry, I happen to be the first doctor in our dynasty. After I graduated it didn't take much time for my family, friends and relatives to grant me recognition and repose their trust in my skills. When I got into the faculty that trust turned into faith, and it has remained implacable over the years. Whatever their health problems – medical, surgical, gynecological, psychiatric etc – they will almost invariably consult me first and foremost. And then, if I find it necessary, I refer them to my colleagues of the concerning specialty. It has been an exciting journey, full of challenges, and not easy to rise to expectations every time, but I never reneged from my duty and commitment.

In the large Chowdhury clan at Rajveri Kadal, my old home where I was born and my formative years took shape, Leelavati, my father's paternal aunt stands out as the quintessential ba`te`n (panditani), alas, now a vanishing breed. Rather diminutive in size, bright brown eyes, a shiny pink face and a finely chiseled nose, she wore a pheron that almost touched the ground, and a Tarnga on her head with a large tail that would trail behind her when she walked with her short steps. The right pocket of her pheron used to be a veritable treasure trove. Ask anything of everyday utility and she would never disappoint you. It was always there - cotton wool and kerchief, safety pins and sewing needles, thread and buttons, coins and currency, teknis and tawiz and, almost invariably, the doctor's prescription. This last was her most prized possession, nay a precious document that she guarded with life, for she was a patient of many hues of migrainous headaches, abdominal pain and acidity, anxiety and fainting fits, besides the aches and pains that afflicted the female species of that age as they do now. But she always wore that warm smile that stole your heart.

For sometime after I took charge of the clan, her acidity and burping had resurfaced and my treatment with magnesium trisillicate and aluminum hydroxide, the salts in vogue to neutralize the gastric acid, had not helped much. She had heard of an investigation - barium screening of stomach and duodenum - that might locate an ulcer in the stomach or duodenum, and account for the pain and acidity in such a situation.

And she asked me most endearingly if I could conduct the test on her or request one of my radiologist colleagues in the hospital to do it. It was a privilege I said and asked my cousin to bring her to my outpatients on the following Tuesday.

Leelavati came by herself - the hospital was not far from our home and she knew the way quite well. She might have been around fifty then. The orderly informed me when she presented in the outpatients and she entered quickly with her short shuffling steps as I rose to receive her. Her eyes gleamed with pride to see me in the consultant's room, her face swathed in a radiant smile.

I offered the stool for her to sit and, as a matter of routine, asked her to recount all her complaints before I would take her for the screening procedure. While she was enumerating the details that I had now become quite familiar with her attention was suddenly distracted. Her ears cocked up on hearing the voices behind the screen where Dr Ali Jan was speaking with another patient in his soft voice. It rang a familiar note as her eyes gleamed with recognition. She craned her neck sideways to look behind the screen and sighted the legend. Her face beamed into a wide smile, 'Ali Jan?' she exclaimed, and continued looking toward him as if mesmerized.

I said yes.

'Ballaye lagay, get me examined by him,' she pleaded fervently.

'Oh sure,' I said.

I can't ever forget that exciting expression on her pink face as I stood up and took two steps toward Dr Ali Jan. 'Sir, she is ...'

'Leelavati,' he completed my sentence. 'How are you, Leelavati?' He addressed her in a tone of familiarity. I was amazed, while she was ecstatic, to hear him call her by her first name. 'Ballaye lagay, you still remember my name!'

'I must have seen her long back, but I can't forget her face,' said Dr Ali Jan. 'Jia Lal once asked me to see her at your old house. She used to get hysterical fits.' No doubt his memory was impeccable

Dr Ali Jan and my father, Pt. Jia Lal, were neighbors at Rajveri Kadal. He moved uptown on his return from England with MRCP much before we moved. He was also my father's contemporary and friend, and would seek his legal advice. In fact, the illustrious Fazili (his surname) brothers were all close to my father, and two of their doctor sons were my colleagues.

The legend examined Leelavati and wrote a prescription which she folded carefully and pocketed safely like a treasure, her face a picture of infinite gratitude. She thanked him profusely; she blessed me with invocations to Sharika and left.

She had forgotten all about the screening of her stomach for which she had pressed me so hard.

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So many boons

An extract from my diary 19 Oct 2001:

I paid a visit to Krishna Ji and Mohan Ji. She was laid up in her bed. He was beside her in a chair.

"Oh, it is Kundan Ji," he exclaimed, his sombre eyes lighting up with excitement. "I have been expecting you ever since I came to know that you have returned from USA. We felt rather helpless while you were away. Now we are secure. You have always been a pillar of support."

A wave of intense emotion travelled down my face, a twinge of pain, a tide of compassion. "Thank you. I have done nothing special. In fact I feel so inadequate when I think of what she has gone through," I replied and turned to Krishna Ji.

"So, how you are fairing," I addressed her.

"Look for yourself, Kundan Ji. What does my face tell you?"

It told everything. Her eyes were deeply jaundiced and her skin too had acquired a faint tinge of yellow.

I examined her in detail. There were nodular lumps in her abdomen and bumps in the scalp – telltale evidence of disseminated metastasis. It is a matter of days, I thought, and prayed that she survive until Raja, her son, returns from USA.

She fathomed my thoughts. "I am counting;" she showed me her finger tips, "waiting for Raja. He is scheduled to fly back on 2nd November. Then there is nothing to worry, and I will be ready to depart peacefully."

"Come on, you don't have to speak like that. You have been a valiant fighter, a courageous patient like I have not seen another in my life."

I have been like Savitri, asking Yama boon after boon, a grace of two months or more at a time, on one pretext or other. After all, that is how I have survived six years. It started with Timmy's marriage. I pleaded, 'It is the duty of parents to see all their children married.' And my wish was granted. Then I asked, 'Pray, let Timmy's wife conceive and give me a grand daughter.' She conceived. Then Raja got the visa for USA for which I have desired so fervently. 'Pray, let him pass the clinical,' I begged. He passed and got a job offer too, starting from next June. Meanwhile I got another lease when I explained to Yama, 'If he passes USMLE 3 test, it will get him an H1 rather than the J1 visa, and that will be a great help for him.' Raja has decided to stay on in USA until he passes the test. Today he has to appear in the test. I know he will do well. Once I see him back I will go contended."

"Would you not wish to see your first grand daughter as well, hold her in your lap like you did Raja's sons? That is also a compelling reason for Yama to grant you yet another boon," I asked her.

"Yes, I would, but this time it is not spontaneous. It doesn't arise deep from my soul," she replied, looking straight at me with her honest gaze, a glimmer of smile on her withered lips that seemed to say, 'You have just seen it in the colour of my eyes and the bumps on my body. How long can one keep Yama hostage to ones desires? There will always be some unfinished task, new desires, and new dreams.' Her percipience has always been striking.

"You have been an exceptional patient. You set an example of courage and perseverance. You have gone through three major surgeries, and never complained, never pitied yourself, never even questioned our judgment," I said admiringly.

"I have always wondered, though, about the nature of this disease. The surgeons removed the growth in the colon six years back. The follow up colonoscopies tell us that the colon is free of disease. They twice excised the metastasis in the liver. And now, new ones have surfaced in my scalp and tummy. Pray, where are they coming from?"

"It is like a tree that we have knocked down, but its seeds had already dispersed in the soil. They are germinating at different times at different sites and sprouting as new saplings."

"You always make it so easy to understand."

I turned to Mohan Ji. He looked radiant and upbeat, always hopeful of a miracle. He just can't imagine the extent of Krishna's pathology; he can't imagine, least admit, that the end is near. He spoke animatedly of the power of faith. He described the existence of an electric field around a sick person and an action to drive pain and sickness away. Then he got up out of the chair and stood beside his wife. He held his hands nearly six inches above her, palms down, and moved them gently from her face down, to her chest, abdomen and legs, without touching her. There was an intense expression in his face, a feeling of power in that gentle action, as if it were physically driving something away from her body. He did it three times while she watched him with great affection, a wan smile on her lips.

"I wonder how it works." I asked rather skeptically.

"It works, but the action has to .be motivated by a strong desire, an unflinching faith and abiding love."

I marvelled at his devotion, his total involvement. I was reminded of how Babar had circled his dying son's bed three times and prayed Allah to take his life instead of his son's. But I dismissed the thought immediately as ominous and wished him a long life. He has stood by his wife, not giving the faintest indication that he was ever tired or sick of it, or that he couldn't go on and on until he saw her fully recovered.

I took their leave and drove home; wistfully recounting our great association and the love and respect we bear each other.

Post – script

Raja returned from USA on 2 November. Krishna Ji's last wish had been granted to have him by her side until her end. It came on 28 February.

But a month earlier, Mohan Ji was detected to have prostate cancer. Raja had to join his residency in USA by June. He wanted to stay back with his ailing father, but his mother's wish for him to settle down in USA prevailed. She had not asked the boons without purpose.

Mohan ji had already developed metastasis at the time of the diagnosis. It was an aggressive cancer that caused him much pain that impelled me to include a section on Pain in my anthology “A Thousand-Petalled Garland and Other Poems”. He never gave the slightest inkling of his terrible suffering to his sons. Romesh, his younger brother, and Usha, his wife took over his care, while his sons suffered the pangs from the long distance across the seas that separated them from their loving father.

Mohan Ji had succeeded in driving away Krishna ji's pain by the unique manoeuvre he displayed on my visit. He had transferred his wife's pain on to himself by that action that sprang from 'a strong desire, an unflinching faith and abiding love'. I wonder if pain, like soul, leaves one body to enter into another.

He passed away from the galloping malignancy six months later on 2 November when both his sons, Timmy and Raja, were away. They came for the funeral.

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A doctor's deportment

I was a postgraduate student at Maulana Azad Medical College, New Delhi, training for my MD in medicine. The year was 1965. Our academic schedule was tough – ward rounds, case presentations, evening clinics, lectures, seminars, research and thesis. We would wait eagerly for the Sunday reprieve and recreation. Going to a movie was one option but I had exhausted my patience with movies during my five-year MBBS stint at Patiala where I hardly missed any movie that came to town. Delhi was different because the theatres were far away from my hostel except Golcha in Daryaganj which was a walking distance, but a movie would run several weeks there.

The next best option was to visit Connaught Place, the heart of the capital, fortunately a bare twenty minute's bus ride from our hostel. But it was not easy to get tickets for a movie in any of the theatres in and around Connaught Place on Sundays. We often landed up in one of the coffee houses.

It was on one such day, after failing to get ticket for a matinee show in Odean that my eyes fell on a hoarding on the front of a building nearby – Dr G C Chawla, Consulting Physician. The name rang a familiar chord. Could it be the doctor I had met at Pahalgam the previous year where I was a medical officer? Unable to curb my curiosity I ran up the stairs and rang the bell. A pockmarked face with a longish chin and close-cropped hair opened the door.

"Does Dr Chawla live here?" I asked.

"Yes, and who are you?" he asked in a funny drawl.

"My name is K L Chowdhury."

"Daddy, there is one K L Chowdhury here," he shouted.

"What did you say?" I heard the familiar voice from inside.

"Tell him it is Dr Chowdhury from Kashmir," I said.

"From Kashmir," he shouted, still at the door.

"Let him in," the voice from inside boomed.

And there he was, the handsome old doctor, whom I had invited to dinner at my lodgings in Pahalgam.

That day, I had cooked a grand dinner for this stranger who was a visitor to the famous hill resort and had, out of curiosity, walked into my outpatients on the left bank of Lidder while I was busy examining patients. Having been a doctor in the army, he was curious to meet the 'lucky doctor' posted to a medical centre in 'paradise'. We instantly struck friendship and it was not easy to curb the Kashmiri hospitality bug that rises like the Kundalini at the slightest prospect of friendship.

The cook laid out the dinner and waited upon us. Dr Chawla looked at the dishes and commented, "Why have you gone to such a trouble."

"It is no trouble, just routine stuff, "I said. "Should we begin?"

"It seems you forgot the chapattis?" he asked the cook.

"Sir, there is rice, the best Kashmiri zag batta."

"Of course, I saw the red rice, but I don't see any chapattis. My dinner is incomplete without chappati and dessert."

We had worked hard for the four-course dinner, including fish and mutton. We would hardly ever eat chapattis for lunch or dinner in Kashmir and rarely a dessert. The cook was not adept at making chapattis, but he got down to the job immediately and retrieved the situation. And while we were eating, I sent him to buy gulab jaman from the confectionary just below where I lived. I believe Kashmiris go to any extent in the matter of hospitality.

Dr Chawla returned to Delhi after his vacation. He neither left a message nor his address and I all but forgot about that chance encounter. And now, here I was, face to face with the old man, playing rummy (papplu) with a group of friends. He didn't register much emotion on seeing me; neither did he ask how I had landed in Delhi. The card players were busy and, except for a brief nod while he introduced me, they were focussed on their game. I watched the game for a while, when he asked me if I would like to join. The stakes were not much. They dealt me the cards for the next game as the servant brought me a cup of tea.

When it was time to leave I informed him that I had joined MD.

"In that case I hope to see more of you," he said casually.

I did pay him a visit once in a while on Sundays and always found the same faces playing the same game which I joined for an hour or two. There was nothing exciting in it except that I forgot the rigors of my training during that interlude.

I had no idea if the doctor practiced – the sign board did not mention any consulting hours. He never spoke about patients. So I believed he was fully retired.

One time, however, Dr Chawla got a phone call while we were playing the game of cards. He looked at me. "Would you like to see a patient? It is a lady, a tourist from London. She has tummy upset."

This was rather abrupt; I don't think I was in the mental frame to visit a patient.

He continued, "You don't have much to do. Prescribe her a novalgin for pain, and mexaform if she has diarrhoea. Well, you know it, I don't have to teach you anything but this is practice; ladies can be finicky."

I was not sure if I should accept the challenge. I was a student again, and out of practice. Before I could say no, he asked his servant to hand over his medical bag and the car keys to me. "She is at Hotel Meridian, just a half mile from our place." He gave me the directions.

At the hotel I was led to the lady.

"Dr Chawla?" she asked rather shrilly.

"No, I am Dr Chowdhury." I said rather nervously, taking the chair by the side of her bed where she lay with her legs stretched. She was around forty, fair and handsome, and quiet at ease with herself.

"I see," she said, giving me a quizzical look.

"I am his partner," I said.

"But I was given the impression that a senior doctor was going to examine me."

It sounded like a question mark on my competence, and her unwillingness to get treated by a junior. That is what I thought she conveyed by her statement.

"It was not possible for him to visit you right away so he asked me. I hope you will be safe in my safe hands," I said rather uncertainly.

"Well, I hope so." She sounded sarcastic, adding to my discomfort.

Here was a patient who expected a different doctor, who had formed some mental image of the one who was going to examine her even if she didn't know him, and now she was confronted by someone she had not expected. Down the years, I have learnt that it is difficult to handle an unwilling patient because you start with a trust deficit.

In any case, I got down to asking her the details. She had arrived in Delhi a day earlier and developed abdominal pain and loose motions since that morning. She didn't run fever and didn't feel like throwing up. She wondered if she was suffering from Delhi Belly that tourists contracted in India. I didn't discount the possibility.

I leaned forward to examine her. While I was palpating her abdomen, she recoiled suddenly.

"Excuse me, Doc; you have dirty nails; you might pass on the infection to me."

I looked at my nails and realised how correct she was. Of late I had been the absent-minded researcher, typing my thesis late into the nights. I hardly got time to look myself in the mirror, not to speak of trimming my nails. But that was no excuse. I was stunned, my face flushed with shame. I didn't know how to proceed further, whether to run away or apologise. I was dumb with disgrace.

"And you smell strongly of onion, doctor?"

She was right. I hade partaken of pakoras served with the tea at Dr Chawla's. But this second charge that sounded like a strong reprimand offered me a chance to retaliate. I suddenly gathered courage to confront her.

"Madam, you are insulting me. It is none of your business if I have taken onions or else. If you don't want to be examined, I don't care." I put the stethoscope back in the bag and started to walk out of the room.

"I am going to complain to the hotel management," she warned.

"Do what you like, I don't care," I said and slipped away, thankful to be out of the hotel.

I drove back to Dr. Chawla's, guilty of having bungled the visit and fearing he might lose the goodwill of the hotel management where he was one of the visiting

doctors. When I related the story, he put me at ease. “Please don't worry. It seems I will have to go and visit her myself right away.”

He was back in half an hour, a satisfied expression on his face.

“Chowdhury, I had forgotten for a while that you are still a student, and raw. And still a naive bachelor.”

I didn't understand in what context he used that last expression to describe me. I just nodded.

“Well, it didn't need any special guile to placate the lady,” he said smugly.

I looked at him in amusement.

“She has invited me to drinks tomorrow evening. Would you like to join us?” And he winked mischievously.

What magic had the wily old man worked on the lady, I don't know, possibly never will. But I had learnt yet a vital lesson. No matter what the qualifications, experience and skill, a doctor needs to be presentable in all respects – as the quintessence of a human being.

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Subdural Haematoma (SDH) – the Great Masquerader

Ghulam Mohammad, a young man of about thirty, worked in a timber saw mill in Chattabal, downtown Srinagar. One day, in mid-seventies of the last century, while he was moving a log from the timber lot on to the band saw for making planks, the log slipped from his grip and fell on his head. He concussed and fell down unconscious. His workmates carried him immediately to the nearby hospital, SMHS (attached to the Medical College). By that time he had recovered consciousness but complained of dizziness and headache. Since there was no neurology or neurosurgical section in the medical college at that time, he was examined by the doctors on duty in general surgery.

The resident surgeons did not find any evidence of external injury to the scalp nor anything abnormal on gross neurological testing. Plain x-ray of head was taken. There was no evidence of fracture. The patient was given analgesics (pain killers) for his headache and kept overnight. His headache subsided by next morning and on re-examination there were no signs of any internal injury.

