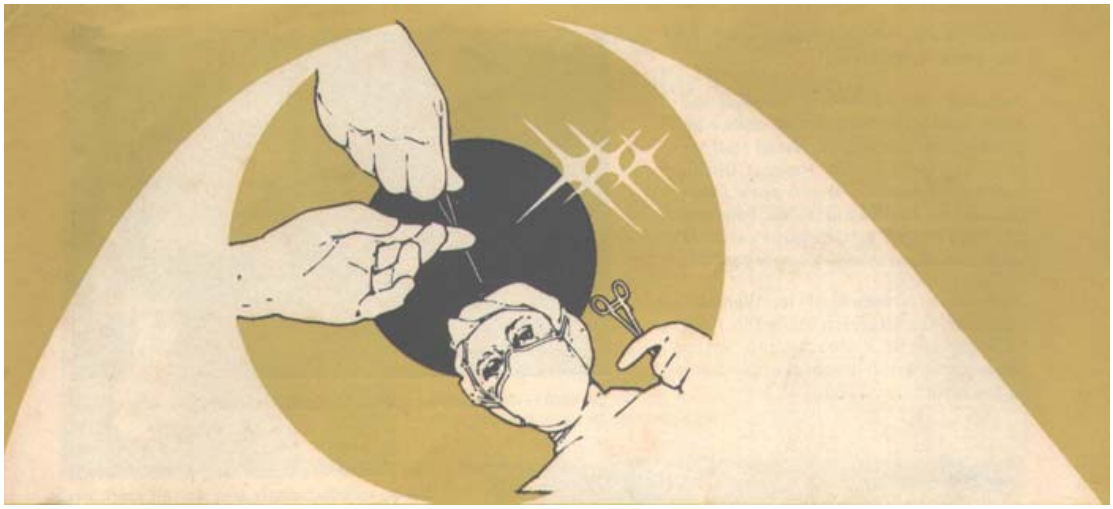


NETHRALAYA INSIGHT

VOL. I **No. 3 JULY 1984**

HOUSE JOURNAL OF MEDICAL RESEARCH FOUNDATION, MADRAS, INDIA

Six months have gone by and a moment has come for introspection and to think back on our activities.

Dr.Eva Kohner Addressing us during her visit for Sankara Nethralaya

Dr.Eva Kohner's visit to Madras and particularly to Sankara Nethralaya heralded a very eventful near. Her oration on "Diabetic maculopathy" organized by the diabetic Research Centre threw open many significant and important aspects of Diabetic Retinopathy. We at Sankara Nethralaya were particularly happy to have her one evening and share her views on the Management of Diabetic Retinopathy.

The "Vision Research Foundation" which came into being on 15th December 1983 has opened new projects have been submitted to the committee which have been approved and work in these directions are going on in full swing. With a scientific committee comprising of

renowned scientists to help and guide us, we have no doubt that more and more basic and clinical research would be possible in the near future.

In the academic field, our consultants have been busy giving guest lectures at Kerala and Karnataka. In a recent post graduate refresher course in ophthalmology held in Bangalore, five of us participated. It was good to share our views and learn from the other lectures which were both academic and practically oriented. In yet another conference at Malampuzha gardens, Kerala, Dr Badrinath addressed the Kerala State Ophthalmic Society on “Anterior pars plana vitrectomy procedure.” The peaceful andsalubrious air of Malampuzha was indeed a superb treat to all those gathered there for the conference.

Dr.H.Ganapathy and his team rendering the ENT Examination

The moment of utmost joy however came a few weeks ago where we learnt that our President Mr. Mohan Rao, was awarded the ‘Dhansheela’ a title was rightly bestowed upon him by the All India Vysya Community, Davangere at their annual meeting. Mr Mohan Rao, is really very close to each and everyone at the foundation and his dedication and devotion to the hospital is incomparable. If the foundation is, what it is today. We do know it is as a result of his selfless service. We are truly honoured and proud. A small party held in our terrace given by the entire staff followed to felicitate Mr. Mohan Rao on this great occasion.

Medical Research Foundation is slowly gearing itself towards modernization in all fields besides instrumentation and surgical techniques. Computerization of Medical records and the out patient department will be introduced this month. This large step ahead, will indeed help us to streamline the growing demands of the out patient population and will help to a large extent in maintenance and storage of medical records.

