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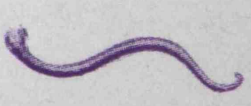

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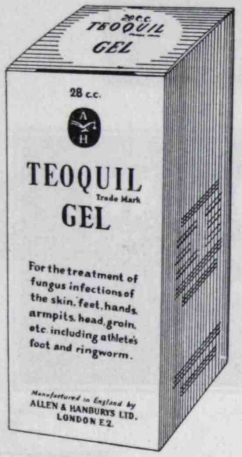

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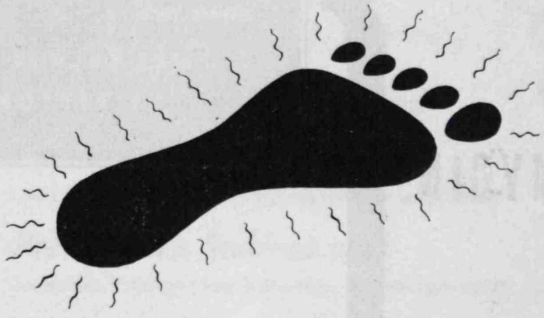

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ELIXIR

Journal of the Hong Kong University Medical Society

PRINCIPAL CONTENTS

(The Editors of Elixir do not accept responsibility for any opinions expressed by any of the contributors)

SUMMER 1958

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FACT, FANCY AND OPINION

ELIXIR FIRST . . . .

Once more *Elixir* emerges under difficulties. The Editorial Board is most grateful to the contributors. Once again, however, the majority of the members of the Medical Association must be taken to task for failing to support their own magazine. Whether their reluctance to contribute is due to complete apathy or mere shyness scarcely matters ------ the latter quality is not usually noticeable in medical students. The Editorial Board is conscious of a great need for some enthusiastic support for our efforts.

It may now be an opportune moment to quote from the Foreword to the first *Elixir*. "The Hong Kong University Medical Society has had a magazine called *Caduceus* since 1922. Before the war it published a great deal of original work and made its mark as a scientific journal. It has not yet resumed publication but when it does will contain serious technical contributions. This new magazine the *Elixir* is not to replace but to supplement the *Caduceus* by publishing items in quite a different vein, articles of general interest for, about and by medical students. The curriculum of the medical faculty is so crammed nowadays that the making of such a magazine as this is a labour which demands great initiative and energy on the part of editors and contributors alike. However there is no doubt of the value of such an effort. . . . ."

". . . . The medical student whose main purpose is to become a sound physician, must never lose sight of the fact that a broad human knowledge and understanding will help him to achieve that end, and he ought to take every opportunity the University affords of living a full life. The *Elixir* provides one of these opportunities".

MORE ARTICLES

In the same edition of *Elixir*, the Editorial Board wrote: "When we first undertook to prepare for publication the first issue of the H.K.U. Medical Society Magazine, we knew that we would be treading on new and unfamiliar grounds. We anticipated difficulties and hardships, yet we accepted the challenge because we felt certain that we would not be fighting the battle alone. The timely appearance of the magazine proves that we were right. The response to our appeal for articles has been most gratifying and encouraging."

"*The response to our appeal for articles has been most gratifying and encouraging* . . . ." Can we truthfully say the same today? Only those who have to do it know the amount of work involved in producing three *Elixirs* a year, and the unnecessarily heavy task it is to wring support from the present members of the Medical Association. We must have more articles, photographs, drawings, cartoons, poems, and indeed anything and everything the Members care to write. It is most un-

MORE POEMS

likely that we would have to reject any contributions from such an intelligent body of young men and women!

Do, please, send your contributions to the next number.

MORE
CARTOONS

. . . . AND LAST ?

. . . . Otherwise our magazine will be in grave danger. Already it is very near the brink, and unless there is a marked effort on the part of the student members of the Medical Society, their sole publication will descend into the depths and be lost forever. It is all in their hands, and if they choose to let our efforts go to blazes, the fault will be theirs.

MORE
PHOTOGRAPHS

MORE
DRAWINGS

A WAY OUT ?

The last two numbers of *Elixir* contained articles of very high quality by undergraduates and staff of the University outwith the medical faculty. Might it not be a good idea if our original mandate, which we quoted above, be altered to include members of all faculties?

We have had the privilage in the past of printing contributions from eminent men like Professor Blunden – to mention only one – but there has been an increasing tendency for the Medical Association members to criticize the inclusion of non-medical material in our columns. Why?

We feel that *Elixir's* future may lie in a wider scope, and not in an ingrown (and rather dull) tendency to be exclusively medical.

If you don't agree, for goodness sake, discuss the matter and write to the Editor about it.

You will notice there are no letters to the Editor in this number, Why? Surely something must have tickled our readers' fancy since the last number appeared? Or are they too busy to spend even half-an-hour writing a letter? We cannot believe it.