He returned after a week with a headache of mild intensity since a day earlier. His wife said he was behaving odd at times. The residents examined him, found no new signs, gave him headache pills, kept him under observation for another night and discharged him next morning, free from symptoms.

He returned a second time after another five days. His wife reported that he was drowsy the day before and became agitated when she urged him to lie down in bed after he staggered while going to the lavatory. He even abused her once, and that was unusual. But he had recovered next day. The doctors found him conscious, communicative and coherent. There was nothing to go by from another examination. The chief of the surgical unit, Dr. Peerzada Abdul Rashid, during his rounds, asked his residents to send me a call for a detailed neurological examination and my opinion before they discharge him again.

By the time I came up to have a look at the patient, Dr. Peerzada Abdul Rashid was still in the ward taking round with his residents. He was a genial person, a good friend, and compassionate with his patients. He was one of those so called 'moderate' Muslim colleagues who would love to discuss the State politics with me even when we were on the opposite sides of the political philosophy and culture of Kashmiris. He thrived on India-bashing and on criticizing and ridiculing the Indian government for the imposition of its writ on unwilling Kashmiris while I retaliated and debunked the double speaks of Kashmiri Muslims, especially their politicians, who milked the Indian secular cow but swore by Islamic Pakistan. He had learned to be tolerant to differing view points

because of his long stint in Edinburgh for his FRCS. Gossiping with him in spare time was a good retreat from talking shop which doctors invariably do when they sit together.

In his characteristic style, puffing away smoke from his cigarette, Peerzada addressed me, 'Chowdhury Sahib, you are the neurologist around here. Kindly examine this patient. He has been baffling us with his bizarre symptoms that come and go and we have no idea what is going. I would love you to join me in my room over a cup of tea after you have examined him?'

Yes, I was the only faculty member in Medical College, Srinagar with interest in neurology. Though I had no postgraduate degree in the specialty, neurology was my passion. My Professor, the legendary Dr. Ali Mhammad Jan, having recognized my aptitude for neurology, would send the most intricate neurological problems from his private practice to me for examination and discussion with the residents and postgraduates. Tuesday of every week was the neurology day in my chamber in ward 3 of SMHS hospital and very special for me.

This was the first time I examined the patient, Ghulam Mohammad, under discussion. I have learned from my experience not to look at case notes from other doctors who might have examined and attended on a patient before I complete my own examination starting from the history. My philosophy in the practice of medicine is simple - Listen to the Patient. This has always stood me in good stead. I do not get biased by what the earlier physicians might have observed and recorded. Of course I do not discard that information; I look at it only after I have done my own study of the case. That is how I proceeded here. The patient's wife was quite helpful. She seemed intelligent and there was no reason to dismiss her observations about the patient's odd behavior and waxing and waning symptoms.

The patient was fully conscious, and I did a detailed neurological examination including a peep at his fundus (in the back of the eyes through an ophthalmoscope) to look for any evidence of raised intracranial pressure. There was nothing on detailed testing except very soft signs of impaired stearognosis (the ability to recognize the size, shape, texture etc. of objects) in the right hand which appeared a bit clumsy and corroborated the wife's observation that the patient was unable to use his right hand right.

Going by the whole presentation I made a diagnosis of Subdural Haematoma (SDH) - collection of blood between outer two of the three sheaths that envelope the brain. I wrote my notes and my advice, suggesting exploratory burr holes in the skull to drain the collection. Then I joined Peerzada Abdul Rashid in his room and told him what I thought.

"But look we have no proof, no other way to confirm your impression and we have never ventured into this burr-hole business, you know. Look Chowdhury sahib, why invite a problem, why not send him to AIIMS (All India Institute of Medical Sciences, New Delhi)?"

Dr. Peerzada was a competent but conservative surgeon with no aptitude for innovation and experimentation. He was not prepared to jump his limits. I agreed with him. How could I force him to do something which I would not be able to prove before exploration? We had no wherewithal to investigate the patient further in our institution. The age of imaging was still in its infancy those days. We had just heard of Cat Scans while MRI was not even born then. The only way we could supplement our clinical observation would be Cerebral Angiography but we did not have the implements to carry it out.

Accordingly, we referred him to AIIMS along with my detailed case report and made a case for angiography to confirm the diagnosis as a prelude to burr-hole exploration. And I forgot about the patient.

A month later, I was sitting in my lawn, flanking the S.P. College backlands, sipping a cup of tea when three people led a patient inside, holding him on either side and helping him limp towards me. Sunday used to be my off day. I was put off at this intrusion. They laid him on the turf disarming me before I could vent my annoyance, "We are sorry to have spoiled your Sunday, doctor sahib, but this is your case, the one you asked us to take to AIIMS last month."

I recognized him immediately.

"What happened; did you not take him there?" I asked.

"Yes sir, we did; we were in Delhi for a full month but it was all futile. He was examined the first day in the outpatients. The doctor said our patient was all right and there was no need to admit him. In any case no bed was available and we could watch him and report any development and come back after a week. We took a room near AIIMS and on the next examination, a week later, they performed an EEG and said there was no abnormality and left it to our choice either to return home or report after yet another week in case of any new developments. Meanwhile the headache went away with pills. We again reported a third time after another week. Our patient was asymptomatic and the neurologist gave us a clean chit. We returned last week, feeling rather sore that you had sent us on a wild goose chase but happy that all was well with our patient. In fact, he resumed work in the saw mill soon after and was well till yesterday when he again complained of headache and developed weakness of the right hand and leg. His speech became slow and words hard to come. He drags his leg and can not hold objects with his right hand. He vomited this morning."

This was a fast and serious development indicative of a rise in the pressure inside the cranium (brain). I examined him quickly while in the lawn. There was a paralysis of his right side and he suffered from a speech disorder (dysphasia). I looked at his fundus. There was early papilloedema (swelling of the optic disc at the back of the eye - an indication of raised pressure inside the brain). It was obvious this patient had now accumulated a fairly large collection of blood inside his cranium and convinced me

further of my initial impression that he had a Subdural Haematoma. I looked at the case note from AIIMS and found three entries on three different dates, the neurologist having found no abnormal signs each time and finally reassuring them that there was no cause for concern and that whatever had been the referring doctor's (mine) findings could not be corroborated or confirmed.

How was I to proceed from here? In the absence of a neurosurgeon in J&K, I had to rope in a general surgeon to do a burr hole. But, before that I had to convince him about my diagnosis, now all the more difficult because the patient had returned from a premier institution of the country with a clean chit!

I asked the patient to report next morning to my registrar in the Medical College with a note that the postgraduates examine the case and make a presentation to me after the rounds. I always slapped my postgraduates with interesting cases and challenged them to come up with a differential diagnosis.

Next day the presentation was done and the students agreed with my diagnosis. We decided to perform angiography on him even without the right tools to do so. Angiography involves the introduction of a long wide-bored needle in the carotid artery in the neck and injection of a radio-opaque dye at great speed and shooting a series of films. If we had a rapid cassette changer we would have to inject the dye only once and taken a series of pictures one after another to follow the flow of blood in the arteries and veins inside the brain. Any distortion, deviation, obstruction of the arterial system is noted and that gives an idea about masses, clots, tumors etc, inside the brain. In the absence of a rapid cassette changer, we had to repeatedly inject the dye, exposing ourselves and the patient to the risk of radiation and the possibility of the needle getting dislodged or cross-puncturing during the repeated attempts. But, we decided to take the bull by its horns, literally. My team of postgraduates and registrars joined me in this procedure; the radiologist, Dr. Shafat Fazili, cooperated. He was my class mate from S.P. College days and now a dear colleague who encouraged innovation and enterprise.

We were lucky. The procedure went without a glitch. And lo and behold when we looked at the films there it was - a large Subdural Haematoma glaring at us, challenging us to drain it before it was too late. By now the blood collection was pressing on the left side of the brain and pushing it to right. Delay could mean death.

I sent my registrar to Dr Peerzada Abdul Rashid with the details of the patient, and a plea for exploratory burr holes. He came down to my ward along with his whole team. "Dr. Chowdhury you will have to explain us all the angiograhphic findings; we have never seen a case and have no idea how an angiogram looks in a case of SDH." Nor had I in my practical experience. I had only read about it from text books and journals.

I put up the x-rays in the view-finder and started tracing the course of the main arterial trunks inside the brain and how some of them had been pushed and displaced

from the normal course because of the blood collection which showed a cutoff of the vessels.

"There seems no doubt, after what you explained, that this is a Subdural Haematoma, but we have never done a case. Is any of you prepared to take charge here?" he asked his teammates, looking quizzically at his assistant professor, Dr Abdul Ahad Guroo. The latter was a dynamic young surgeon, always ready to have a go at difficult cases, always ready to try new things. Dr Guroo readily agreed. "I will try. It will be nice to have Chowdhury Sahib also with us in the theatre."

That was a clear call for moral support and I readily joined the team of surgeons. It is surprising how little physicians like me follow their cases into the operation theatre once we have diagnosed and handed them over to the surgeon. As an example, I must have diagnosed hundreds of acute appendicitis, yet, hardly watched an appendix being surgically removed!

The patient's head was shaved and he was taken immediately to the theatre and we marked the area on the scalp where a large hole was drilled in the skull by Dr Guroo. He punctured the duramater (outer covering of the brain) and dark blood started flowing out. Nearly 200 ml was drained. The hole was sealed.

The patient recovered fast after that. By next morning he was free of headache. The power of his limbs returned soon after. He walked unaided on the third day and was discharged on the 6th. He resumed his work after three weeks.

Subdural Haematoma can occur after any trauma to the head. But it may result in the elderly from a trivial trauma that may have been forgotten. Often such patients come with deceptive symptoms which wax and wane for weeks, and sometimes months, and remain undiagnosed and untreated. That is why I call it the great masquerader. In this case it presented variously as headache, bizarre behavior, drowsiness, subtle sensory defects, weakness, speech disorder, alternating with periods of total normalcy. The doctors in AIIMS were deceived by the absence of signs when they examined him, did not seriously accept my findings nor entertain my suggestion for performing cerebral angiography. In the process they missed the diagnosis. One man's failure could be another man's challenge. In the cut throat competition of medicine, success is not measured by the number of cases a doctor has seen but the number of cases he/she has picked (diagnosed) correctly where others have failed.

After this landmark case, which was presented in a clinical meeting of surgeons and physicians of the medical college, a new awareness dawned about Subdural Haematoma (SDH) and more and more cases started being diagnosed and explored in our hospital. We started performing cerebral angiography routinely in suspected brain tumors, aneurysms and haematomas. The general surgeons were encouraged to explore patients with acute extradural and acute and chronic subdural haematomas and we stopped sending them all the way to Delhi, except the complicated ones. It was the

beginning of a new era in neurology and neurosurgery in J&K, yet another frontier in the fledgling Srinagar Medical College.

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What makes a legend?

Remembering Dr. Ali Jan

I don't know what makes a legend in medicine except one who has spent a lifetime in research and invention, made a remarkable discovery, or worked in communities to bring succor to a large number of patients. There are no such doctors in Kashmir that I know of. When I was much younger, father would relate the stories of a few Christian missionary doctors, and of some local physicians and hakims, known to have performed miracles, so to speak. These were anecdotal cases, nothing on a major scale to create a difference in the lives of people or their health.

Yet, there was a physician who was neither a researcher nor a missionary nor a community activist. He was an astute clinician who sharpened his clinical skills as he grew in stature with time, and went about his work with dedication. He never compromised with quality, abhorred mediocrity, and set a trend that the doctors of J&K still follow. It was to write a brief clinical note of the patient on the prescription, followed by the medication that he prescribed. It was the briefest clinical file of patient, a guide for others with whom the patient might land. It was no substitute for a proper medical file that doctors maintain for every patient in the west but it did not miss the salient points. It is difficult if not impossible for a busy doctor in India to maintain a proper file, what with the lack of infrastructure and the pressure of large number of patients that need to be examined everyday. We had the poorest doctor patient ratio in Kashmir, not to speak of specialists who could be counted on fingers. I remember patients falling prostrate in front of the car of this doctor not allowing him to move unless he agreed to examine them. His name: Dr Ali Mohammad Jan (Fazili), Ali Jan in short.

I had the good fortune of working with him for a year and half before he took premature retirement. Sitting in outpatients together, I mustered courage to ask him why he was retiring early. He was a man of few words; he just smiled. Much later I realized that he felt shackled by the changed administration that had taken cudgels with him.

I asked him (and this was deep from my heart), “Sir, whom will we turn to for guidance now?”

“I am not going anywhere; I will be in town,” he replied.

And true to his word, whenever in difficulty about a patient he gave me his opinion and advice ungrudgingly.

I didn't see him performing any miracles but I saw perfection. Frankly, there are no miracles in medicine except when you make the right diagnosis where others have failed. Dr Ali Jan was an ace diagnostician, a keen listener, a keener observer, quick-witted, and highly intuitive, he possessed that extra sense - the common sense. That made him the miracle man.

Short in size but handsome, he had an intelligent look and exuded hypnotic charm that mesmerized his patients. A doctor of few words, his answers to questions that the patients asked were brief, terse and metaphoric. He was updated with the latest advances in medicine, and subscribed to medical journals. He was a great learner and appreciated the worth of colleagues and juniors. When he realized my aptitude for neurology, he started referring most of the neurological problems for my review - he didn't have the time to perform a detailed neurological examination in his private clinic - and we would discuss the cases on every Friday in my room in ward 3 which he used to grace with his august presence.

People would travel from distant villages of Kashmir, even from Jammu, to seek his consultation. His prescription was a document of faith with his patients who preserved it at all costs and valued it more than any other material possessions. I have two personal stories in this regard that might give the reader an idea.

The first is of my grand aunt. She had gone for a wedding and on her return found to her shock that her pocket had been picked by someone. The pheran pocket of a Pandit woman used to be a veritable treasure trove, a depository of almost every item of daily utility - coins and currency; buttons, thread and needles; wicks and matchboxes; teknis (astrological chart) and other vital documents. My grand aunt cried foul. She said she wouldn't mind the loss except for a missing prescription by Dr Ali Jan that she guarded with her life. She wouldn't rest quiet for days together until my father (a friend, neighbor and contemporary of the famed physician), accompanied her to the doctor, who wrote a new prescription for her. I was still a medical student then and wondered about this celebrity whose prescriptions mattered like life and death to his patients, not knowing one day I would get to know him personally, closely.

I have been blessed with the guidance of wonderful teachers all through my school years and in the medical colleges where I obtained my degrees. I adored them. Ali Jan was not my formal teacher in that sense; he was a senior doctor with whom I worked. But I took instant liking to his style and he turned out to be my best mentor in the short span I worked with him. I can't forget his mannerisms, his soft speech, and the shrug of his neck, nor his intelligent looks and sharp intellect.

The second instance came to light much later in my life, when Ali Jan was no more, and I had moved to Jammu in the mass exodus of Kashmiri Pandits from the Valley. I had taken up residence at New Plots where I happened to see a patient, Somdatt Khanna, who suffered from migraine that was resistant to many of the established anti-migraine drugs. Over the years, our acquaintance grew and he is now like a family member. His migraine attacks have subsided to a large extent, partly because migraine tends to diminish in frequency and intensity with advancing years, and partly due to the new drugs that have come in the market.

The other day, while I was speaking with him about my association with Dr Ali Jan he gave me a meaningful smile and said, “I have been to him once for my headache and he was the first to diagnose migraine. In fact, I have preserved his prescription in my file and also his letter.”

I was surprised. “Really? When was it? ” I asked.

“Way back in 1973,” he replied. That was 46 years ago! And next day he came with both the letter and the prescription. My heart jumped with joy to look at the familiar handwriting, the brief clinical note on the right upper corner of the prescription and the prescribed medication and his signatures. But I was even more surprised with the letter he had found time to reply that revealed him in new light to me.”

There are many facets of legends that unravel only with time. When history of icons and legends is written it is the archives that we fall back upon to tell us a lot more that has remained unrevealed about them. I am in possession of the two documents that are a prized archive on the legendary doctor.

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The puzzling case of temporary return of speech

During my long practice I have come across uniquely puzzling cases that have defied scientific explanation. One such case concerning the mother of a friend is vivid in my memory and merits narration. Since it pertains to an era long past, I again taxed my friend with queries in order to fill the hiatuses in my memory especially about the finer details

Raj Laxmi, as she was called, had traveled to Delhi to spend time with her elder son, an employee in the Central Secretariat. She had been in good health except for high blood pressure detected a decade earlier when she was around fifty. One afternoon, when she was barely three weeks at Delhi, she got a mild headache and, in a matter of about ten minutes, lost her consciousness and came down with paralysis of the right side of her body. Cerebral thrombosis (brain stroke) was diagnosed at the hospital. She gradually came out of coma in around ten days, but the paralysis was total. She had also lost speech. Her younger son flew her back home to Habba Kadal in Srinagar. Next day, I was called to pay a home visit.

I found Raj Laxmi conscious but unable to communicate and paralyzed on her right side. She was neither able to comprehend speech nor produce it, a condition we call total aphasia that results from damage to the speech centre in the brain. She did not understand anything you said, nor could she utter a word. Only some degree of sign language was retained and I advised the attendants to develop communication with her through signs and gestures. Her emotions had become flat and she seemed stoic in spite of the devastating paralysis and speech loss. She had to be helped to sit up; and to be spoon-fed. I removed the catheter from her bladder to give voluntary urination a chance. Thereafter, she was able to urinate in a bedpan provided to her at regular intervals, despite which she sometimes soiled her clothes.