Mr.Mohan Rao being Felicitated by Mr. Narayan Guptha –looking on is Dr.Badrinath.

As a token of our appreciation to all the employees of the foundation and for their dedicated service we intended to conduct a health check up for the children of all our employees. It comprised of a composite health screening programme and included eye check up, ENT, paediatric, dental, mass minature X-rays and laboratory tests. The enthusiasm and prompt acceptance by our colleagues in the other fields of medicine was most encouraging. The one day check up helped us evaluate the health of the children and advice them adequate treatment when required.

Ophthalmic checkup being done by Dr.S.Natarajan

Dr.Nandhini Hasan giving a complete Paediatric Examination

We are truly grateful to Dr.Hampton Roy of World Eye Foundation, Little Rock, Arkansas, USA for having come forward to send us 25 copies of the American Academy of Ophthalmology. Basic Science Series. These excellent books have been distributed to the various ophthalmological education centers in India with a primary aim of integrating modern ophthalmological teaching and training in our country.

Finally we are extremely grateful to you readers, for your letters, ideas and suggestions and we do earnestly solicit your continued interest and constructive criticism.

Mary Abraham

Editor

Endodrainage of Sub Retinal Fluid

Dr.S.S.BADRINATH

Sub retinal fluid can be drained internally through a retinal break. It can be a simple endodrainage or combined with fluid gas exchange.

Endodrainage is done under microscopic control. Endoillumination through one of the sclerotomies and a contact lens for viewing the fundus are essential accessories. Saline or Ringer lactate is gravity fed into the vitreous cavity through one of the sclerotomies.

Following sub total vitrectomy, extrusion needle introduced into the eye through one of the sclerotomies, passes across the vitreous cavity and through a retinal break into the sub retinal space.

As sub retinal fluid is thus internally drained, the retina settles down reattaches and the vitreous cavity volume increases with saline filling it. This is simple endodrainage.

1.It should be in an accessible location , for example, inferiorly in the region of the equator.

2. It must be large enough to admit a 23 gauge needle.

3. Ideally it must be located in the most dependent part of the fundus.

Retinal breaks not suitable for endodrainage are :

1.Those located very far anteriorly in the region of the ora.

2.Tears located on the previous buckle.

3.Tears in the upper part of the fundus between 10-30 and 1-30 meridians clockwise.

Clarity of the media is imperative for proper endodrainage. If the corneal epithelium is oedematous, it must be removed. If the lens is cataractous it can be removed either by fragmentation or by conventional techniques. Presence of a thin film of blood on the anterior surface of the lens, due to hypotony induced hyphaema, hinders effective endodrainage.

Endodrainage is performed only after sub total vitrectomy. Strands of vitreous attached to the retina adjacent to the retinal break tends to get embrocated, at the inner end of the extrusion needle. If the needle is moved by the surgeon not aware of such an entrapment of vitreous, traction on the retinal results and leads to formation of new retinal breaks or enlargement of the old one. Vitreous must be cropped as short as possible near the endodrainage site, particularly from the operculum of the horse shoe tear or surrounding the lattice degeneration.

As the retina settles down, the red glow of the fundus visualized through the microscope gradually improves. The fundus is grey white in colour when the retina is detached and pink in colour when the retina is reattached. The marked difference between the two is easily observed during the endodrainage. As the retina is reattached, the choroidal pattern through the transparent attached retina becomes visible. Sub retinal fibrotic bands in longstanding detachments are also noted.

Schliren:

When the extrusion needle is placed just in front of a retinal break and suction is applied, sub retinal fluid which is straw yellow colour is drawn through the retinal break to the tip of extrusion needle and an optical phenomenon called schliren is observed. The difference in the optical density between sub retina fluid and the fluid in the vitreous cavity causes this oil slick like phenomenon known as schliren.

Demonstration of schliren confirms the presence of a macular break in suspected cases. If schliren is a absent, it means that the lesion observed is not a true macular hole and probably is a cyst or a lamellar hole.

If there are multiple retinal breaks or if the retinal break is a large one, such as, giant tear, simple endodrainage does not work to reattach the retina. The sub retinal space continues to remain filled with fluid. In such situations one has to resort to fluid gas exchange.

Fluid gas exchange :
Air is injected through the infusion sleeve by means of a 50 cc syringe or a mechanical gas injector.

Air is injected as fluid from within the vitreous cavity and sub retinal space is evacuated by the extrusion needle.

To begin with the tip of the extrusion needle is placed over the optic disc. As suction is applied, fluid from the vitreous cavity is removed, through the extrusion needle and the injected air fills up the upper part of the vitreous cavity.

As air fills the vitreous cavity, it floats upwards pushing the iris diaphragm forwards.

To see the structures in the posterior vitreous cavity, besides the microscope and endoilluminator, a contact lens is required. In aphakic patients, visualization of the optic disc and structures of the posterior fundus becomes possible without a contact lens as air is injected into the vitreous cavity. However, there is minification of the details observed and a minor adjustment in focusing of the microscope is necessary at this juncture. In phakic patients, with air in the vitreous cavity a 60D neutralizing contact lens is required to see the fundus details.

As the fluid level in the vitreous cavity goes down, one observes a meniscus level around the shafts of the extrusion needle and the endoilluminator.

If the endoilluminator is held, in such a fashion to illuminate the vitreous cavity diffusely, one observes the light reflexes from the fluid surface. This recedes as more and more fluid is removed.

In some cases as the fluid from the vitreous cavity is being evacuated, the retina is observed to ballon around the optic disc, sometimes even obscuring it. This is due of air flattening and reattaching the squeezing the the remaining sub retinal fluid posteriorly. One can at this stage, resort to external sub retinal fluid drainage, but such a drainage site would have to be lacated very far posteriorly in a highly vascular inaccessible area.

It is best to avoid the crowding of the retina around the optic disc, by observing the following simple technique. Perform partial fluid gas exchange and evacuate only apart of the fluid from the vitreous cavity. When the vitreous cavity is thus, partially filled with air and fluid, move the tip of the extrusion needle through a retinal break into the sub retinal space and continue performing endodrainage, By this technique, the entire subretinal fluid can be evacuated and the retina totally reattached.

If the surgeon is careless, detached retina with the traction relieved by vitrectomy, bing highly mobile, gets sucked into the extrusion needle tip on activation of suction.

Follwing fluid gas exchange if any fluid is found to be entrapped in the anterior chamber in an aphakic patient , the extrusion needle can be directed forwards through the pupil into the anterior chamber and the fluid removed by activation of suction. Air then fills the anterior chamber, pushes the iris diaphragm backwards and improves the fundus view.

Following fluid gas exchange and reattachment of retina, small quantities of fluid tends to collect over the optic disc which needs removal a couple of time befoe a total fill of the eye with air can be achieved. Fluid perhaps seeps down through the retinal break and represents

very minimal clinically undetectable quantities of sub retinal fluid and as air fills the vitreous cavity, it tends to gravitate down to the optic disc. This fluid may also be from the anterior chamber.

Sub retinal air :

During fluid gas exchange, one suddenly observes air in the sub retinal space. It appears as a grey white, dome-shaped detachment of the retina under which there is a bubble of air. The convex surface of the air bubble reflects the endoillumination light. It is seen in the periphery and as the air injection border extends more and more posteriorly. Air in the sub retinal space vitreo retinal traction, keeping the retinal break open. The surgeon has to stop the fluid gas exchange procedure, fill the vitreous cavity with fluid, if necessary look for the unrelieved traction and using the ocutome relieve the same. Following this, if fluid gas exchange is repeated, drainage of all the sub retinal fluid and reattachment of the retina can be easily achieved.

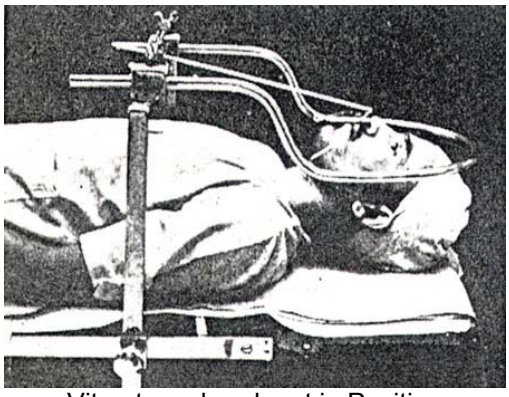
During the final stages of fluid gas exchange the extrusion needle sucks out mostly air and a small quantity of fluid. The tip of the needle is held in close proximity to the retinal break. If the syringe used for air injection needs to be refilled, the air injection is interrupted momentarily. At this stage, if intraocular pressure goes down, air from the inner end of the extrusion needle may be regurgitated back and get lodged in the sub retinal space.