Over the subsequent weeks and months, Raj Laxmi registered progress in the control of her bladder and bowel functions but without any improvement in her speech or the paralysis. Thereafter, life went on from one day to another for her and for the family members who took over the care-giving of the matriarch with ungrudging devotion. In order to maintain constant vigil she was moved into the family room every morning and back into her bedroom for the night.

Raj Laxmi was married to Gopi Nath, a social activist who sacrificed his own good for the community. During his younger days, he was a member of Mahavir Dal, a nascent Pandit organization that spearheaded social reform in the community. It exhorted Pandits to cultivate the spirit of non-dependence on other communities for what they believed were lowly jobs – menial work such as carrying monthly rations from the ghats (food depots in boats); cutting fuel wood; taking up the professions of cooks,

tailors, barbers, etc. He had no job and no income. For practical purposes Raj Laxmii was the sole breadwinner, with the meager wages she received as a peon at a school. Sadly, Gopi Nath was afflicted with chronic asthma made worse by a smoking habit acquired from his childhood. Over the years his disease had progressed until he was incapacitated from end-stage lung disease. I used to visit him in his second-floor attic looking over the window at Hari Parbat. Sitting on his haunches, he struck the classical asthmatic posture – wheezing and grunting, puffing and coughing, bringing up phlegm, blowing his cheeks out with each respiratory exertion, hardly able to speak a sentence without visible effort and discomfort. He had to be catheterized for his urinary obstruction as a result of prostatic enlargement. Coincidentally, Raj Laxmii too developed urinary obstruction in her later years. I trained my friend in the art of catheterization so he didn't have to depend upon nurses and doctors every time. I admired him for his devotion to his bed-ridden parents, and gave him the honorific of Shravan Kumar, the mythological hero of Ramayana and a shining example of parent-care.

May 1990, when religious frenzy was at its peak in Kashmir, Gopi Nath developed acute retention of bladder. His son failed to introduce the catheter so I was called in. When Gopi Nath's bladder was drained, he thanked me profusely and said, “Doctor Sahib, you know I am on my last legs; I don't understand why my son inconvenienced you. All the same I will feel happy to quit without having to carry this shame with me.” I could see the end coming, and so could he.

The next morning, Gopi Nath was found crouched on the bare floor of his bedroom. He had removed his clothes, pulled the catheter out, and was bleeding from the urethra.

“Father, why are you naked?” his son asked him.

“Because my time has come; I came naked, I will return naked. Please give everything that belongs to me away in charity.” True to his premonition, his lungs finally gave up and he left his frail body at 7 p.m. on the same day.

The family members debated for some time whether to let their paralyzed dumb mother know about the demise of her husband. At 9:30 p.m. she was moved from her room and made to sit up by the side of her husband's corpse, as her sons tried to communicate the tragic news through gestures.

She sat there looking at the shrouded body for some time. Then she pulled away the shroud with her left hand, looked at Gopi Nath, rubbed his chest and suddenly got her speech back. “Oh, why did you quit ahead of me. That was not the compact when we were married. Why are you so selfish? To whose care have you left me? Oh, why have you deceived me?” She had spoken again after 14 years but turned speechless soon after and just sat there for nearly three hours, unemotional, like a statue, no crying or sighing or beating of her chest. Her son carried her to her bed. Next morning, she was again moved near the corpse, but she remained speechless all through the funeral

ceremony until the bier was being carried out of the room when she regained her speech for one last time.

"Oh, where are you taking him. Please don't leave me behind. Take me along with him." Soon she fell silent and resumed her former stance, never to speak again. She lived three more years.

In spite of the extensive damage to her brain from the stroke, Raj Laxmi understood the meaning of death. She felt it strongly. She must have been conscious of the entire goings on for all the fourteen years but unable to give voice to her thoughts and expression to her emotions. That must have been the greater tragedy, worse than the loss of function of her right side. But I have not been able to comprehend the dynamics of the temporary miraculous return of her speech. In all such cases one naturally goes back to the genesis of events, seeks past history of illnesses if any, including the personality and behavioral patterns of the patient that may offer some clues. So I went back into her past and some sketchy facts came to light.

The first clue surfaced from an event in 1978, when Raj Laxmi had sustained a fall in her bathroom while taking a shower. Her family had found her lying on the floor, eyes open but making no movement whatever, and unable to speak. A group of relatives had carried her to the legendary Dr Ali Jan. He had ordered the distraught relatives to go out of his consulting chamber and not to create unnecessary ruckus while he examined her. In a matter of about ten minutes, he was seen helping Raj Laxmi out of his room, as she walked slowly and spoke feebly. He had discovered the high blood pressure and asked them to restrict her salt and give her the pill that he prescribed. The sons described the whole event as a miracle, but it certainly seems to have been a hysterical manifestation, an over reaction to a trivial fall sustained in the bathroom that the astute clinician had not only diagnosed correctly but also treated promptly. This episode clearly reveals the psychiatric proclivities of Raj Laxmi.

There was another event that came to surface. This happened much earlier in nineteen sixties when some prominent members of Mahavir Dal deserted the social organization to join lucrative careers offered by the then government to wean them away from this Pandit organization that was gaining popularity in the community. Their betrayal had demoralized the dedicated activists, including Gopi Nath, and left them high and dry. He couldn't show his face to his relatives who ridiculed him for being a parasite on his wife, wasting his time in an organization that had lost its luster as also its relevance. This had infuriated Raj Laxmi who had lost self control, poured imprecations at them, turned aggressive, and even violent. She had to be confined in a room until medical help was sought and she had quietened down in a week's time.

These two events give us some idea about Raj Laxmi's persona. She emerges as impetuous, emotional and psychoneurotic and even subject to mood disorders under stressful situations. However, it does not explain the sudden temporary return of speech

after 14 years. The right sided paralysis and loss of speech were no doubt pathological, and not a hysterical conversion reaction. And her neurological examination confirmed it was a stroke. Besides, I have not heard of hysterical paralysis of such a long duration. Hysterical aphonia (loss of speech) is well known; again there is no recorded case lasting as long as 14 years.

The only theoretical explanation that comes to my mind is a burst of neuro-chemicals from the brain under extreme stress, firing signals in the neurons and prompting the temporary return of the speech mechanism. In the case of Raj Laxmi, it was the shocking news of her husband's demise. We know of Parkinson patients regaining muscle power in conditions of extreme danger, enabling them to run. But, as I said, it is a wild postulation in the present case, and the temporary return of Raj Laxmi's speech will remain an enigma.

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Lesson for a lifetime

It was the golden summer of 1968, a season of breathtaking beauty in Kashmir, of song and dance, picnics and outings, treks and hikes, swims and boat rides. And, of course, cinema, Hollywood movies in particular, which drew the lay viewers as much as the educated elite – college students, engineers, professors, lawyers etc. Only two cinema halls projected Hollywood movies, a single evening show everyday that started around 7 pm. Generally an English movie would not last more than a week. You missed it at your own peril, for the next time you met your friends you were dumb during a discussion on the latest movie. You didn't want to be left behind, yet your profession did not grant such license. Practicing doctors like me were almost invariably engaged with their patients during those peak evening hours between seven and nine.

Alas there were many other simple pleasures of life denied to us. We hardly had time to go to a club with our families or enjoy a game of cards or tennis or a swig of wine with friends. Even the privacy and freedom of Sundays at home were denied to us. I remember in particular the Sunday telecast of Mahabharata and Ramayana on Doordarshan that were everyone's favorite, mine as well. In spite of Sunday being a declared off day in my practice, patients would drop in just at the very time when the epics were being telecast. I would ask my domestic help tell them I am not home, but many of them were like family; they would enter the family room anyways and sit and watch the serial while I hid in my bedroom!

But then, medicine is a noble profession, we are reminded every time. Pleasure and medical profession don't go together; a little sacrifice will raise our stock both here and the hereafter.

Besides the routine days, it was the days we were on emergency call that kept us pinned to our homes. You could not afford to delay or miss a call. Of course that was as it should be, and I always stuck to my duty like the boy on the burning deck, except… Except once in my life, and that was a lesson I never forgot.

That day I was on emergency call. But it was also the last day of Doctor Zuhvago showing at Broadway Cinema. There were rave reviews. Besides, I had read the novel, an English translation of the original Russian by Boris Pasternak. It was lyrical. I would not miss the movie at any cost. I decided to take the plunge, hoping that during that short period there would be no emergency or if there was one, my juniors on duty would tackle it. They were competent to deal with most emergencies and it was rarely that I would be called. As a precaution I took my mother into confidence, just in the case a call came up during that time.

I got a ticket with much difficulty for I was at the nick of time when the counters were closing and the cast was already showing. I hoped I was in for an exciting viewing.

But it was not to be. Hardly a quarter through the movie, there was a sudden pause and a notice appeared on the screen. “Attention Doctor Chowdhury. Hospital Ambulance is waiting outside for an emergency call.”

There was a moment's hum in the hall and then a mummer of disappointment and disapproval that rapidly rose to a high decibel as heads turned in different directions to find the culprit who had caused the sudden distraction. I cowered in my chair, hoping nobody saw me. The movie resumed immediately and I quietly got up from my seat and emerged from the cinema hall.

It was one of the very unusual calls, not from my hospital directly but from the Director Health Services who had no jurisdiction on Srinagar Medical College where I was an Assistant Professor. It so chanced that the Central Minister of Health happened to be visiting Kashmir. He had come down with pain in the left arm while holidaying at Gulmarg. The local medical officer had rushed him to Srinagar. Being a VVIP, the Director Health had been immediately put on the alert. As soon as the Minister reached the Guest House at Sonwar, the Director arrived on the scene, examined the minister and reassured him that it didn't seem a heart attack, but he would order an electrocardiogram and send for the physician on call. By the time the Director left, the ambulance was on way to my residence. When my father realized that I had gone to watch a movie, he was frantic. He wrote a notice on a piece of paper, handed it over to the ambulance driver and directed him to ask the manager of Broadway to project it on the screen.

I sent the ambulance away and drove to the guest house. The minister informed me that the Director had already seen him, but offered to be examined again. He seemed gentle and pleasant and, for a change, there was no officiousness about him, no hubris. He complained of pain in the left arm that exacerbated by neck movements. It was most probably a root pain from cervical spondylosis. ECG did not show any abnormality. I wrote down a painkiller and drove home, missing the rest of Doctor Zhuvago, not imagining what lay in store for me at home.

As soon as I stepped inside, father burst into one of his worst tempers that I ever faced. “Did you see the patient or did you come home straight from the cinema hall?”
“Yes, I saw him, Thank you for the notice, father.”

Now he was really angry. “How can you be so irresponsible? If you are on call, how dare you go to a movie? This is gross dereliction of duty.”

I had no gumption to argue with him. I gently explained that I was not negligent, that I had informed mother, that I lost no time to attend to the patient, and that it was not really an emergency, but a trivial problem that was blown up because the patient happened to be a minister.

A lawyer of high professional ethics, he was unforgiving. “I think you acted irresponsibly. You can't leave station on your call days, not even for your own important

work or emergency. You must know it more than me; even a minute can make the difference between life and death. Personal comfort or convenience, impulse or inclination should have no precedence in the discharge of professional duties of a doctor."

I couldn't agree more. Nor have I forgotten that lesson to this day.

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The cutting edge of clinical diagnosis

(Concealed Hemorrhage of Heart Attack)

It was the summer of 1971 in Kashmir. I was an Assistant Professor of Medicine at the Medical College, Srinagar. Tuesdays were my admitting days.

Mohammad Shaban, a 48-year male was brought to the hospital in a state of shock around 10AM on a Tuesday. By the time I arrived in the ward, an hour later, the medical residents had gone through his history and examination. They were still fumbling for an answer to the cause of his shock.

Mohammad Shaban was a short stocky man. He woke up fine in the morning as on any other day, went to the rest room, passed urine and felt nauseous. He returned to bed for more rest. After nearly an hour and a half he walked to the rest room again but felt giddy and weak, slumped on the floor, and returned to his bed with difficulty. He was brought to the hospital with an acute onset of weakness and sweating.

On examination he had telltale signs of shock - fully conscious but quite restless and apprehensive, pale and sweating profusely, breathing fast (22 per minute) with a rapid pulse (116 per minute), low blood pressure (80/60 mm Hg) and subnormal temperature (96.8 F). A full review of all his systems did not reveal anything. There was no evidence of any rash on the skin, the lungs were clear and the heart sounds normal. The abdomen was soft; there was no tenderness anywhere.

Mohammad Shaban was a milkman, a moderate smoker of hookah, non-alcoholic, with no history of substance abuse. He lived an active life, tending his livestock and delivering milk to homes every morning. There was no previous history of trauma, allergy or anaphylaxis, diabetes, hypertension, cardiac disease, abdominal pain. He had not taken any drugs in the recent past and had never suffered any major illness nor undergone any surgery. He had moved bowels the previous morning.

We put in an intravenous line and ran basic investigations. The urine analysis was normal, Hemoglobin (Hb) 10.5 G, Packed Cell Volume (PCV) 32, white cell and platelet counts within range, a normal blood sugar, a normal chest x-ray and an unremarkable electrocardiogram (ECG). By that time the Professor and Head of the unit also joined us in the rounds and we reviewed the case for him. We ran through the possible causes of unexplained shock in this case – a heart attack, severe sepsis (infection), loss of fluids including external or internal bleed, anaphylaxis, endocrine emergencies etc.

“This is a heart attack, a myocardial infarction (that results from a clot in one of the coronary vessels supplying the heart muscle),” the Professor declared. I argued against that possibility because there was no pain, the electrocardiogram (ECG) was normal, and there were hardly any risk factors. “But heart attacks can be painless and it may take some time to show changes in the ECG,” he argued, and reminded us that smoking

history was a possible risk factor. I vouched for an internal bleed in this case and advanced the reduced Hb and PCV levels as two significant features of blood loss, but he dismissed them. “That level of Hb and PCV was almost normal for our population,” he said, “and the patient has no history, whatever, of ulcer in the past.”

He advocated vasopressors to raise the blood pressure and heparin to dissolve the clot in the coronaries. This was the age of heparin. There were several reports in medical literature of better outcomes with heparin in middle aged males with heart attacks. But if this were a case of internal bleeding, as I strongly suspected, it would be disastrous to administer heparin; in fact, it could be fatal. “In any case heparin is not a must, it makes only marginal difference statistically, and we can wait till the picture clears in this patient,” I said, making a case against its administration to the patient.

"Where do you suspect the bleeding from, Dr. Chowdhury?” he asked rather quizzically

“Most likely a duodenal ulcer,” I said.

“But there is no previous history of duodenal ulcer in this case. He is 48, rather late in life for an ulcer to manifest first time. Besides, it has to be a massive bleed from the ulcer to cause such shock; the blood should have shown by now. He has neither vomited blood nor moved his bowels.”

“I feel he will soon show up with melena (black stools); I can almost smell it,” I said with conviction; “it is not uncommon to get a duodenal ulcer in middle age with bleeding as the presenting symptom. Ulcer bleed is notorious as a common cause of medical shock in Kashmir. We may be losing time by withholding blood from this man,” I augmented my reasoning.

The Professor had joined the institution only a few months earlier. Having come fresh from a long training programme in USA and been appointed directly to that high rank, he was, understandably, not yet fully conversant with the common emergencies in our part of the world. Heart attacks were on the rise in the west, no doubt, but so uncommon in our setting and painless heart attacks such a rarity.

He did not agree with me, stating it was several hours since the onset of shock, and the bleeding should have become manifest by now. But he agreed to withhold heparin for some time, and directed the staff to send a blood sample for cardiac enzymes (as a marker of heart muscle damage) and run ECGs every hour. It was lucky aspirin, and other platelet inhibitors were not in vogue then (as blood thinners), or he might have hedged his bet on their administration in lieu of heparin.

Working in a hierarchical system in medical profession may have its strong points but the decision of the Head always prevails even if he is frightfully wrong. I asked the residents to monitor Mohammad Shaban for his vital signs, watch for any evidence of manifest bleeding, and, to repeat blood counts, Hb and PCV. Our labs were still primitive and not very reliable and the estimation of cardiac enzymes would take a day or more in

the central laboratory. But blood counts, including Hb and PCV could be reliably and promptly performed in the side-room lab right in the ward.

Over the next hour the patient stabilized somewhat. His sweating stopped, his pulse improved to 100 and the blood pressure rose to 100/75. He passed urine but no stools. A repeat ECG did not register any change but the Hb had dropped further to 9 and the PCV fallen to 28, which was quite significant. I sent one of the residents to the Professor's chamber with the new information but he was not impressed by the drop of one and half gram in Hb stating that estimation by the calorimetric method in vogue with us was not always accurate!

Another hour passed and the new ECG remained unchanged. The Head came down to have another look at around lunch time. He was on his way to the Medical College to deliver a lecture. He seemed satisfied with the line of treatment since the patient seemed out of woods. In his view it was no longer prudent to withhold heparin in the patient. The registrar was directed to administer 20 thousand units of the drug intravenously every 6 hours. I again intervened and vehemently argued against this fallacy which could prove disastrous, but the Head's word was final.

"The blood would have shown by now," he said in his genial manner, it is a heart attack and we must approach the case as one," he declared with a finality that discouraged any other argument.

I did not mind a painless heart attack being kept in mind as a possibility here even when the diagnosis of an internal bleed was staring at us; what incensed me was the obstinacy about the administration of heparin. The residents looked at me with sympathy and at the Professor with awe. They eyed each other as they found the two of us almost eyeball to eyeball. The Professor left for the lecture and I returned to my room, to collect my thoughts and find answers to my questions: "What is going wrong? Are we losing precious time? Are we missing some vital step in the diagnosis and management of this case?"