Vitrectomy Hand Rest

Dr.IAN SUNDARRAJ
& Dr S.S. BADRINATH

Modern operating tables have provision for incorporating a large number of accessories such as the anaesthesia. Barrier, stirrup poles for lithotomy and IV poles. The clamps on the side of the operating table which slide, have holes and tightening screws into which these accessories are attached.

Using such clamps, one on either side, a flat topped 'bent U' shaped shromium plated bar which forms the basic part of the instruments system, is fixed around the region of the patient's chest. The bar can be moved up and down, or forwards and backwards.



Vitrectomy hand rest in Position

The vitectomy hand rest is fixed to the horizontal bar by means of tightening screws. These screws are located in the upper portion of the horizontal bar described earlier. The hand rest can be moved away or towards the surgeon in the horizontal meridian.

An adjustable curved metal rod, with a nose arch is fixed to the horizontal bar. This prevents the drapes from falling over the patient's nose and mouth and thus prevents suffocation. Oxygen can be piped in under the drapes for better paitent comfort through the hollow vitrectomy hand rest.

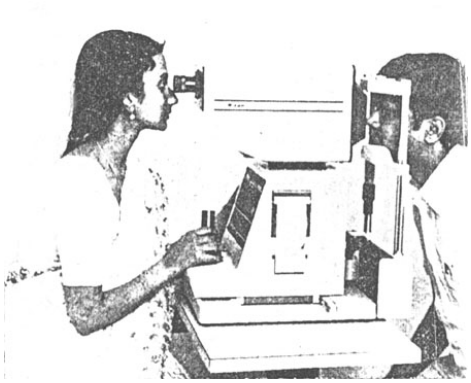
Vitrectomy hand rest is autoclavable and thus sterility is maintained even if the plastic or cloth drape developes holes. The system described can be used in all ocular surgeries such as cataract, glaucoma etc. Drapes do not choke the patient. Thereby ensuring their comfort and co-operation during surgery.

Department of Bio-Engineering

K.SANTHOSH KUMAR
Bio-Medical Engineer

A REVIEW

A novel thought to provide inhouse servicing and maintenance for the imported equipment at MRF came into reality on June 1st, 1983 by appointing a Bio-Medical Engineer. Though the department started in a modest way, it could solve many day-to-day minor and semi-major problems. On an average two to three minor problems per day which hindered the routine work are solved either on the spot or repaired in the department's temporary office. Most of the O.T. jobs are done at the site. Many time an immediate solution is provided during surgeries. The down time on major breakdowns is also brought down to a minimum by corresponding directly with the manufacturers and thus eliminating the dependance on the agent's service engineers.



Autorefractometer

The department has been largely responsible for the implementation and installation of our second Ocutome-Fragmatome Unit, Auto Refractometer, Projection Vertexometer, Ocular Cerebral Vascular Monitor (OCVM) system and replacement of laser tube in our second Argon Laser Photocoagulator.

Projection Vertexometer

Apart from the servicing and maintenance work, the DBE submitted two projects on “Power Gas Injector” and “ Endoilluminator”. The former has been approved and will be taken up for implementation soon.

The DBE co-ordinated for two important allied projects of “Video system for Ophthalmology Syrgery” and “Computerisation of MRF”. Beginning with the system designing to selecting a suitable manufacturer the department went through every minute detail.

The department successfully repaired and serviced the EMG unit of VHS medical center. This first outside job was done as a complementary work and it in the process of receiving more outside jobs. It is gearing itself to receive more outside jobs and to provide consultancy services to other similar institutions. With the measuring instruments and tools available, the DBE will be able to tackle minor and sem-major jobs of other hospitals.

The further plans of the department are to establish Mechnical, Electrical / electronics and Optical jobs for which the proposal has already been submitted. Apart from servicing equipments of other hospitals, the DBE will also conduct courses on Medical Equipments Serviicing and Maintenance. Collabrating with Physicians, more research projects will be undertaken. With emphasis on mechanization of various fields for accuracy and speed, Department of Bio-engineering is gearing itself to keep the mechanization on the move.

Denervation and Extirpation of the Inferior Oblique

Dr.T.S.SURENDRAN

Surgical management of superior oblique palsy with 4 plus overaction of the inferior oblique is controversial. Weakening of the inferior oblique – the direct antagonist is generally the recommended procedure in the presence of contracture and marked overaction of the ipsilateral inferior oblique. Various procedures like myotomy, myectomy, disinsertion and graded recessions of the inferior oblique are recommended as weakening procedures. The surgical result in one patient with unilateral superior oblique palsy and lateral rectus palsy in the same eye with contracture and marked (4 plus) overaction of the inferior oblique muscle treated by denervation and extripation of the inferior oblique is discussed.

CASE HISTORY :

SK a 13 year old girl had a fall when she was 4 years old, following which she developed diplopia and deviation of the left eye. Diagnosis of epicanthis folds with left esotropia and left hypertropia was made. The left superior oblique and lateral rectus were underacting with marked 4 plus over action of the left inferior oblique. Epicanthic folds were corrected by our plastic surgeon using Mustardi's technique and this was followed by squint correction of the left eye, at a later date.

They primary procedure was denervation and extirpation of the inferior oblique with differential recession – resection of the left eye for the associated "V" phenomena and left convergent squint. The following technique of denervation and extirpation of inferior oblique was adopted. The inferior oblique muscle was dissected in the usual way and disinserted. The inferior rectus was hooked and the eye held in an elevatd position. The conjunctival incision was retracted inferiorly along the temporal border of the lateral rectus. The nerve to inferior oblique was identified by looking for a fusiform expansion on the under surface of the muscle. The nerve was hooked along the undersurface of the muscle near its posterior horder. It is accompanied by an artery and vein which bleeds profusely and hence denevation is accomplished by cautery. Following denervation the released muscle moves forward and as the muscle is pulled, it invaginates under the tenon's capsule. A 5-0 absorbable suture is used to obtain haemostasis of the muscle of stump.

Left interior oblique 4+ overaction before surgery

Post-Operative result showing normally acting interior oblique

The following table briefly shows the particulars of the patient pre and post-operatively.

SK 13 years
F

PRE	OP	DEVN	POST	OP	DEVN
35△	BO	L/R 15 △	10 △	BO	L/R 3 △
D 40 △ 50 △	 BO BO	 L/R 15 △ L/R 15 △	D 10 △ 10 △	 BO BO	 L/R 3 △ L/R 3 △
N 40△	 BO	 L/R 15 △	N 10 △	 BO	 L/R 3 △

Denervation and extripation of the inferior oblique is predictable so far as eliminating the marked overaction. This technique was described by M.Parks. With this technique we found no recurrence of overaction in the period followed up so far. Carefull is isolation and identification of the entire muscle is mandatory in order to prevent recurrence of overaction. This approach appears to hold promise andhas hypothetical advantage over other weakening procedures of inferior oblique is cases with marked overactions.

Ref:

1) Parks MM : Atlas of Strabismus Surgery – ed. I, Philadephia 1983, Lipton cott Harper & Row publishers Inc. 182-87
2) Parks MM: The Overacting Inferior Oblique Muscle : Am J. Ophthalmol. 77 : 787, 1974

Neutralising Fundus Contact Lens

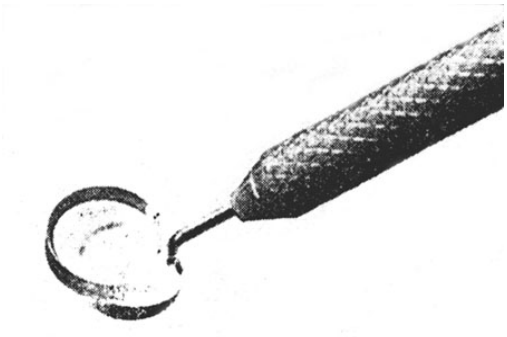
Dr. S.S. BADRINATH

During vitrectomy, visulalisation of the anterior and mid vitreous cavity are possible by focusing the microscope down. Structures in the posterior vitreous cavity and fundus details, can be visualized only by using a neutralizing contact lens of approximately – 40 Diopters. Endo illumination is requird to visualize cavity including the retina. The 40 D contact lens works both in phakic and aphakic eyes.