The answer came in a flash. I had missed a simple diagnostic procedure to prove my point, that of passing a Ryles tube (a thin rubber tube) down the esophagus into the stomach of the patient to find the evidence of blood there. I realized how the mindset of the Professor had offset the sequence of logical thought in the rest of the team, and even the urge to seek answers in a challenging situation. The tendency to close your mind to possibilities and become fixated on one idea is the bane of medical practice that needs to be resisted at all costs.

I rushed to the patient. Heparin was fortunately in short supply in the hospital and the attendants had been asked to buy it from the market. The patient had not received any shot yet. I asked the nurse for a Ryle's tube and meanwhile went over the patient again. He smelled of melena! I felt his tummy; it was soft but there was brisk gurgling. I

put my stethoscope and heard loud barborygmi (whooshing sounds) that spoke of rapid passage of intestinal contents.

"Would you like to move your bowels?" I asked Mohammad Shaban.

He replied that he was passing a lot of flatus.

"Let us get you a bed pan," I suggested.

"No sir, I would like to go to the lavatory."

"OK." I called the ward boy to help him with a wheel chair. But as soon as he was made to sit up in the bed he swooned, and as we lay him back he passed a massive black motion, the characteristic tarry stools of duodenal ulcer bleed, soiling his clothes and the bed sheet, enveloping the whole ward in a miasma of offensive smell so unmistakable of melena stools.

The cat was out of the bag. For full 5 hours the bleeding had remained concealed; quite unusual but not unknown. There was no need for the Ryles tube now. I called the residents and directed them not to administer heparin, now that there was no doubt about duodenal ulcer bleed being the cause of shock. I asked them to transfuse two units of blood.

The medical registrar came to my room a while later. He had phoned the Professor and informed him about melena and asked if heparin was to be given. The answer was an emphatic 'yes' for heparin but for the transfusion an equally emphatic 'no'!

This was insane. I was furious and warned him not to administer the drug that was sure to kill the patient. He seemed caught between the devil and deep sea.

"The Professor will be mad at me, sir," he said in all humility.

"Me too," I retorted. I wrote on the case sheet of the patient in bold letters - NO HEPARIN - and warned the residents, "I want no heparin to be administered to this patient, and that is an order.".

Nobody in medical profession can claim to be exempt from a diagnostic error. In the present case there were two probable diagnoses on presentation, but only for a while, till hemorrhage became manifest. After that there was no point persisting with a wrong line of thought that was inevitably leading to a disastrous line of action. This was not the occasion to stand on prestige especially when the life of an individual was involved, a life that was a sacred trust with us.

Next morning I went to the ward with great trepidation, not knowing whose instructions were finally carried out by the residents and what turn this case had taken during the night. The residents had struck a truce; they had neither transfused blood nor administered heparin!

Time is a great healer and Nature the best doctor. It is in the nature of a living organism to mobilize all the reserves in the face of danger. That is what happened with our patient. The bleeding had stopped, he had stabilized again and his vital signs had improved even though the Hb had now dropped further to 7 and PCV to 28, as I

expected. The Professor came for the usual rounds and when he saw the patient he was very happy and waxed eloquent about the usefulness of heparin in acute myocardial infarction (heart attack). He cited references from literature and stared theorizing about the role of anticoagulants (blood thinners that help dissolve the clot).

The residents looked from one to the other and I felt the onus was on me to intervene.

"But he received no heparin. He bled from the ulcer and I dissuaded the residents from administering heparin; there would have been grave consequences," I said.

"I do not believe he had an ulcer bleed." Surprisingly his tone was conciliatory; there was no sign of exasperation.

"We can't deny he has bled. Nor that the source of blood must have been somewhere high in the gastrointestinal tract. Nor that bleeding was the cause of shock and not a heart attack," I reasoned out the sequence of events in this patient.

"On the contrary, I believe he had a heart attack as the primary event that led to shock which, in turn, must have led to ischemic colitis manifesting as blood in the stools," he said smiling and shaking his head in self-affirmation.

This was a long, long shot, indeed! This was stretching the realm of possibilities to incredible limits and committing the mistake in medicine that should be avoided at all costs - of making the diagnosis of an uncommon disease with an uncommon presentation and an uncommon complication when an alternative diagnosis is crying for recognition.

The professor's explanation was the proverbial last straw of a drowning man. He could have even now gracefully retracted from his erroneous position and earned our admiration. But he was plunging deeper and deeper into the quagmire of blunder, and there seemed no end in sight.

Because, even if one accepted that shock was from a heart attack and the bleeding a result of ischemia of the gut from shock there was still no point persisting with heparin. It would kill any one with any bleeding from whatever cause.

I felt helpless in the face of his obduracy and ignorance and could not hide my exasperation. "I see no evidence of heart attack at all; his ECG has stayed normal now for more than 24 hours. It must be a first ever case where a heart attack is massive enough to result in shock and the shock as severe as to cause gut ischemia and hemorrhage, and yet not produce any changes in the electrocardiogram!"

"Let us take another ECG. It may yet show the changes," he persisted, making a mockery of himself in the presence of residents and nurses.

An ECG was run while we all stood by the side of the patient. He held the graph in his hands and peered at it keenly like an astrologer looking at a horoscope and gave yet another smile of triumph. Taking out an ECG scale from the top left pocket of his apron

he started showing us the 'changes' - a subtle depression of ST- segment in the chest leads of the ECG which he said were 'distinct early' signs of a heart attack.

"But these are only non-specific changes that are the result of acute anemia from the loss of blood in this patient;" I countered.

"In any case, let us wait for the result of cardiac enzymes from the lab. I am sure you will find them elevated, but even if they are not, that does not go against heart attack," he shook his head even more vigorously.

That was my limit. But, strangely, my annoyance left me and he amused me now, even as I felt sympathy for him.

Luckily for the patient, the Professor did not mention the word heparin again and I did not pick any more discussion on the case during the subsequent ward rounds.

Mohammad Shaban stabilized fully by the next day. He wanted to go home by the 5th day, but was advised by the Head to stay back for three weeks, the recommended duration of hospital stay for a patient of heart attack. His ECG was taken every day, the Professor going through the ritual of taking out his pen and ECG scale to show the 'changes' that were not there. The cardiac enzymes sent thrice returned normal levels. The patient grew impatient with this routine that seemed as pointless to him as to me, and possibly the rest of the staff. At his insistence he was discharged 'against medical advice' on the 12th day and asked to come for follow up. The discharge summary by the registrar was stark fiction. The professor saw to it that the diagnosis entered there was Acute Myocardial Infarction!

Mohammad Shaban must have had the last laugh. He never turned up.

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Half a calari for home visit

Amongst other interesting incidents during my brief, yet intense, stint at Pahalgam in 1964, I recall one vividly for its poignancy. It was a home visit, the very first of my career.

Around 3:30 PM, when I had just finished attending to the last patient at the hospital, and was about to call it a day, Bushan Lal, my Medical Assistant popped in along with a young Gujjar.

"Sir, this is Kadira. He desires you to make a home call. His wife is badly injured in her foot. She is in pain, unable to move or stand."

"Where do you live, Kadira?" I asked the Gujjar.

"Phraslun," he replied.

"Where is Phraslun?"

"It is a village half way to Chandanwari."

"How far from here?"

"Three kos. Don't worry, Doctor Sahib, I have a horse."

I didn't know how much one kos meant.

"How far is Chandanwari from your village?"

"Three kos, may be four."

'Do you mean Phraslun is midway between here and Chandanwari?"

He nodded uncertainly. But I knew Chandanwari was about 16 kilometres from Pahalgam. It would take me nearly three hours on foot even if I had to walk all the way to Chandanwari. If his village was really midway, it would be a cakewalk.

It was tempting - make the house call and enjoy a horse ride and the bewitching evening scenes.

I mounted the horse; Kadira followed on foot.

Bushan Lal shouted at him, "Doctor Sahib nu achi fees dena."

"Zaroor devunga," the Gujjar shouted back. It made me laugh, for the fees were least in my calculation. I was bracing myself for an exciting excursion.

Soon out of the marketplace, we passed by the club, and on towards the end of the town, as the stream gushed and gurgled on our right along the road to Chandanwari. Nearly two kilometres out of Pahalgam, I dismounted. It was an old decrepit animal, and rather wobbly up the steep path. Kadira felt a bit offended, but I assured him that I I enjoyed trekking more than riding and asked him to mount instead. He frowned as if I had made preposterous suggestion, and asked, "How can I ride and let you walk? Not once has any customer offered to walk and let me ride my horse."

I engaged Kadira in conversation. He looked around thirty-five. His family was small – his expectant wife and two kids. Tragically, two other kids had died, one during a difficult childbirth, another two weeks after he was born, from, what sounded like acute

bronchopneumonia. Kadira lived off his cattle - two buffaloes and a cow. He sold their milk. Sometimes he made kalari or maish krej (mozzarella), a round flat loaf of stretchy cheese, and sold it in the market. Of slightly sour taste and sticky feel in the teeth, kalari used to be a delicacy, a hot favourite of all Kashmiris. I believe it still is.

Somewhere near midway, we turned left from the main path, and halted two hundred meters away near a kotha. That was his house. We had reached in an hour and half.

Inside was dark, dank and dingy. Smoke came out of the fireplace and the mud walls were black with soot. A woman lay on a dirty mat on the floor; two kids played with marbles by her side, and a cow ruminated in the corner. There was a distinct odour, an eerie mix of human and animal breath that coalesced with the smell of dairy and dung. “This is my wife, Zubeda. She can't move her right leg after she tripped while picking corn in the field the day before yesterday.”

Zubeda's hair was plaited in several strings, her frock worn out and dirty. She was small and emaciated, her face weather beaten. Her belly bulged from a six-month pregnancy. She was immobilized from a swollen and tender right ankle. She couldn't move her foot, nor stand on it. Passive movement was painful.

It did not require special acumen to figure out that she had sustained an ankle fracture. Her pelvic bones were tender, possibly from osteomalacia, a bone disease arising from calcium and vitamin D deficiency, so common in Gujjar women. That was possibly why a trivial fall had caused her the ankle fracture. It was a classical example of scarcity in plenty. These people produce milk, the richest source of calcium, which they deny themselves but sell it to earn a living. They live under the open sky where they have sunshine aplenty, but their women spend time inside the dark kothas with hardly a chink of sunlight, resulting in Vitamin D deficiency. Multiple pregnancies drain their last reserves of calcium and render the bones weak and fracture-prone.

I asked Kadira to get a strip of cloth and a small plank of wood. Luckily he had an old bed sheet. We tore off a 3 inch wide, 4 feet long strip from one end. I rolled it up into a bandage. He cut two small planks of wood for the splints. Placing them on either side of Zubeda's ankle, I secured the fracture site with the bandage. The idea was to immobilize the joint until it healed over the next six to eight weeks.

On our return journey, the long evening shadows cast a magic spell. We were faster on our feet since we were descending, and it hardly took us an hour to reach the culvert over the stream at the far end of Pahalgam. By then dusk had fallen; the sky was a flaming red and the stream in her full song. I had no problem walking alone from there. I asked Kadira to return to his kotha for he seemed worn out and hungry.

“Doctor, mere kun koi paisa nahi hai. Yeh tum rakho, yeh aadi kaladi bachi hai. Yeh tumhari ujrat hai. (Doctor, I have no money to pay you; here take this half kalari that

is left with me. This is your wages).” He had no compunction to offer me the kaladi, half of which he had nibbled away slowly during the journey to feed his hunger.

I was already touched by his immense poverty; now his threadbare innocence and his rustic candour caused a pang in my heart. “I rode your horse part of the way; I had a great outing; I treated the first patient of fracture; and I saw god everywhere. That is a huge lot of fee. In fact, I should pay you for this unforgettable experience.” I said in genuine gratitude.

I took a rupee from my pocket and gave it to him. “Here, buy yourself some refreshment; you look famished. And take care of your wife. She is carrying and needs good food, milk, fruit, chicken, and…kalarai,” I said, pointing at the half kalari in his hand that he wanted to offer me. He smiled shyly. “One of these days, bring her down and I will examine her again. If need be, I might send her for an x-ray to Anantnag.”

He accepted the rupee unhesitatingly and blessed me: “Allah tumko mehfooz rakhe.”

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The Bear Hug

(A case of Pericardial Effusion)

Abdul Razak was admitted with exertional breathlessness, weakness and easy fatigability. This 38-year old salesman with a cloth merchant in Amira Kadal, Srinagar, enjoyed excellent health till 2 weeks before his admission to our ward, when he started getting progressively out of breath on walking and during normal activities related to his profession. He was not able to lift a roll of cloth from the shelves to exhibit it to his customers or to climb a flight of stairs without stopping a couple of times catching his breath.

During my rounds I found this rather lanky and lean fellow slightly puffy in the face. His pulse was feeble and fast, his neck veins stood out and remained bulging even while he sat up, the blood pressure was low normal, the pulse pressure narrow and there was a paradox. He had developed mild pedal (of the feet) edema. His heart sounds were feeble and distant even as the heart was enlarged, and there was a pericardial rub (scratchy sound) in front of the heart near the sternum. His liver was enlarged two centimeters and tender to palpation.

It die not require any special acumen to suspect Pericardial Effusion (collection of fluid in the sac surrounding heart) as the cause of his clinical presentation. By next morning we had done the preliminary investigations, taken his chest x-ray and ECG. The heart, on x-ray, looked like the typical moneybag and ECG depicted a low-voltage tachycardia, both of which corroborated the clinical suspicion.

The blood tests and biochemistry on Abdul Razak did not make us any wiser about the cause of this effusion. He did not run fever, there was no history of trauma, nor of any rheumatism, his kidney functions were normal and so was the examination of systems other than heart.

What was the cause of his effusion? He did not fit anywhere in the list of common causes of effusion in our setting - rheumatic, tubercular, traumatic, kidney failure, etc. Could he be a rare case of a malignant tumour of the heart or pericardium?

We decided to aspirate the fluid. Those were the days with limited imaging facilities. Echocardiogram was not available. The tapping of fluid had to be undertaken blindly by introducing a longish needle directed from the abdomen below towards the base of the heart or from the chest wall along the left border. I took the former route and was lucky to hit the pericardial sac and draw blood! Yes, it was frank blood and I wondered had I penetrated the heart, but the blood did not come out in jets and spurts with each heart beat as it should have in that eventuality. Instead, it had to be drawn by a gentle suction. Besides, it did not clot; that was a sound indication it was from the pericardial sac and not the heart. I drained about 200 milliliters.

Abdul Razak felt relieved of a 'pressure' on his heart almost immediately. His breathlessness abated and the pulse and blood pressure improved. But that did not solve the puzzle. We examined the aspirated fluid and it was blood and nothing else; it did not reveal any evidence of a tumour or tuberculosis. We yet conjectured about the possibility of one of these conditions and started treating him for the treatable - that is tuberculosis.

By next morning he was accumulating again and in another two days he became breathless and developed a typical tamponade - a condition where the fluid in the pericardial sac accumulates quickly in quantities so large as to hamper the contraction and expansion of the heart, strangulating it so to say. If not relieved, shock and death would not take long to ensue.

I went in again and now drained another 250 milliliters - again frank blood. It was baffling. Tuberculosis was out of question. Even if it were a hemorrhaging tumour it would not bleed that fast. It had to be an open, bleeding vessel. But what was causing it? I again asked him if he was ever hit on the chest or had sustained a fall. He denied any history of trauma.

We continued anti-tubercular regimen and added steroids with the hope of stabilizing the bleeding, whatever the cause. We followed up with serial x-rays from different angles to look for any evidence of a tumour. In another three days the process repeated; he re-accumulated, I drained again.

Abdul Razak was a gentle, amiable fellow; he lauded our efforts and even joked about his hiding a spring of the vital fluid in his breast that was forcing itself in a fount. But, by now, he developed anaemia and we transfused two units of blood. His attendants were concerned and we were utterly baffled. I went home that day brooding about the possibilities, looked at the literature on blood in the pericardial sac and came to a naught about this case. I could only come to one conclusion - he had sustained a trauma about which he forgot.

It was a difficult night. I dreamt of blood being spilled in a fight, someone hitting me in the chest and causing a bloody effusion. Yet, I woke up with a clear mind and was in a hurry to rush to the hospital. We started the morning rounds directly from Abdul Razak. He was slightly dyspnoeic (breathless) and certainly re-accumulating.

"Doctor Sahib, when will blood stop welling up in my heart?" he asked as the whole team stood by his side trying to grapple with the aetiology in this case.

"Only when we fathom the cause, Abdu Rakak. And now tell me are you sure you were not hit in the chest?"

"Yes sir, I am sure."

"Yet do I feel that you have been hit or crushed by something. Try to recall. A roll of cloth falling on your chest, or a fall from a table or chair on your face, hitting the chest?"

"No sir, I can tell you for certain, nobody hit me. I did not fall, nothing fell on me."

And then it suddenly flashed in my mind. "Did someone hug you hard?"

He thought for a while and his eyes widened as he remembered. "Yes sir, I recall it now that you ask about this embrace. My elder brother returned from the pilgrimage (Haj) to Mecca last month. I went to the airport to receive him and he hugged me long and hugged me tight, almost crushing my chest. I even felt a twinge of pain then but quite forgot in the excitement of reunion. I never thought about it ever since. If that is what you are asking."

"Exactly that. It was a Bear Hug, Abdu Razak. An affectionate hug by a strong man that tore a blood vessel in the sac of your heart."

"Yes sir, he is well built and strong and has returned stronger from the pilgrimage!"

"Let us hurry then," I addressed my team who were looking on almost dumfounded, "Let us call the surgeons and open him before he tamponades again."