Different types of neutralizing contact lenses are available. Luma lens supplied by the Cooper Division as an ocutome accessory is a 12mm wide contact lens made of soft plastic material. It should only be steam sterilized. Prolonged usage may discolour it. Luma lens rests on the cornea and is held in place by the capillary action. In order to produce a firm adhesion between the lens and the cornea, one has to gently press the center of the lens to squeeze the air from underneath it, thus initiating the capillary traction effect. It is exceptionally good for visualization of the posterior fundus. However when the eye is moved up, down or sideways during bimanual pars plana surgery, the lens get pushed out of place by the lide margins or the speculum.Air gets underneath the lens and the fundus view is lost irrigating contact lenses of Machemer. Overcomes this difficulty. The assistant holding the contact lens moves along with the movements of the surgeon keeping the contact lens in such a position that is optimal for visualization of the fundus. These plano concave irrigating contact lenses of Machemer are often made up of glass.

Ophthalmic Instruments Co. of Madras have utilized PMMA hard contact lens material and a 40 Diopter, 12mm wide contact lens has been designed. It has a hole ground on one side through which a metal infusion cannula, glued in place, provides continuous irrigation underneath the contact lens. These lenses have to be sterilized by ethylene oxide and thoroughly aerated before use.

In aphakic patients, if air fills the vitreous cavity, the fundus can be observed without the aid of a contact lens. In phakic patients however, during fluid gas exchange, fundus view is lost as soon as air enters the vitreous cavity. In such a situation a 60D fundus contact lens or sandwiching of two luma lenses, permits visualization of the posterior pole. It is possible to see only a limited central portion with the sandwich lens, Manipulations tend to dislodge the lens.



Sand wiching of two luma lenses aiding in visualization of posterior pole.

In one case, air entered the anterior chamber, In other words, air was present both in front and behind the crystalline lens of the patient. When this happened, as in aphakic eyes fundus visualization was gain possible without contact lens. During vitreous lavage when only two openings, for infusion and extrusion are made, fundus visualization ispossible only by Indirect Ophthalmoscopy. This is cumbersome, tedious and time consuming. A metal rim held over the cornea as an irrigating contact lens filled with Saline or “Visilon’ permits limited visulisation of the posterior fundus. It permits a quick glance but does not allow prolonged manipulations . The coaxial illumination of the microscope provides the necessary illumination. The Aqua lens thus described aids in quick evaluation of the fundus details and eliminates the need for third sclerotomy for the endo illuminator.

Lastly, a 40D plano concave lens made up of hard contact lens material supplied by Asia Contact Lens Laboratory, Madras which can be sterilized by autoclaving can be fixed to the eye by 'Vision'. Visilon manufactured and marketed by Shah & Shah of Calcutta, is a transparent material made up of Methyl Cellulose. (It is a good substitute for healon and is recommended for intravitreal injection besides it's use in the intraocular lens implantation) Visilon when used as a single drop between the contact lens and the cornea, firmly holds the contact lens down on the eye. The contact remains good for 40 minutes approximately after which it could be reapplied if necessary. Currently a metal rim with a ring light of illumination is being developed to provide better illumination for quick visualization of the fundus especially for short procedures such as vitreous lavage where a third sclerotomy can be avoided.

Infusion for Neutralising Contact Lens

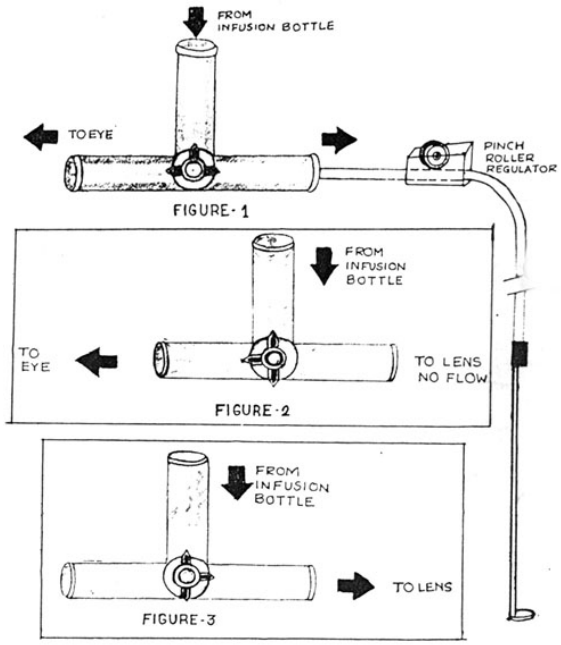
Dr. MADHIVANAN NATARAJAN

The Machemer Lens is an irrigating fundus contact lens.The irrigating solution bathing the cornea could be Saline, Ringer Lactate or Balanced Salt Solution. Usually, two separate infusion systems, one into the eye and the other for irrigating contact lens are used. The two can be combined into a single system by way of an infusion manifold.

A simple three way stopcock has been found to be an exceptionally good substitute for the more expensive and cumbersome infusion manifold.

When both infusions have to be open, the three way stopcock is positioned as shown in the figure 1. If infusion into the eye only is required the position is changed as in the figure 2. It is also possible to infuse only the lens and connect the infusion sleeve to a gas injector when performing fluid gas exchange figure 3.

Flow rate to the lens can be adjusted by a pinch roller regulator.



Stop Press . . . .

The Board of Management, Medical Research Foundation congratulates Mr.M.A.M. Ramaswamy on being elected PRO-CHANCELLOR of the Annamalai University.

Medical Research Foundation – A Retrospect

The first phase of development of Sankara Nethralaya culminated with the remodeling and the expansion of the Operation Theatre Complex. A function was held on 29-03-84 at the Music Academy under the president ship of Mr. S.R.Subramanian, Vice-President, Larsen & Toubro Ltd., Bombay His Excellency S.L.Khurana, Governor of Tamil Nadu Inaugurated the following projects :

1. Operation Theatre Complex donated by M/s. Larsen & Toubro Ltd., Bombay
2. Smt. Lalita B.Kothari Conference Hall
3. C.J.Shah Corneal Surgery Centre
4. Smt.Jadavbai Nathmal Singhvee Glaucoma Service
5. Smt.Ambujam Srinivasan Florescein Angiography Service
6. Shri Chamanlal A.Kothari Medical Records Department
7. Medical Photography Centre donated by the Water development Society, Hyderabad
8. Visual Acuity Service donated by Mr. R.S.Gae

As a finishing touch to first phase, the out-patient department was streamlined during the month of April 1984 leading to the functioning of fourteen self contained Ophthalmic consultation units. The reception hall is being expanded and modernized with a view to provide essential amenities and facilities for the progressively increasing number of out-patients.

The commencement of construction of Dharmashala in June 83 heralded the second phase of development of Sankara Nethralaya. While the ground, first and second floors of the Dharmashala will be used for the Postoperative after care of outstation patients, the construction has been extended to the third and fourth floors with a view to provide a home for nurses and a hostel for post-graduate trainees. The building will be ready for inauguration towards the end of this year.

The results of the streamlining of the functioning of Sankara Nethralaya are reflected in the following figures.

Year	Consultations	Surgeries
April 1984	5573	284
May 1984	5403	307
June 1984	5715	300

Vision Research Foundation

In view of the increasing emphasis on research a separate Registered Society styled as “Vision Research Foundation” had been formed to take up exclusively research work in Ophthalmology. This organization has Dr.S.S.Badrinath as its President and Dr.S.Bhaskaran as its Secretary and it has enlisted a host of experts in the Medical profession to serve on the Board of Management and Sub-committees. This Foundation has initiated detailed studies on five research projects. It has been notified by the Government of India, Ministry of Finance, for exemption of donations for purposes of Income Tax from 26-3-84 to 31-03-85. This Foundation has been fortunate in getting a big donation of Rs.5 lakhs contributed by Sri.S.Jindal of Jindal Aluminium Co.Ltd., Bangalore.

Appreciation

WORLD EYE FOUNDATION

1000 MEDICAL TOWERS BUILDING
LITTLE ROCK, ARKANSAS 72205

I appreciate so very much receiving the April, 1984 issue of “Nethralaya Insight”, It is a very informative journal and I enjoyed reading it very much, Thank you again for being so kind as to include me on your mailing list, This helps me to keep up with the happenings regarding eye care in India, which I have long been interested in.