The surgeons incised the pericardium, drained the accumulated blood to find the culprit - a bleeding vessel in the pericardial covering. They sutured it and the bleeding stopped. The sac was stitched back.

There was no looking back from there. The drugs were stopped and the patient recovered fast. There was no re-accumulation and he was discharged on the 5th day.

Dear reader,

Beware of the Bear Hug
That may bear down
on your tender chest
And fracture a rib
Or tear a vessel
Rupture a lung
Or sear the heart.

❑❑❑

Where veterans didn't dare

A young boy was brought to SMHS Hospital, Srinagar on a bright summer noon in deepening coma. He was hit hard on the head by a cricket ball while fielding at point position. Bang! He fell down in an instant. The game was stopped; the players rushed near and found him unconscious. A bruise had appeared on his left temple. They brought him in a tonga and he was admitted in the general surgical unit.

The doctors made a provisional diagnosis of concussion. But his coma was fast deepening. An x-ray of his head revealed a fracture in the temporal bone. There was nothing you could do in such cases except to take care of the vital signs, fold your arms and pray that the patient opens his eyes again and walks out of the ward without any stigmata of head injury.

I was called in to examine the patient and give my opinion. I found the boy unconscious, with a slow pulse and low respiration. His pupils were unequal. He was in grade 3 coma. There were unmistakable signs of an acute epidural hemorrhage (collection of blood between the brain and its outer sheath).

There was no time to lose; the only way to save his life was to evacuate the blood collecting on the brain surface.

I discussed the case with the surgical registrar and asked him to start the traditional therapy with intravenous mannitol to reduce his brain edema (swelling), and drill burr holes in the skull to drain the blood. Just then the chief surgeon walked in. I described my findings and the need for urgent intervention in the case.

A professor of surgery, the chief was known for his competent yet conservative approach. He preferred to handle only the 'clean' cases. That meant no risks, no heroics, and no innovation. He had no experience in neurosurgery, even less with neuro-trauma. In fact there was no qualified neurosurgeon in the institution at all. Neurosurgical cases were invariably sent to AIIMS, New Delhi.

"But we are not equipped to handle this case," he declared after hearing me out.

"Do we just wait and do nothing." I asked rather impatiently.

"No, I am asking them to shift him to Delhi," he snapped.

"It is already late in the day. It will be risky to send him in a car or ambulance. The earliest air flight will be tomorrow, if at all the plane takes off. In either eventuality it means twenty-four hours from now. By that time I do not think this boy will be alive," I cautioned.

"But, I would not risk touching him in this state," he said with note of finality. "Let us hope the decompressive measure will tide him over until tomorrow."

I was sore and disappointed with his insouciance, but did not show it except by a loud grunt, an uncertain nod and a 'thank you for asking me to see your patient.'

I trotted back to my ward and noticed the father of the boy catching up with me.

"Sir, please save my child. He is my only son. He was a promising cricketer. Curse this game that he should have been struck on the head."

"I have put in my advice. They are doing their best."

"Will he survive?"

"I don't think so unless someone opens a hole in his skull to evacuate the clot," I said without mincing words.

"Can't they do it here; is it so very difficult?"

"The fact is, no one has performed this surgery before in Kashmir, though in theory it is not difficult," I replied his queries in all honesty.

"Why can't they do it if it is not difficult?"

"Because they have not done it before; because they do not have all the implements; because they are afraid of the consequences," I replied almost in exasperation.

"Do you let my son die, then?" He asked in extreme desperation, almost putting us all in the dock. It caused me an excoriating sensation. I had to do something, find a way out of this impasse.

"Are you prepared to face any eventuality while we try to give your son the only chance I feel he has of surviving?"

"Yes, as long as you try something."

"All right, tell the surgical registrar to see me again."

The registrar came down to my room. He was a bright young surgeon and one of my former students.

"Sir, you asked for me."

"It is about your head injury patient. How is he doing?

"He is deteriorating."

"Why don't you take him up for burr holes?"

"You already suggested that to the chief. I don't think he will let me touch the boy."

"Suppose we bypass your chief?"

He gave me a quizzical look.

"Would you accept the challenge?"

"I would love to."

"Well then, after the hospital hours, when your chief is gone, send me another call to have a fresh look at your patient."

"I will do it, sir."

By four everyone except the doctors on evening and night duty would leave for home. The surgical registrar sent me a call at 5 PM with a request to have another look at the fast deteriorating patient. I rushed to the hospital. There was a crowd of evening

visitors in the ward. The boy was in deeper coma. His breathing had assumed an irregular pattern, another sinister sign of raised pressure on the vital areas inside the brain. His parents were in acute mental agony. There were a dozen relatives speaking in hushed tones, looking pleadingly at me.

I wrote my detailed findings on the patient; and a concluding note: the patient has no chance if we don't immediately drill holes in the skull to drain the blood out. It will be too late to wait until the next morning. We must act now and do whatever is possible to save a life.

The registrar looked like one having an epiphany. .

"Ready for the assignment, then?" I asked.

"Yes, sir, since you are there to back me up." He replied like the brave soldier on the front facing a superior.

"Give it a shot then. Move him to the operation theatre, drill holes in the temporal region, and drain the blood out. You don't need to inform your chief," I winked at him.

"Yes, sir," he smiled meaningfully.

"Good luck then," I said and left for my home.

Postscript:

This is a tale of nineteen seventies. Like all the stories I write in these columns, it is true to the last detail. The 'heroics' I speak of here look so simple, so mundane in the present age. The modern-day neurosurgeon will no doubt have a good laugh reading it. But I speak of a bygone age when we had no CT or MRI, not even good x-ray machines; when there were only general physicians and general surgeons, when we didn't even have an efficient drill to make holes in the skull. There were run-of-the-mill doctors who were good by the average standards, not wanting to take chances. But there also were heroes who looked at an opportunity to prove themselves, to venture where veterans didn't dare.

What about the characters in the story, you might ask? Well, the patient survived and regained full health. He is a middle-aged man, settled in a career, and a happy family. The surgical registrar, who performed the emergency surgery, bypassing the diktat of his superior, is a successful practicing surgeon who would have made it big in Kashmir, except that he was forced to relocate to Delhi during the mass exodus of Kashmiri Pandits. The chief surgeon is now in retirement.

And I am here to tell it all.

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A short stint at Pahalgam

I was the Medical Officer of Primary Health Centre, Pahalgam. It was the only rural posting ever in my career, just for three months from June to August 1964. Yet, that short stint was memorable for many reasons. You couldn't have asked for a better season to be there. Pahalgam was magical, romantic and sublime – the mountains awe-inspiring, the green pastures soothing to the eyes, and the pine woods a climber's delight.

But there are two other attributes to Pahalgam that you don't often see elsewhere. One: the captivating Lidder that forms right in the heart of Pahalgam from the confluence of two freshwater streams one each from the Kolhoi Glacier and the Sheshnag Lake. The river beckons you even before you have entered Pahalgam, and then you never tire listening to its eternal song that backdrops your existence and reaches your subconscious even in your dreams. Two: the beautiful blue sky and the clouds - languid and tantalizing; a poet's inspiration that takes you to Kalidasa's immortal lyric, Meghaduta.

There is a third attribute as well, especially for the devout – the towering proximity of the divine ice lingam inside the Amarnath cave and the most bewitching scenes and spots on the way – Chandanwari, Sheshnag, and Panchtarni – a trekker's paradise, no doubt.

I would never tire sitting by the riverside, or looking across the window, or in the open, at the sky, watching the clouds in their infinite variations, their confluences and drifts, as they materialized from behind the peaks and lingered onto the hills and disappeared as quickly, leaving you wondering at their whims and moods.

My short stay at Pahalgam was eventful. One event is worth recalling. But, before that, a word about my daily routine: The day started with a morning walk into the woods or across the green fields to the historic Shiva temple of Mamleshwara, or up in the villages. Then, a quick breakfast, and an open-air clinic in the sprawling hospital lawns as the Lidder flowed by and the mountains looked on. Sometimes I wondered how people could fall ill in such divine ambience.

At around 1 PM, I walked across the street to my residence for lunch, returning in twenty minutes for the afternoon clinic that lasted until 4 PM. Some patients needed active intervention - suturing a cut or wound, draining an abscess or haematoma, setting a fracture or sprain, or some other minor surgical procedure.

The evening was entirely my own. I would spend it in walks or at the club playing golfing green, or on the bank of the Lidder upstream, or reading. Occasionally, I got to visit a sick tourist in a hotel.

One time, the Civil Surgeon, Anantnag (my health centre was under his jurisdiction) sent me a message that Dr Naidu, Director Health, would be visiting Pahalgam. He gave me no idea about the timing of the visit, nor if it was official or private. We had no phone connections then, and no way to find out the details. Since it was a working day, I asked my staff to spruce up the hospital.

We conducted the morning clinic. I ordered my lunch to the hospital just in case the Director drops in during that period. We finished the second session by four, but there was no sign of the Director.

Exactly at 4:15, I left for my residential quarter. My medical assistant and the orderlies were surprised. “Sir, the Director may come any time; don't you think we should wait for him?” asked Bushan Lal, the medical assistant.

“Look, our duty hours are done. We don't need to wait here. He might have cancelled his visit otherwise he should have been here already. If he does come, he can send for me. I will wait at my residence.”

“Sir, should we close the hospital?” he asked.

“I think we should. If he comes, and if he wants to inspect the hospital, you can open it for him and inform me.”

Bushan Lal lived in his official quarter within the hospital premises. So there was no way he would miss the Director. But I could sense his trepidation when I left.

Around 7:30 PM, Bushan Lal came running to inform me that the Director had arrived along with his family. He had received him at the hospital gate and asked if he should open the hospital. The Director said it was not necessary and asked the driver to proceed to the Club.

“Did he look for me?” I asked.

“Yes, sir. He inquired about you. I said you were at your residence, and that we were all eagerly waiting for him.”

“Did he ask you to inform me?”

“He said nothing, but I feel he may be expecting you.”

I decided not to see the Director. It was evident that he was on a private visit. He had not asked to see me, nor was I bound to meet him after duty hours.

The next morning I went to the hospital as usual and got down to examining the patients. Bushan Lal kept an eye on the road. At about 12:30 he saw the Director's official vehicle driving out of Pahalgam, back to Srinagar. He did not oblige us with his visit. My staff was dismayed, even afraid of the consequences. I tried to mollify them, but that didn't help much. We carried on with our work.

I forgot about the incident except that the Secretary Club came to see me in the evening to express his surprise that I had not met the Director when all the officials were there to see him. Everyone wondered why I was missing. I should have been the main person with him, he said.

"My job is to do my duty. Beyond that, I am a master of my time. I didn't need to see him if he didn't care to ask for me." He was flabbergasted.

That same evening, the Civil Surgeon sent me a message that I should not leave station without his permission. On the following Saturday, I had to go home to see my ailing grandfather. I eschewed the Civil Surgeon's message and left for Srinagar but decided to stop on the way at Anantnag to hand over my leave application personally to him.

"Sorry, Dr Chowdhury, I can't grant you any leave," he said tersely.

"But you can't stop me, sir."

"These are the Director's orders."

"I wonder why?"

"There are complaints against you that you are arrogant with the patients and that you left the station on two consecutive Sundays."

"Sir, arrogance is a trumped up charge. As to Sundays, I committed no breach by traveling home on two Sundays. I believe Sunday is an off day for all government employees. "

"That is unacceptable especially since any State or Central dignitary might visit Pahalgam and need your services."

"It is a hypothetical question. What facilities do we have here for such dire emergencies? Pahalgam is just two hours from Srinagar."

"I am sorry, this is an order."

"But I must see my grandfather. He is not well. Tomorrow is my off day and I will be back on Monday before ten."

"Dr Chowdhury, you are too young and inexperienced with the guiles of officialdom. Why take unnecessary cudgels with the higher ups."

"I did nothing of the sort."

"You didn't receive the Director despite my advance information about his visit."

Finally, he came to the point. I explained the whole episode. Of course, he must have known it already.

"But you should have waited for him at the hospital."

"I am glad I didn't, because he arrived three and half hours after the scheduled closure of the hospital. That is a lot of time to waste. I am sorry, I can't do that."

"But this is government duty."

"Yes, but not slavery."

"It is slavery. You will get used to it by and by."

"Not my cup of tea."

"You will suffer; then you will remember my words." he warned me.

"I will face it, but not deviate from my principles. I am committed to the Hippocratic Oath and the service rules. None of that enjoins me to wait on my superiors

during or after my duty hours. I will give them their due respect, nothing less, nothing more." I said and took the bus to Srinagar.

I got the first taste of my insubordination, as one might call it, when I met the Director in his office a month later to obtain his permission for higher studies. I had received a letter of admission for MD Medicine at Delhi.

The Director refused outright. I knew that nearly a dozen doctors had already been granted no-objection. I named some of them.

"Sorry, I can't permit you. We need you at Pahalgam. This is a busy tourist season."

"How can you pick and choose? Is there a personal grudge against me for something I don't know?"

He looked away from me and said, "Sorry, but you can't go for MD."

"I will go anyways." I said defiantly and left. The rest is history, as they say. I did go for my MD. I was suspended from service and later, dismissed. On my return in 1966, I was reappointed. I lost my seniority in service but it didn't matter, for I got into the Medical College and remained there in various positions until forced into exodus in 1990. I remembered the words of the Civil Surgeon all through my career but never reconciled with his advice. In the process I did suffer, but never compromised my integrity or independence.

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Syndrome of the exiles

(An Evolving Personality Pattern)

Kashmiri Pandits are now in their fifth year of exile. An insidious and well orchestrated programme of marginalization, denial and deprivation in different spheres of civic functioning - social and cultural, political and economic - was launched against the community ever since Jammu and Kashmir changed over from monarchy to 'popular rule' in 1947. Over the years, extremist elements in the populace fanned a cult of hatred and persecution that peaked in the wake of a fanatic upsurge of religious fundamentalism and intolerance in late eighties. Armed militancy and terror followed and changed the paradigm of persecution. Kashmiri Pandits became victims of covert and overt threats to their life, abductions, torture, rape and murder, driving them to seek refuge outside the valley. Scurrilous propaganda accompanied them in their exile, and, as refugees in their own country, they found themselves up against a hostile and tyrannical administration. Even after five years they are battling for sustenance, security and shelter in the face of insurmountable obstacles, harassment and humiliation from all sides. The meager relief of Rs. 250/- per head per month which now has been raised to Rs. 375/- does not come easily and they have to wait long hours in the sun, and face the ire of corrupt officials. The tents are torn, tattered rags. Medicare is in name only. Children and youth are facing untold hardships in their growing up and education. Qualified young men and women are jobless. Traders, orchard-owners and professionals have been rendered defunct because of loss of assets and opportunities. Sick people are dying from lack of resources and care. Older people are counting their days of misery, waiting for final redemption.

A community which has, by and large, been conscientious and hard working to the extent of being labeled as mulish; which was supportive to all, obedient to authority and loyal to rules to the extent of being dubbed servile; which was docile, friendly, accommodative and non-violent in the face of provocation - qualities which were construed as weakness and cowardice - was suddenly thrown into a cataclysm of unforeseen magnitude, wreaking havoc with its sensibilities and psyche.

It is a tribute to the fortitude, resilience, and the versatility of Pandits that they have not fallen on evil ways in the face of crises, not taken to violent means to seek revenge for the genocide, not even harbored hatred for their persecutors, but are fast moving on and trying to adapt to the changed, albeit insalubrious, milieu in which they find themselves. They have remained disciplined and law abiding to the core and are facing with courage and dignity the terrible consequences of lost havens, lost jobs and lost identities. Idleness has been a huge challenge but young boys and girls have not sunk into sloth but gone out whole hog in the search for avenues of self employment. Exile

has been a leveler of sorts and many social aberrations are disappearing fast. As a result, dignity of manual labour has dawned upon the community which no longer feels compunction in taking up any type of job - be it running a pavement shop outside INA market in New Delhi, a vending of cloth on foot or on bicycle, and even fish-mongering in Jammu. In the process, there has been a wide scatter leading to breaking down of large families into smaller, harder-to-sustain, units. As a result a sense of deep insecurity has grown, getting deeper with the dwindling hope of an early return to Kashmir, as more and more of the property left behind by the community is being looted, vandalized and firebombed in the valley or sold for a song. The qualified professionals, technocrats, scientists and scholars have been made redundant due to the criminal neglect of the State and Central Govt. and are wasting away. No doubt, in spite of their adaptive traits, a deep sense of pessimism is seeping in the collective psyche of the community. The premises and perceptions, the outlook and thinking, the beliefs and value systems are undergoing a sea change. A new personality pattern is evolving.

It is this constellation of evolving changes in the personality which includes the psychological, intellectual, emotional and physical characteristics and behavior of the community over the last five years in exile that manifests in, what I call, the 'Syndrome of the Exiles.' It exteriorizes, from time to time as a loss of confidence, a paucity of thought, reduced initiative, lack of energy and drive, failing intellect, lapses in memory, easy fatigability, dwindling physical strength, waning sexual drive and, sometimes, with loss of interest in life, apathy, despair and lassitude and at other times as a feeling of worthlessness, loss of self esteem and even guilt and remorse at having left Kashmir. Negativism and withdrawal dominate the picture in some, while belligerence, argumentativeness and aggression in others. Suspiciousness, skepticism, loss of faith and belief, and fatalism color the psychic mosaic from time to time.

Add to this picture the mannerisms which range from enfeebled voice and dull monotone in speech, a haunted look, a helpless shrug of the shoulders, a twitch of the facial muscles, and a hesitant and stooping posture, to involuntary gesticulations, self talking and absent- mindedness and you get some idea of the syndrome. Mind you, I am not touching in any detail here the psychiatric fallout of terrorism on the community like anxiety syndromes, nightmares, panic attacks, phobias, depressions, post-traumatic stress disorder, psychosis etc. which have seized the community in epidemic proportions. In fact, the evolving syndrome of exiles is the collective result of the physical, psychological and mental trauma to which Pandits have been exposed over the years before, and the insult to injury after their exodus.

As long as we continue to be refugees, as long as we continue to face denial and deprivation, as long as we are the victims of persecution, as long as our fundamental rights as equal citizens are denied to us and we are made to feel like pariahs, as long as the scatter gets wider and wider, we are in danger of a total metamorphosis. That will be

the time that Kashmiri Pandit will become extinct in psycho-morphological parlance. And it will be a terrible tragedy. Can we stem the rot?

Jammu – 14th February, 1994

Post script – We have certainly stemmed the rot. We have passed the fire test and fought off the aberrations in the personality that had crept in during the immediate aftermath of exodus and emerged tough mentally and psychologically. We have evolved into a strong and vibrant community, confident of the present and hopeful of the future.

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The 10th 12th Syndrome

(A psychiatric syndrome in senior high school students)

Young Kashmiri Pandit boys and girls of the age group 14 to 18 years are blissfully ignorant of the terror and mayhem of the last decade of the previous millennium in Kashmir that forced their parents and ancestors from the valley into mass exodus and exile. They were either yet to be conceived, or in the wombs of their mothers or in the arms of their parents and grandparents around that time, with little memory of those turbulent times. Whatever little they know now is from the word of mouth or from what, some of them may have gathered from newspapers or the journals of the community.

Therefore they are not the subjects of the numerous physical, psychological and psychiatric syndromes that have come to be associated with the exiled Pandits. Not that they do not suffer their share of the deprivations and hardships in the camps and in other KP habitations. But, the fact that they have no direct knowledge of the days back home in Kashmir where their parents lived, there is no earlier period of life for them to compare with. For them there is no feeling of loss, material or physical, for they came to live in deprivation from the very beginning. Nor do they suffer loss of roots or of identity, for they struck their first roots in exile and began their identity as 'migrant children'. Nor is there the social and spiritual vacuum, which their elders faced, for they made their debut in life under the flaps of tents or the asbestos roofs of single ten-by-ten rooms to lead a claustrophobic existence. Their stresses are, therefore, different from what their parents suffered - in form, content and in intensity. They are subject to the constraints of cramped existence devoid of basic amenities of life in their camp dwellings and 'migrant' schools.

However, adversities may have their blessings too like the silver linings in clouds. First, these young boys and girls, unlike their parents, are spared the fear and the humiliation of living as a minority in the valley. Second, having lost everything, their parents now invest all their hopes, aspirations and energies on the future of their wards and stop short at nothing to provide them, what they consider, the best possible education and care. Third, while they became pariahs in their own State of J&K and were herded into camp schools, denied admissions in professional colleges and the universities, the other States of India, literally opened the floodgates of the professional institutions, especially in the disciplines of engineering and technology for them. But that is where the blessings stop and a new tragedy begins to unfold.

The strong incentives for admission into professional colleges have led to a race, nay, a mad rush, for these colleges. These children grow under the constant exhortation and indoctrination, to score for the entrance at any cost. Their timetable is all set for the next three or four years according to a pattern, the moment they move into the 9th or

10th class. They are subject to the tyranny of a calendar that allows them not a breathing space for themselves. They breathe and live for and in the books of the curriculum, their hearts beat with the rhythm of chemistry, physics, biology and/or math. There is no other discipline, no other knowledge to be gained.

Their parents or alarum clocks wake them up before dawn to begin their odyssey for the day. They hardly get time for their breakfast and rush to the private tutors before they land in their school, chewing a morsel of food on the way. Going to schools is a mere formality for them, a sheer waste of time and only to complete the mandatory attendance. They are uninterested in what the teachers there have to teach, howsoever qualified and dedicated these schoolteachers might be. That kills the teachers' enthusiasm to teach. It is a vicious cycle and a colossal waste of precious time, both of the disinterested student and the demoralized teacher! They return from the school in the hot afternoon and hurriedly gobble up their lunch to dash to the remaining tutors, three or four in all for equal number of subjects. Therefrom they return famished and fatigued with the sunset. Without a breather, the homework and the rote start. And soon it is night and while the rest of the household is sleeping, they are burning midnight oil. They sleep amid the sheaves of carbon copies or Xerox notes of the tutors.

It is all work and no play. They do not help in the household chores and even if they would like to lend a helping hand or participate in the domestic affairs they are firmly discouraged by their parents. They might be able to steal or snatch a few minutes for their favorite TV serial, movie or the cricket telecast. There are no picnics for them, no recreation, no vacations. In fact, it is during the vacations that they cover the syllabi, months ahead of its regular coaching in their schools. And preparatory to the final examinations there are special coaching sessions in private teaching 'academies' that launch an advertisement binge to lure the students and their parents for the final putsch to make it to the professional colleges.

They do not get time to read a newspaper or a journal or borrow a book from the library. They grow so innocent and so ignorant about life and the world around them. This stereotyped, straightjacketed, tunnel existence of 3-4 years wreaks havoc with the psyche of these young girls and boys, finding expression in a varied symptomalogy for which I have coined the terminology 'The 10th-12th Syndrome'.

In medical terminology syndrome is a constellation of signs and symptoms that falls into a pattern and may be caused by various disorders. The 10th–12th Syndrome is essentially a psychiatric syndrome characteristic of the students of this category, who are in the 10th, 11th and 12th classes. Here age is not as important as the school grade. Sometimes the manifestations start much early, in the 8th or 9th class or even earlier, depending on the stage at which the hard-driving parents decide to introduce the rigors of academic discipline to their wards

While the 10th–12th Syndrome, in some of its manifestations, is ubiquitous in the Indian urban student and has spread like a virus to the Indian Diaspora, it is almost unique in its wide reach and deep penetration in the Kashmiri Pandit students.

Why the Kashmiri Pandit students in particular? These young boys and girls are not only exposed to chronic overdrive in studies resulting in psychological stress over a long period but also a repression of natural drives and urges in their formative and impressionable years. They seek release from emotional conflicts and internal and external stresses through various psychological mechanisms that manifest in various disorders – psychosomatic disorders, behavioral disorders, anxiety disorders including panic states and hysterical conversion, depression, and even personality disorders or a mixture thereof. The symptoms are varied and referable to almost any system in the body. Yet there is a telltale pattern.

The commonest presentation is a boy or girl complaining of unexplained fatigue, weakness and giddiness. Others complain of 'suffocation' or shortness of breath and a smothering sensation, a feeling as if there is not enough air and oxygen available. On the other extreme is a visibly distressed student who is overbreathing with deep and fast respiration that may result in cramps and spasms, dizziness, and faintness - that is hysterical hyperventilation, as we call it. I have seen many of them with these breathing problems being treated as asthmatics. Yet others present with palpitations, or a missing or fluttering of the heart, an uneasy sensation in the chest where the heart is, and chest pain, dryness of mouth, sweating and cold, clammy hands. Many of them have run through the gamut of unnecessary tests and investigations.

Headaches are common, and of all varieties ranging from heaviness to pressure sensation to pain, often brought on by attempts to concentrate on studies, perpetuating their undercurrent of anxiety about academic performance. Nausea, giddiness and insomnia may be associated. Frank migraine headaches may start around this age and are precipitated by late waking hours or going out in hot sun to attend the tuition. Often the students complain of mental block, memory problems, both of retention and recapitulation, and even a fugue state where they lose the awareness of themselves and their surroundings for a brief span of time. Many have been subjected to CT and MRI scans that don't come at an easy price.

Symptoms referable to the gastrointestinal system are common. Nausea, belching, loss of appetite, fullness after meals, vague bellyaches are routine. A few may complain of typical ulcer symptoms of pain in the pit of stomach and heartburn and reflux. Constipation and irritable bowels are not far behind in occurrence. Most of the complaints are the result of erratic eating habits, fast foods, food fads, and lack of physical exercise. Investigations are, most of the times, unrewarding. However, they exclude serious or organic disease and confirm the psychological basis of symptoms in most of the sufferers

Sleep disorder is not uncommon. Often it is insomnia due to anxiety and unavailability of time for sleep, the timetable being so cramped. Sometimes there is 'excessive sleepiness', as the ambitious and overdriving parents often describe it, when it is only the student trying to snatch any available moment to fill in lost sleep hours. It is useful to know that an optimum 7 to 8 hours of sleep is necessary for proper cognitive functioning and that prolonged wakefulness can impair concentration, judgement, and memory and the proper execution of tasks.

Body pains especially pain in the back and neck is common. They are mostly the result of a faulty posture during studies. Very few of these students use a chair and a study table and most assume unnatural and unhealthy postures during studies. Some suffer from pain, fatigue and cramps in the arm due to overuse in writing for long hours with ball point pens that involve extra use of force of the pen on paper if the ink does not flow easily. I wonder how many of them may land with the intractable condition called 'writer's cramp' in the future.

Stooped postures, wan faces and glum looks do not reflect the bubbling confidence, the impetuosity and impatience or the driving energy that should normally define a youth. Nor do they inspire with the spirit of inquiry and discovery that should be the guiding force during these formative years in life.

The long-term fallout of the 10^{th}–12^{th} Syndrome in these young boys and girls are not yet known but I have seen many of them, who finally make it to the professional colleges, reporting adjustment problems there. Some seek a reprieve and a release from their 10^{th} -12^{th} days and fall into bad ways with dwindling academic performance. Others feel disillusioned for having chosen a career for which they had no aptitude. Yet others are subject to phobias, personality and even paranoid disorders. A few cases of frank psychosis have come under my observation. The dropout from the professional colleges is a matter of concern.

In their over-enthusiasm are the parents driving their wards into psychic wrecks, grooming bookworms, telescoping knowledge, creating valetudinarians, sowing the seeds for lifestyle-related and stress-provoked diseases like hypertension, diabetes, obesity, ulcers, irritable bowels etc? The evidence is already accumulating with more and more young executives working in multinationals seeking medical advice for these disorders. They come to me from far off Delhi, Bangalore, Pune, Mumbai, etc. The manifestations are a timely reminder for an in-depth reappraisal of our perceptions and priorities in education.

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The Spell

We swim in the narrow gulf
between life and death;
we are the intangible mirage
of our image in the mirror;
we hover in the twilight
between lucidity and insanity;
we keep flitting for ever
between dream and reality.

(From: "More Poems in Exile" by K L Chowdhury)

...

I rang the bell for the next patient.

In sauntered a familiar face, a woman in her early forties, one of my old patients. Ambling along was a lean and thin girl struggling into adolescence.

"Salaam, Doctor Sahib," her tone was familiar, friendly, respectful.

"Salaam. She must be your daughter?" I asked as they took their seat in the chairs.

"Yes sir, she is Shabnam, the eldest of my three daughters. Why, you should be remembering, you have been treating our whole family since the time you pulled me out of the grave when others had written my epitaph. You also rescued Shabnam from the clutches of pneumonia nearly seven winters back. Of course, she was small then. She has suddenly leaped out of childhood and grown as tall as a poplar; that is why you may not recognize her. How fast these girls outgrow their own mothers!"

"Well that is the way with nature; a tiny seed grows into a big tree. The same is true with kids who grow into adults," I cut her short. "Now, what brings you here today?"

I had forgotten her name but remembered having diagnosed her as a case of Sheehan's syndrome several years back when she was brought to me in a semi-comatose state. Since then she had not only fully recovered but added her whole clan to the list of my patient population.

"I came for her," pointing to her daughter, "look how weak she has grown, how pale and frail. She does not seem to be putting on any flesh; just growing skywards when other girls her age are pink and round and healthy. After all, she has come of age; she will have to go to someone's home one day. Who will accept her as a bride in this state of health? What will people think about us; as if we do not rear our kids properly?"

"Like mother like daughter," I remarked matter-of-factly. "Why don't you look at yourself? She has only inherited your genes."

My patient was a thin and lean woman ever since I knew her, only lately had she been growing a little paunch.

She laughed. “Doctor Sahib, my days are over. At her age I was plump like a pumpkin, pink like an apple, trotting like a mare. But look at her sallow complexion, her wan figure, the ghostly hallows round her orbs. There is hardly any blood in her. That is possibly why she has had no periods for the last three months. I urge her to eat well but she refuses food, does not like her favorite dishes any more, throws up milk; in fact, she has lost her appetite and feels sick every day. If anything, it is pickles and chutney she would want to live on. She used to be docile and obedient but now she has become moody and cantankerous.”

While the mother was racing on and on with the litany of complaints the girl kept looking into her own lap, fiddling with her nails, avoiding eye contact with me or her mother. She was scantily built, rather hungry-looking with sharp shiny eyes and a curved mouth, her breasts barely surfacing underneath her frock. There was no sign of adolescent sensuality and she looked rather remote. If she was far removed from anything it was womanhood and, yet, I was on guard, for, going by the story her mother narrated, I imagined the first stirrings of life within her.

“Do you know her age?” I asked.

“Sir, we keep no records of birth, no horoscopes like you Pandits. But I remember she was born during the war.”

“Which war are you speaking about?” I asked.

“The war between India and Pakistan, when brave Pakistani women piloted Saber Jets and one of them, waving the green flag with the crescent, dived and picked a lotus from Lake Dal as a memento for her country. Shabnam was born during that war.”

She was alluding to the Indo-Pak war of 1965 and it was obvious where her sympathies lay. It was not uncommon to hear such tales of heroism of Pakistani soldiers and fashionable to extol their acts of courage. She might even repeat the commonly held notion of one Pakistani soldier being a match for ten Indians! I shrugged my shoulders for I was more concerned with the history of her daughter than that of the subcontinent and it was fairly certain her daughter was around 16 years.

“Did Shabnam miss her periods ever before?” I asked.

“No, never since they started 5 years ago. There was some irregularity during the first year but never afterwards. I am sure sir, it is nothing but weakness; her blood has dried up for certain. What she needs is a good tonic, something to restore her appetite and to put some flesh on her bones.”

I directed a few preliminary questions at the girl to gain her confidence before examining her. She had never attended a regular school but had some religious lessons at a madrassa. She helped her mother with household chores and learnt embroidery from her. The only recreation she indulged was the game of hide-and-seek with her

sisters during spare time. She replied my questions in low monotones, all the time looking away from me at the floor. She was visibly shy but there was no suggestion of nervousness or guilt in her voice.

I took my time examining her. She was bony but looked fine and there was no evidence of anemia or jaundice. There was a fine pigmentation on her cheeks, or was it my imagination. The examination of her abdomen was normal.

Her symptoms were unmistakable but if she were pregnant there were no tell-tale signs; it was still early days.

"I feel I should get a report from a gynecologist," I addressed the mother after finishing with her examination.

She looked at me in disbelief. To suggest a gynecological examination for an unmarried girl was nothing short of blasphemy. It was not done, for it had terrible connotations. I dared because the family trusted me and would not be offended by my suggestion.

"What will people think if they see me with her in a gynecological clinic? It is better to die than be shamed. Why can't you treat her yourself? I am not worried about the periods if that is what you are asking us to see the gynecologist about. The periods will return once her appetite is restored and her weakness addressed."

I realized it was not easy to convince her about the need to establish pregnancy and do something about it. The days of ultrasound were still away. We had to carry out a urine test for pregnancy, but to send her to the laboratory for the pregnancy test would evoke curiosity with the technicians and raise eyebrows. Rumor travels faster than wind in these climes. Even if the test were negative the very fact pregnancy was suspected would be slanderous. In order to protect patient confidentiality the test had to be carried out in utmost secrecy. I asked her to provide a sample of her daughter's urine for a routine test and to report next day.

Next evening when the mother returned, the report was on my table. There was no mistake; the report was positive. How do I break the news? How do I tackle an unwanted pregnancy in an unwed girl? How do I ensure that this girl has a proper compassionate termination done in a sterile environment, preferably in the hospital rather than landing in the lap of quacks for abortifacients and other antiquated methods of putting an end to the germ of life within her womb or in the operating dungeons of abortionists with barely any idea of the technique or the risk of bleeding, sepsis and death.

I was battling with these vexed questions even as the mother was unaware and unguarded, looking at me for yet another miracle to bring appetite back to her daughter, to fatten her up and make her brimful with blood so it starts flowing again with regular ease every month as before! I had also to think about her other two daughters, who could land in a similar situation unless we knew who the offender was. All these issues

had to be addressed tactfully with utmost steadfastness and sincerity. It is never easy to succeed in such detective work; most of the time the perpetrators go undetected and unpunished.

I decided to catch the bull by its horns.

"I am sorry madam, my fears have proved correct. This report on your daughter's urine has confirmed pregnancy. That is the reason she has had no periods for three months." This was incredulous, offensive, and outright blasphemous.

"Doctor Sahib, it is not true; it just can't be. I am sure you are making a mistake. You saw my daughter yesterday; she is still a little girl. And her tummy, it is flat like the palm of my hand; do you think it is holding a life within? And how can it ever be; my girls are pure like the lotus, untouched by the mud in which it grows, not wet by the water in which it floats. They are incapable of any misdeeds and far removed from sin. Sir, my courtyard is clean; I do not allow filth to gather, rank weeds to grow, and outsiders to pollute it."

"On the contrary it seems some outsider has stepped into your clean courtyard and sown his wild oats without your knowledge," I said all courtesy and compassion. "If it is not an outsider it could be one of your trusted people who visit you. It is also possible your filly may be jumping the fence. There is no mistake, let me assure you. It is in your good to accept the verdict and seek a solution and not doubt what I say. I only speak in your interest. But, in any case, you are welcome to seek another opinion."