MOORFIELDS EYE HOSPITAL

City Road, London ECIV 2 PD

I was interested to read the April 1984 edition of your journal I am enclosing a reprint related to the article “ Venous Stasis Retinopathy with Branch Arteriolar Occlusion” by Dr.Cyrus M Shroff. I wonder if you would be so kind as to pass this reprint on to Dr.Shroff since his address is not published. I think if Dr Shroff re-examines his cases, he will find that these are examples of central retinal vein occlusion associated with infarction of the territory of the cilio-retinal arterioles.

Dr.DAVID McLEOD, FRCS

Dr HARI MOHAN

Daryaganj, NEW DELHI-110 002

Thanks for sending the first volume of your Research Foundation. Please accept my heartiest congratulations. The Journal is very illustrative and I pray for its success in the future. There is no doubt that you are doing a commendable work at the Institute.

Dr.HARI MOHAN

The Swan's Flying Start . . .

July 22nd 1984 was another memorable day in the history of Sankara Nethralaya.

The Sankara Nethralaya Women's Auxiliary known as 'SWAN' made a big start by organizing the superb dance drama 'BILIPATRA' featuring three Gujarati Plays, "Balidan, Ayakhanu Daan and Zer to Pidhan Javeri".

The SWAN comprises of a group of dedicated housewives who have given a large part of their time of this voluntary service. To start with, they assisted in the outpatient department by way of dilatation and record keeping and slowly moved on to welfare work in the institutions.

With the growth of Sankara Nethralaya, this group of volunteers bravely decided to grow with it and became a vital link for the insitution. Provision of free food and milk to the poor patients, free medicines and subsidizing surgical expenses teaching eye care and essential hygiene are some of the daily activities of the team.

President of the evening Mrs.Sushilaben C.Shah (Centre). Seated from L-R are Mrs.Ramaswamy, Mr. Vaidyanathan, Dr.Badrinath, Mrs.Shantaben B.Shah and Mrs. Badrinath, Mrs. Sushilaben Shah, Mr.Mohan Rao, Mr. Laichand Munoth, Mrs.Janyantilal Javeri, Mr.Shyam Mithaiwala and Mrs. Saroj Mehta.

The Sankara Nethralaya Women's Auxiliary Trust was formed on June 22nd 1984, with an aim to mobilize larger funds to serve the poor, It is a charitable trust registered under the Income Tax Act (Section 80G) according to which donatiojs received will be exempted from Income Tax. The trust proposes to raise a substantial amount and crate a corpus, the interest out of which will be spent on various welfare schemes that are being purused by the trustees.

This dance drama Bilipatra was organized by the unstinting efforts of Mrs. Sureka Mehta, a key member of the Trust. Together with the active support given by Dr.Vasanti Badrinath, the Sankara Nethralaya Women's Auxiliary gave us an evening of sheer entertainment.

The artists belonging to Palanpur Samaj Kendra were mainly amateurs – students with a flair for dance and their rhythmic steps and colourful attire was indeed a feast to the eyes.

Mr.Shyam Mithaiwala, Director of the troupe kept the Madras audience spellbound with his excellent choreography and direction.The entire musical score was composed by Mr. Pinakin shah whose lilting melodies are still ringing in our ears.

To Mrs. Sureka Mehta and the other trustees we are trulyindebted. Special reference has to be made about Mrs. Vasanthi Badrinath, Mrs. Kousalya Appukutty, Mrs. Ramaswami, Mrs. Indira Hamdev, Mrs. Sudha Haridas and Mrs.Deviben Kothari, all of whom are largely responsible for the success of that evening.

Scene From “Ayakhanu Daan”

The SWAN, does not wish to stop at this but will continue to grow, arrange more benefit performance and even aid Sankara Nethralaya in other areas like obtaining eye donations or organizing rural eye camps.

SWAN SOLICITS YOUR SUPPORT.

Kindly make your donations to

SANKARA NETHRALAYA
WOMEN AUXILIARY
18, COLLEGE ROAD
MADRAS 600 006

Published by : Medical Research Foundation, (Regd.) Madras 600 006. Editor. Dr.(Mrs.) Mary Abraham & Printed at Gnanodaya Press, 40, Anderson Street, Madras 600 001 (For Private Circulation only)