"No sir, there is no question of going anywhere else. You are our family doctor and we have implicit faith in you and trust you fully. But I cannot believe my innocent little girl has committed a sin. I will throttle her for it."

"I am not passing a judgment. On the contrary I know your daughter to be blameless and a victim of her ignorance and innocence. The world is full of scheming villains on the prowl, looking for a prey, out to besmirch the purity of innocent girls, to rob them of their girlhood, to violate their virginity, to deflower them and leave them maimed in body and spirit. It is the ignorant and the innocent that get into the trap of these vultures before they know it. If your daughter were a willing partner in this she would not conceive. Every one, even kids know, how to avoid pregnancy these days. The radio, TV and the media are full of advertisements on family planning. I am sure your daughter is an unfortunate victim of great subterfuge by a wily man who has taken you off guard and breached your trust and disgraced you family. Generally such offenders are not strangers but people whom you never suspect of such a heinous deed. Pray do not waste time doubting. Try to find out who did it before the devil lays his hands on your other daughters."

She gave up arguing, convinced of my sincerity and my desire to help.

"I will go and dig the truth and catch the fiend who has heaped ruin on us. My husband will cut off his head as soon as we find him." She was fuming with rage, her small eyes flashing in anger, her tiny hands trembling with nervousness.

As she rose to leave I advised her to exercise great tact in handling the situation. She should not vent her anger on her daughter but approach her with love, understanding and compassion to gain her confidence and extract the facts from her.

She reported again next day bubbling with confidence and a picture of triumph, the fine wrinkles in her face making thin wreaths when she smiled.

"Doctor Sahib, I was sure there is a mistake. I tell you there has been no transgression, no sin. I have taken my daughter into confidence; she has sworn by the Holy Scripture that she is untouched, unblemished. She is still a virgin, pure like the morning dew. I will vouchsafe for my daughters. They are the pride of the neighborhood. People swear by their virtue and their attributes. How can iron rust if not exposed to air and water? My daughters do not go anywhere and I do not allow a stranger inside my sanctuary. Now, please write a prescription for her so that she regains her health."

"I feel so sorry for your faulty convictions. Obviously your little girl has not confided in you. She must be under a pall of fear. I repeat, dear madam, your daughter is quick with life. There has to be a seed sown before a sapling sprouts. There is a man. You have to find him."

My last word seemed to ring an alarm.

"Talking of a man, yes, she did tell me of a man chasing her in her dreams. Eerie dreams and nightmares that frighten her so much she can not recount them properly. She seemed terribly scared when I asked her. I set her fears at rest and advised her to forget her dreams lest they impinge on her real life. But what does one make of dreams; dreams are after all are just dreams. Who believes in them anyway, so far removed from reality that they are. I often dream of making a pilgrimage; have I made it? May be she needs a good soporific to give her a quiet sleep, undisturbed by nightmares? It may be her weakness that makes her so vulnerable to the fancies of the mind, doctor."

"The greatest pilgrimage you can make is to go across the ocean of this mystery. Did you ask her any details of her dreams? Does she remember who the man is that appears in her dreams?"

"Yes sir, it is the same dream every time, she told me, the same man who haunts her, who chases her through a narrow and long tunnel. A naked man! Doctor Sahib, my little girl is too frightened to describe her dream."

"Can she recall the man in real life; how does he look like. Where does the chase end?"

"Well, it is same man every time. A naked man who appears holding a shining sword unsheathed from its scabbard in his right hand. Yet, he is not wild or angry but with a genial face, a benevolent smile. He moves slowly, but inexorably towards her,

mesmerizing her with his hypnotic gaze. When he gets close, almost to a touching distance, she wants to run away but feels paralyzed, unable to move. She can look at him no longer; she shuts her eyes to avoid his gaze and goes into a trance. She remembers nothing after that."

"Can she recognize the man? Any likeness to anyone you know?"

"I did ask her, and she said he had some likeness to Pir Sahib. She was so flustered that I had no heart to pursue the inquiry and waste time in the ramblings of the sleepy mind. After my long session with her she was breathing hard, her eyes closed and her face convoluted in fear as if she were dreaming again. She has become moody these days, vacant and withdrawn most of the times. I feel all the more convinced that she needs a good restorative of the mind and the body."

There was no need for a dream analysis. The beans had been spilled. The story was so devastatingly simple. The Pir had to be stalled. The girl had to be salvaged.

Who is this Pir Sahib?" I asked.

"He is our family priest," she mumbled slowly.

"Do you and your daughters visit the Pir often? Does he visit you house?"

"Yes sir, we have to consult our family Pir on all important matters. That is the practice with our community. But generally I do not allow my girls to visit him except in my company. He is a powerful Pir, having attained special powers through penances and magical practices. He has Djinns at his command that can do anything at his bidding. He may have commanded one of his Djinns to frustrate my poor daughter. I have no doubt now that he materializes in her dreams to frighten and subdue her by his magical powers. He may be annoyed with us for some reason."

How credulous, how simple minded! She was still unable to fathom the treachery of her family priest; his blatant knavery.

"I avoid inviting him to my house as far as possible since we came to learn that he exercised his spell on some girls in our neighborhood," she went on. "He has the power to freeze the blood inside their wombs so it stops flowing every month. There was a young girl under his spell. He froze the blood in her womb, not once but twice. Only he knows how to unclog the blood and restore the flow. The Pir has a long reach and can harm anybody who earns his displeasure. Nobody can escape his curse. It follows a girl wherever she goes, so powerful it is. So revengeful is the Pir that we dare not offend him."

"My poor dear woman, this is no dream. Don't you understand your priest is a vile person, a monster?"

She would still not believe me. She was so utterly confused and crestfallen, neither able to accept the truth that stared her in the face nor reject the faith that had duped her. She left, never to return. And yet there was no doubt about this tragic tale. The pure and innocent virgin growing in a clean courtyard, a dream where a naked man appears and

moves slowly and surely with a benevolent smile and hypnotic charm, unsheathing his flashing sword, coming near and nearer, freezing her under his spellbinding gaze, immobilizing her, subduing her till she remembers no more. And then the blood clots, the monthly flow ceases, the little girl grows lean and thin and pale and loses her appetite and her mental equipoise.

The curse of the Pir has fallen upon many other girls in the neighborhood. This will continue to happen because the innocent girls will be taken off guard and fall in the clutches of this vile beast and the credulous mothers will be frightened of the consequences of his terrible powers.

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Tic Douloureux

(Facial Pain from Trigeminal Neuralgia)

Robin, my older sibling, had arrived from Australia. Friends, relatives and neighbors had come over to meet him. We were basking in the afternoon sun of a late summer's day of 1970, in the lawn of our home, savoring snacks and tea, as he answered our queries about his life and work in the continent down under, which we had only seen on the world map. He had settled down in Wollongong, a small town nearly hundred miles from Sydney. We were meeting after three years and I would feign miss a treasure than the absorbing details of his exploits in his inimitable style - about the mountain and the sea, the kookaburra and the kangaroo, the year-round temperate climate and the university where he taught soil mechanics. But, for a phone call! It was from a colleague, Dr. Tanvir Jehan. She and I had spent a full year together in the same ward as residents in 1963-64, after which she specialized in Anesthesia and I got a postgraduate degree in Medicine. Presently we were faculty in our respective disciplines in the Medical College.

Dr. Tanvir Jehan was calling from the Government Nursing Home at Gupkar. It was about a patient, Mohamed Shaban. He suffered from Trigeminal Neuralgia, a painful condition of the face, rightly named Tic Douloureux because of the paroxysmal jabs of pain that may be so intense as to make the victim to squirm, jump, and contract his/her face as if suffering from a debilitating tic. A day earlier, Mohamed Shaban had sought consultation for his affliction from the legendry Dr. Ali Jan practicing at the high profile Polo View, who sent him across the street to Dr. Sikand for an injection of ethanol (absolute alcohol) into the trigeminal (5^{th} cranial) nerve, that was the source of the pain in the patient.

Dr Sikand, a leading surgeon, had never treated a patient of trigeminal neuralgia because it is essentially a medical condition. He had never injected into the 5^{th} cranial nerve before. Yet, a referral from the doyen of medicine, even when retired from the Medical College, was an order to be complied with, a challenge to be met. But he had no idea how to go about it.

The trigeminal nerve (5^{th} cranial) takes its origin from the brainstem, deep inside the cranial cavity, and runs a checkered course under the surface of the brain, on the bony surfaces along grooves and canals, to a confluence at the trigeminal ganglion from where it branches into three divisions that traverse their own separate intracranial courses to finally emerge on the face from three openings (foramina). From there, the three divisions of the nerve ramify to supply the skin of the face and the mucus membranes (insides) of the nose and mouth. It carries the sensations of touch, pain,

heat and cold etc. from its area of supply. When afflicted with neuralgia, the slightest touch may be so intolerable as to make a patient cry.

Where, along the long course of the nerve, should he inject the patient, Dr. Sikand wondered. When such a situation arises doctors go back to the basics in reference books and journals. He decided to look up Lee McGregor's 'Synopsis of Surgical Anatomy', the bible of surgical anatomy, and asked the patient to report next day to Government Nursing Home, Gupkar where he would administer the injection in the operation theatre under aseptic conditions. Going home, he opened the text to recapture the surface anatomy of the nerve and study the procedure for injection. It was all there beautifully illustrated but the procedure of percutaneous injection of 5th nerve lying deep inside the cranial cavity seemed very daunting. It called for a lot of measurements and demarcations on the outside to localize the nerve and its ganglion within the skull before one could direct the needle to the precise location. He did not feel he was up to the task. Since he had asked the patient to return next day all the way from Tangmarg, it was a matter of prestige and commitment. He decided to seek the help of an anesthetist. Anesthetists are trained in giving nerve blocks during various operative procedures. That is how Dr. Tanvir Jehan came in the picture. But she too had never given a trigeminal nerve block, she informed him. "I have looked up the surface anatomy from McGregor. Let us try it; the two of us together can sure work it out," he had reassured her.

Mohamed Shaban arrived duly next day. He was ushered in the operation theatre and seated on the table. The two doctors started with the surface markings after consulting the 'bible', drawing lines on his head like a draftsman, using the measuring tape like a tailor, and discussing the route and direction of the injecting needle like two drillers looking for a mine. There was a debate as to how deep to go and an apprehension of the needle hitting a wrong target, and alcohol causing permanent damage to a sensitive area of the brain. It was essentially a blind procedure and the whole thing looked even more difficult than opening the cranial cavity and injecting the nerve under direct vision.

What were these doctors up to, Mohamed Shaban wondered. Two years earlier it had taken a doctor just a few minutes to give him the nerve block and he had performed the procedure in his own chamber and not in an operation theatre. But he had forgotten his name. What were these elaborate measurements and discussion all about this time? He sensed that the two doctors were in some sort of a predicament, and he would not allow himself to be subjected to a wild adventure. He believed the redoubtable Dr. Ali Jan could not err in referring him to the right person, but something now seemed greatly amiss. And he must speak out.

"Excuse me, Madam; I would like to inform you that a young doctor working with Dr. Ali Jan gave the first injection into my nerve two years back. It took him just a few minutes. It was a simple. He introduced the needle on my cheek and not in the temple

where you are drawing the lines and taking measurements. When the pain returned and I sought Dr Ali Jan again, I reminded him about the injection his subordinate gave me last time, but he could not recollect him since he has retired from the Medical College. When Dr Ali Jan sent me to you, Dr. Sikand, I thought you would do it in your consulting chamber like the earlier doctor who gave me the injection in his own chamber in the hospital. Instead, you called me here in the nursing home and I believed you would perform a different procedure to give me permanent cure."

That sent the two doctors thinking. They would not venture into an off-beat tract when the previous approach had been so simple and direct. Who could the young doctor be?

"How did he look like, this doctor who gave you the nerve block? Which year was it?" Dr. Tanveer asked him.

"It was in 1968 in ward 3 of the hospital, in the doctor's chamber. He was about thirty, medium height, with hairs curly and receding from the temples. I remember he was a Pandit."

That clinched it. I was the only Pandit doctor who had worked with Dr. Ali Jan in 1968.

"It is Dr. Chowdhury, for sure," Dr. Tanveer blurted out, "let us call him."

That is when the phone rang and she explained her predicament and asked if I remembered the patient. Yes, I remembered having given the injection to a patient once, I told her. It would be a favor if I came along and helped her out of the situation, she pleaded. She was not in a mood to try it on her own when I offered to give her instructions on the phone since my brother had just arrived from Australia.

I had no heart to disappoint a lady in distress. That would be most unchivalrous. For old time's sake I could not say no, especially to a delicate lady, who though sharp in tongue was soft at heart. She had been nice to me during that formative year when we worked together, and there were many moments to share over cups of tea she made so readily for us during lunch breaks.

I excused myself, and left my brother with the fawning crowd around him, looking at him as if he had descended from the other world. I asked him to reserve further anecdotes and episodes till I returned.

Gupkar Nursing Home was just a couple of miles from my home in S P College lane. I was there in 10 minutes. The patient's face beamed with recognition and relief on seeing me. I remembered him well. He hailed from my favorite week-end retreat, Tangmarg, a pretty hamlet seven thousand feet above the sea, on way to the famous Gulmarg resort, with the Ferozepur stream gushing down on the left and the dense pine forests on the right. Sometimes I wondered how the denizens of those celestial places, where fairies danced, angels sang and gods resided, could suffer such painful conditions; even how they could die like other mortals!

Mohamed Shaban was the only patient I had ever given a nerve block in the trigeminal. That time also he had sought Dr. ali jan's consult who had directed him to report on a Tuesday when we held the neurology clinics in my chamber in ward 3 of the Medical College. I was the medical Registrar (chief resident) with an aptitude for Neurology. Dr. Ali Jan, my Professor, recognizing my interest, granted me the privilege to conduct, what came to be known as, 'The Tuesday Clinics' which he blessed with his august presence. We had taken the decision to try absolute alcohol injection into the 5th cranial nerve of Mohamed Shaban since he had not responded to the drugs available at that time. Those were still early days in neurology. There were hardly any drugs for this painful condition. Phenobarbitone and phenytoin gave relief in some. Others took recourse to codeine. Carbamezapine, the wonder drug, was still a few years away. Not only do we now have an array of new drugs for treatment of Tic Douloureux - from Carbamezapine to Gabapentine - but we also have the MR imaging techniques so advanced and perfected as to provide exquisite 3-D images of the ganglion and the nerve inside the cranium which can be targeted fairly accurately for surgical procedures without opening the skull, through thermal and radio-surgical destruction of the nerve (Percutaneous Stereotactic Differential Radiofrequency Thermal Rhizotomy and Stereotactic Radiosurgery using a gamma knife).

But those were different times. The best option we had in patients with intractable facial pain was Alcohol injection to destroy the 5th nerve. I even remembered that the patient had procured a vial of absolute alcohol from the department of Chemistry of S P College for Boys, since the chemical was not sold from chemist shops. I had injected it into the second division of the nerve. But peripheral nerves, unlike the neurons in the brain have the potential to re-grow and re-innervate at a rate of approximately ½ mm a day. There was always the likelihood of a relapse within a year or more even after alcohol injection. Mohamed Shaban too had relapsed.

"So how are you doing, sir?" I asked him as he grasped my hand in gratitude for the previous service rendered and the service about to be provided." He was around fifty with short stubble and wore a fur cap, a short waistcoat over a shirt and *shilwar.* He was in pain.

"After you gave me the previous injection I did well for one and a half year. Then the pain started coming back - mild and occasional to begin with but getting more intense and more frequent every day. Even light touch causes me to wince now; food in my mouth evokes severe pain and chewing is out of question. I cannot shave nor can I wash my face; even a soft breeze blowing in my face is like a whiplash and I hide my face in my *pheron*. The pain is burning, pricking, stabbing and lancinating at different times. It comes and goes on its own and leaves me tired, sleepless and depressed."

"Can you trace the painful area with your finger?" I asked him and, without touching his face, he pointed out the area between the eye and the mouth, including the middle

portion of the cheek, the side of the nose, the lower eyelid and the upper lip on the right side – area supplied by the second (Maxillary) division of the trigeminal nerve (5th cranial).

I looked for trigger spots by lightly touching or tapping in the specified area, and there were quite a few. Then I turned to the two doctors.

"We will inject the Maxillary Division of the nerve (second division) inside the infra-orbital foramen. That is what I did two years ago."

I marked the junction of the medial (inner) and intermediate thirds of the supra-orbital margin (the bone that overhangs the orbit) and drew a line from here down to the lower border of the mandible. The infra-orbital foramen lies about 1 cm. below the margin of the orbit which I marked with a dot as the point of entry. I filled a syringe with I ml. of a local anesthetic and another with ½ ml of absolute alcohol. Directing the needle with the local anesthetic from the point of entry into the tissues till it hit the bone I moved the needle tip around to push it through the foramen. When I got there I introduced the local anesthetic. I tested with a cotton wool and a pin. The area under our scanner became anesthetic to touch and pinprick which confirmed that the nerve had been targeted. Leaving the needle in place I now injected absolute alcohol from the second syringe. The whole procedure took ten minutes.

"What you were trying to inject is the main trunk of the nerve inside the skull. I have never attempted that procedure nor does he need it. If the whole face were involved it would be justified. But here we had a simple solution since only the second division of the nerve was affected." The doctors thanked me profusely.

"It was so simple, so commonsense," Dr. Tanveer said with great relief.

"We were off track, because we did not take a proper history. It was a humbling experience," Dr. Sikand acknowledged with humility and I hurried back to hear more of my brother's adventures.

But it was the patient who pronounced the last judgment when he came to my house after a week to say thanks: "When doctors do not know they should be honest and say so, rather than make a patient pay for their ignorance," he proclaimed.

I explained that the practice of Medicine was not like solving a simple mathematical equation. It was a science that called for experimentation and an art that had to be perfected and re-perfected through innovation. It needed determination, dedication and daring from its practitioners and patience and sacrifice from the patients. That convinced him that the two doctors were only trying their best and in his interest.

He continued to see me and received some more injections down the years till I had to leave the valley. I miss the gift of the best apples from his small orchard which he would bring every fall.

Pain

The phantom stalks all the time,
now lurking in the shadows,
now only in the mind,
now seizing hold -
inflicting itself on me
with unerring constancy.

With its invisible armory
it pierces and bores,
crushes and grinds,
saws and hammers,
cuts and tears,
burns and sears,
and delivers lightning bolts,
any place of its choosing,
now forewarning,
now catching me unawares.

From 'A Thousand-Petalled Garland and Other poems' By K L Chowdhury. Published by Writers Workshop, Kolkata.

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What difference does dress make?

Does it matter what dress I wear
So long it is clean
and my conscience clear?

What a doctor needs is a soft touch
A sweet tongue, a patient ear
A strong intuition, a quick insight
And an eye that sees far and near.

Hippocratic Oath is my moral code
Medical texts my scripture
The patient my laboratory
The hospital my house of prayer.

From 'More poems in exile' (unpublished)
By K L Chowdhury

Barbarshah Bridge and Barbarshah Road are the life line between the ancient and the modern city of Srinagar. They link Sathu and the rest of downtown with Regal Chowk, Residency Road, and Amira Kadal - the bustling 'civil lines' and heartthrobs of the city. It was into a cul-de-sac from Barbarshah Road that we moved house from Rajveri Kadal in 1962. The site was just ideal for a home, being the junction between the old and new city and, yet, a retreat flanked as we were on two sides by the sprawling lawns of SP College from where with the foliage of huge Chinars overflowed to our backyard. Across the road is the famous Ramji temple and, further away, near the bridge, the mosque from where the morning bells and the call of the muezzin, respectively, would float gently into my bedroom in perfect accord and harmony.

Barbarshah Road was also called the 'love lane' not because lovers would pass by hand in hand like they do now-a-days, but because it brought streams of students from the old city to the two premier institutions of Kashmir, the S P College and the Govt. College for women. They buzzed on the street in the morning when the institutions opened and in the evening when they closed. Girls walked in their own groups and so did the boys, desiring and eyeing each other discretely but hardly ever speaking or walking together. There was love in their hearts - unexpressed and unrequited - not that an occasional eve-teasing incident did not occur.

I graduated the same year as we moved to Barbarshah Road and began my professional career from there. Being centrally placed, I was quite accessible to patients. I started with my own relatives and friends who put implicit faith in me and it was they who, by word of mouth, were instrumental in building my practice. Charity begins at home and so did my practice of medicine on my own people.

It was the winter of 1979. By then I was an Assistant Professor of Medicine in Medical College Srinagar and fully established in practice. It was snowing lightly on a morning. I was home, enjoying my winter break of six weeks from the Medical College and sipping a cup of tea when an uncle of my mother stepped in, panting and puffing. He was a patient of chronic bronchitis and asthma. He dusted the snow off his umbrella, left it in a corner on the verandah and sat on a chair by my side, visibly breathless. It took him time to collect his breath, inhaling it with all the effort of his chest, neck and shoulder muscles and exhaling it in white streams from his pouted mouth, blowing out his cheeks and flaring his nostrils with every respiratory excursion. Though he lived across the bridge in Sathu Payeen, less than a half mile away, he should not have come out in snow. I told him so.

"I have not come for myself; I am doing fine with the medicines you have prescribed." He managed to speak through pauses and breaks. "But, I would like you to come with me right away."

I did not like to be disturbed on this halcyon morning, the dulcet grey sky sending down swarms of snow flakes which danced and landed softly, noiselessly on every conceivable object from rooftops to trees to bushes to lawns to fences to walls to eaves to verandahs to porches to window panes – slowly changing the landscape into a fairyland. I wondered what had brought my phlegmatic, asthmatic granduncle early in the morning if it was not concerning himself.

"Please, pick your bag and come along," he said in a plaintive, yet confidant tone.

He knew that I did not like to go for home visits. But this must be a desperate situation and it was difficult to say no to him for, Gopi Nath Khan, as was his name, was a fond cousin of my mother. She would often recall wonderful memories of her childhood spent in his house. When she lost her mother young, Gopi Nath and his wife stepped in to fill the void. Being older, he was more like a father than a brother to her and she revered him. If he asked a little favor I had no heart to deny him, neither the nerve, even as he asked it on that snowy morning when I was looking across the window re-living the snowy memories of my own childhood. I was planning a snowman with the help of my little daughters who were also home for the winter break.

"Where are we going in this snow?" I ventured to ask.

"I will tell you on the way. Come along as you are; you do not need to change your dress."

I was wearing my Pheron, a Kangri keeping me warm under its broad span. I did not mind his suggestion to visit the patient in the casual dress I was wearing; I was in a hurry to go out in the snow and leave footprints on the virgin white path before the morning strollers spoilt it. I picked my bag in one hand and umbrella in the other and we both set out.

"You are going to examine Nila Kanth. You know him; he has been ill for quite some time. A couple of doctors have visited him and prescribed medicines but he is making no headway. He asked me yesterday to bring the best doctor of the town to examine him and I could not think of anyone better than you."

Nilkanth was an old bachelor living a reclusive life in the outhouse of Gopi Nath. He had nobody to call his own. His sister, Rajreni, who was Gopi Nath's aunty, had invited him to live with her in the outhouse after her husband's demise. Rajreni lived only a few years after that and Nila Kanth was left on his own. A court case was hanging fire for many years between Gopi Nath and Nila Kanth regarding the outhouse to which Nila Kanth now claimed ownership. But that did not stand between the two when he took ill and was not able to fend for himself. Gopi Nath and his family took upon themselves the moral responsibility to feed him and look after him. They brought doctors and medicines.

We walked along the snowy path up the Barbarshah Road. I made a bow near the portals of the temple, invoking lord Ram to grant me the healing touch. The canal under the Barbarshah Bridge was a pretty ribbon adorned on either side with Dongas with white sloping roofs. Snow flakes came down in swarms dissolving in placid water of the canal like lovesick creatures on a fatal tryst. The street shops were still closed. It was a difficult walk because of my companion with whom I labored to keep my pace slow. Speaking with me, while we walked, made it more laborious for him.

"Some years back you advised me to move to the plains during the winter months because of my asthma. Since then I have been going to Jammu every winter from December to March. It is already 16th of December this year but Nil Kanth is holding me back. We cannot leave him behind to die. Please do something to revive him enough to be able to travel with us to Jammu. If I do not move to the plains I may not last the winter."

Nila Kanth was crouched in a bed on the floor, almost invisible under a huge quilt and three blankets, a skullcap worn down on the face to just allow a glimpse of his slit eyes that were glued with exudate, fish mouth that was bluish from cyanosis and nostrils that flared in and out with respiration. I took my place by his right side. On the left, Gopi Nath, removing a Kangri from under the layers of his coverings, spoke in his ear: "Nila Kanth, I got you the best doctor. Now tell him all your problems."

Nilakanth lifted his bent head with difficulty and we supported him with cushions behind his back. He was barely audible; his words came out slowly, haltingly with a nasal twang from an un-repaired cleft palate. That might have been one of the reasons

for his lifelong bachelorhood, even when his menial job would qualiy him for a spouse. He was short in stature, bent in his back, hard of hearing and breathing hard from the mere effort of speaking. He strained to open his eyes into a narrow chink, peering at me and trying to speak from behind a grizzled beard and emitting foul odor, the yellow of turmeric from a previous dinner staining the angles of his mouth. He complained of fullness and loss of appetite, breathlessness and loss of sleep, restlessness and loss of strength. Examination revealed that he suffered from an advanced heart failure from hypertension complicated by chronic bronchitis, asthma and anemia. His legs were swollen, pressure sores forming under his heels and buttocks.

I wrote out a prescription and asked my leave. The return walk home at my usual brisk pace was a treat; it took me just seven minutes. I forgot about the patient as I got down rolling snowballs to fashion a snowman out of them with the help of my children.

Next morning was clear. A bright sunrise, piercing through the mesh of Chinars, started flirting with the snow, thawing it with the warmth of love, dripping it from the roofs, raising little spouts as drops fell down in small puddles on the ground below the eaves. I was lighting a fire in the saw-dust heating stove in our family room when Gopi Nath Khan announced himself again with his guttural cough and a gruffly good morning.

"I am so sorry to bother you again, but you will have to do an encore."

"But why?" I was puzzled and irritated.

"You know, I made a mistake asking you to visit Nila Kanth in your pheron yesterday. After you left, we got the medicines from the pharmacy but he refused to take them. 'I have not heard of a physician in a pheron,' he was sarcastic as he fished out the pass book of his post-office savings account from his shirt pocket and tossed it at me. 'What use my savings if they can't fetch me a good doctor?' Please save me from a difficult situation; I will feel guilty if he dies unattended and uncared."

"Oh, I thought he seemed too ill to notice my dress and bearing. In any case, does it matter what dress I wear? And, if I visit him again, don't you think he will recognize me? Please try some one else?" I suggested some names.

"Yes, it now seems to me that it does matter what dress you wear. I beg you to visit him again; for my sake. You will have to put on your jacket and trousers, sport a necktie, and don a hat. Please do it for me; I will never ask you again." He was very earnest.

I had no choice. I changed into a professional outfit and went visiting again. Nil Kanth was told that I was a foreign-trained doctor who had worked wonders with patients. He got animated. Collecting his last shreds of energy, he waxed satirical in his dry, quivering, halting, nasal voice, about how a novice had visited him the pervious day and how he had flatly refused to accept the drugs for he valued his life more than money and would not be mismanaged by a quack in a pheron masquerading as a physician. He did not elaborate on his problem but spoke about Dr. New and Dr. Wasper, two missionary doctors who revolutionized the practice of medicine in Kashmir, Dr. Gwashalal Koul who

introduced quixotic forms of therapy, even one time giving a good thrashing to a patient as an antidote to poisoning, and Dr. Alijan, the living legend and a household name.

After a brief examination of the patient I rewrote the previous day's prescription. Gopi Nath Khan walked with me back to my home, much against my admonition. He was a bespectacled sick old man, baldish and slightly built, wasted in the cheeks and temples, stopped from advanced respiratory illness, barely managing to walk and talk simultaneously. But he had questions to ask.

"I know he is quite ill and will take time to rally and recover. Yet, there is no way I can postpone my departure to Jammu. I am already late by two weeks and feel the pressure in my chest after yesterday's snow fall. Can I stand the frost and the cold winds that will follow? I want to take him along with us? That is our only option. Do you think he will make the journey?"

"No, he won't. I do not think he will cross the Banihal tunnel," I said in a reflex even before he had completed his question. It was not a considered opinion; it just came out in a flash. This was not the first time I surprised someone with a fatal prognosis, without a second thought, when asked how long a patient would survive a terminal illness. One time, a patient of heart block was admitted with me. He would go into repeated cardiac standstill and we revived him every time. He stabilized and his attendants thought it was time to take him home since he had had no attacks for a full week. The patient lived nearby at Nawab Bazar and they would bring him back if the attacks recurred, they said. I could not persuade them to stay on and when it was time to take leave they thanked me for all I had done. I made a passing remark: I hope he crosses the Nawab Bazar Bridge alive. The bridge was only a half furlong from the hospital. We were still with our ward round when they brought him back hardly after twenty minutes. He had sustained another cardiac arrest while crossing the bridge and they had returned midway from the bridge. But it was too late!

A second time, my brother-in-law brought with him his landlord from Shopian where he was posted as an agricultural assistant. I diagnosed terminal cancer of stomach and asked my brother-in-law to take him back for it was no use wasting time and effort when he should be spending his last days with family.

"I live in the room directly below him and he groans with pain for the whole night. I can't sleep a wink. Can you do something to relieve his pain, please?"

"I will write an analgesics but he won't have to suffer long."

"How long?" he asked

"Three weeks." It was not a calculated answer, nor a prophecy, just a flash. The words come out even before they were formed in my mind.

It was exactly twenty one days later that the patient departed for the other world where there is no pain, no loss of sleep.

There have been many incidents of this unintended, reflex prophesying. And yet, there are numerous occasions I retort back that I am no soothsayer, or astrologer, when asked how long a patient is going to take to complete his mortal journey.

This time, however, Gopi Nath Khan did not heed my pun. Armed with my prescription and spurred on by a marginal improvement in his patient, he boarded a bus to Jammu along with his wife, his son and his patient. The overdressed patient was laid down on two seats booked for him, and draped from foot to face with a heavy blanket, warmed with a Kangri. The driver, who raised a minor objection to carrying a sick patient, was told that he was not as sick as he was weak. The fellow passengers asked questions which were duly replied about the nature of his illness, the treating doctor, the drugs, the food he could take and the reason they were traveling. A good bonhomie was established and the bus trundled and labored along the road disfigured by ditches and potholes. The temperature had dropped to 10 degrees Celsius and it got colder as they reached Anantnag and on to Qazigund. Gopi Nath and his family spoon-fed their patient every hour with warm tea from the thermos, speaking loud in his ear every time. The passengers showed lot of concern and sympathy. Soon the bus negotiated the curves to gain the heights of Lower and Upper Munda and reached the tunnel. This was the end of the valley. Gopi Nath was happy that they would cross the tunnel in another ten minutes to be on the other side on their way to Jammu.

The tunnel was dark, the temperature dropped another degree and the bus took a somber look. My parting words suddenly rang an eerie note in Gopi Nath's ears. No, I had just spoken at the cusp of the moment and could not be serious, he reassured himself. Besides, the journey had been quite uneventful till now. He collected his thoughts and asked his son to keep a watch on Nil Kanth as they trundled along.

As the bus reached near the middle of the tunnel there was a sudden gasp from the patient. Gopi Nath's son, who was occupying the seat near him, bent down to see. Nil Kanth had stopped breathing. He put his fingers on his pulse but could not feel any flow of blood. He became nervous and whispered in the ear of his father, sitting across the isle. Gopi Nath's heart gave a thud. He had blundered. He had not accepted medical advice. He was responsible for this catastrophe. The passengers would get very upset and angry. The driver would get mad; he had made inquiries at the time of their boarding and now might force them to disembark. All these thoughts rushed and he thought out a plan. He counseled caution and silence and admonished his son against breaking this news to any passenger and to play the farce of speaking in the ear of the dead person from time to time.

Soon light appeared at the other end of the tunnel and they were on the road again. It was bright outside like Nila Kanth going to a world of new light! The passengers asked the welfare of the patient. Gopi Nath's son spoke in the ear of the dead body.

"Why does he not make any sound?" one of the passengers asked.

"He is fast asleep; I think we should not disturb him," the son replied.

But Gopi Nath's wife sensed trouble looking at the pale and frightened faces of her son and husband. Gopi Nath told her to shut up and not create a ruckus. She could wail and weep after they reached their destination. Till then no tears, no sobbing, no crying, no browbeating. The lady choked herself with grief but did not utter a sound. The bus kept moving.

It was all a charade from there onwards. They kept on mumbling nothings in the patient's ear, 'would you care for some milk, would you like to eat a biscuit, what about some orange juice?' and so on, and then to the passengers, 'he says he has no appetite and would like to be left alone.'

When it was lunchtime, the passengers wondered why none of the family ate anything. In Hindu custom, you do not eat till the last rites of the dead are performed.

"We are full from a heavy breakfast. Bus travel makes us sick, so we keep to tea and water. The patient is not hungry. He felt very cold and wants to sleep undisturbed."

But the proximity of a dead body and choked emotions got the better of the family and they decided to get down at Udhampur where they had a relative who could be depended upon to help in the cremation. By the time they reached Jammu, another 90 kilometers away, it would be dusk and they would not be able to perform the last rites till the next day.

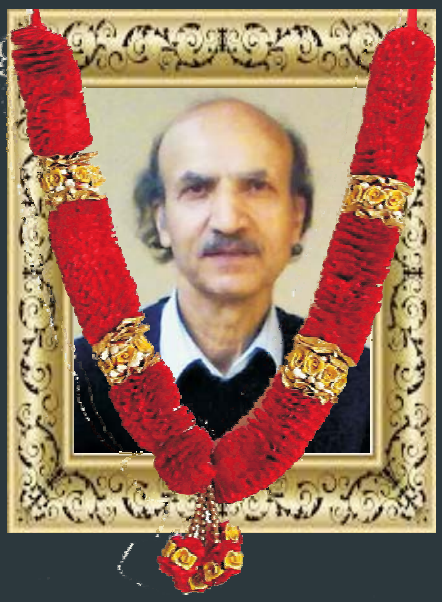
When the bus halted for a break in Udhampur, they announced the sudden demise of their patient. Lady Gopi Nath started beating her chest, crying aloud, weeping for the departed. Gopi Nath and son maintained their composure and asked the driver to deliver their baggage. The passengers were awe struck; they sensed that death had taken place much earlier but empathized. The driver and his conductor remarked that next time they would not be duped into allowing a dying passenger on board.

Cremation took place the same day with the help of their relative in Udhampur. After a couple of days the ashes were immersed in the stream that flows in the town and the family moved on to Jammu to spend the winter there.

My change of dress to a formal wear did not matter in the final outcome of the patient.

❑❑❑

Shraddhanjali



Dr. Kundan Lal Chowdhury
1941 - 2021

Heartfelt Condolences from Praagaash