MORE
OF
EVERYTHING

NON-PENETRATING TRAUMATIC WOUNDS OF THE ABDOMEN

By KENNETH K. L. HUI *

In selecting a subject for a presidential address one is mindful of the desirability of choosing one that has a general appeal such as a philosophical dissertation or a historical survey. But the former can only be acquired by wisdom distilled through many years of clinical experience and the latter was covered by Professor Stock in his presidential address to you. I have therefore chosen another type of subject, "Non-penetrating traumatic wounds of the abdomen". Injuries to the abdomen are becoming more and more common. The increase in number of motor vehicles on the roads in Hong Kong and the rapidly expanding population, especially in the crowded central districts, have led to a higher toll of traffic accidents.

Apart from injuries to the skull and long bones the abdomen is most frequently involved in civilian injuries. They are vastly more difficult to diagnose accurately and also they may be more often associated with severe injuries elsewhere which tend to obscure the intra-abdominal wounds. Furthermore, the signs of abdominal injury may be slow to develop and may not become obvious for some time after the trauma.

Because early recognition of the injury and immediate surgical treatment are imperative in saving the lives of many of these patients, and because of the increasing incidence of such cases, it is essential that prompt recognition and proper management be carried out.

This review of non-penetrating injuries to the abdomen is an analysis of all such cases admitted to the Surgical Professorial Unit of Queen Mary Hospital from 1952 to 1957. Including two cases, in which there was rupture of two organs other than the spleen, the number of cases under review is 30. Although this number is small, averaging just more than four cases per year, during the six years under review (during which there were approximately 12,500 in-patients) it will be clear that with prompt and proper treatment the prospect of survival is extremely good, whereas a delay in diagnosis will lead to a fatal outcome.

The most common injuries of structures in the abdominal cavity may be divided into three groups:

1. The solid organs, spleen, liver, kidneys and pancreas.
2. The hollow organs, stomach, small and large intestines, urinary bladder and gall-bladder.
& 3. The supporting structures, the abdominal wall, mesentery of small and large bowel, the peritoneal reflections, blood vessels and nerves.

Trauma to the supporting structures and solid organs may cause lacerations and tears which in turn result in haemorrhage. The immediate bleeding may vary from slight to exsanguinating and exsanguination can occur after delay.

Hollow organ may vary in size according to the time of day and the type of recent activity (food intake, defaecation, micturition) and they tend to rupture more often when distended than empty.

Certain regions of the bowel are ruptured more often than others by external force. These are the portions which are immobile and cannot move away from a crushing type of blow and, therefore are caught and injured. Likewise the bowel cannot move with an acceleration type of accident, and thus tears at the points of attachment. Injuries of this nature have been found often in the retroperitoneal portions of the duodenum, the caecum and the hepatic and splenic flexures of the colon.

INITIAL SYMPTOMS:

Injuries to an abdominal organ may be indicated by shock, collapse, pain, tenderness, rigidity, rebound tenderness, absence of bowel sounds, and in the case of a hollow viscus, by physical signs of air and or free fluid. However, these findings are variable. Intraperitoneal air may not be evident until

* Senior Lecturer in Surgery, University of Hong Kong.

sometime has elapsed after the rupture, and signs of free fluid may be indefinite. Although pain is always present to a greater or lesser degree, the severity of pain does not necessarily indicate the severity of the injury. According to one series reported by MacAuley, up to 60% of injuries resulting from non-penetrating violence present as delayed perforations with associated peritonitis. Fractures of the thoracic vertebrae may produce a picture closely imitating that of intra-abdominal injuries because of referred sensory pain, tenderness, hyperesthesia and spasm to the abdominal wall.

STANDARDISED PRELIMINARY MEASURES:

Careful, judicious and rapid handling of these patients is urgent in order that early accurate diagnosis and proper treatment can be carried out. For maximal efficiency, a standardised approach should be familiar with all personnel in the surgical wards.

While an evaluation of the type of injury is carried out, four basic steps are taken:

1. Treat shock.
2. Assure an adequate airway.
3. Institute Ryle's tube and gastric aspiration.
4. Institute indwelling urethral catheter for drainage of urinary bladder.

TREATMENT OF SHOCK:

Should be started at once.

Cut down of the long saphenous vein above the medial malleolus must be done and an intravenous drip of normal saline is started. Either a canula or a large plastic catheter may be used. At the time the cut down is made, blood should be drawn for grouping and cross matching. The haemoglobin and red blood cell count are done to establish a baseline for future examination and treatment. When blood is available, it should replace the saline drip. If, while waiting for blood, the B.P. falls with saline drip, dextran or other plasma substitute may be used. In severe cases where the hypotension is marked, nor adrenaline 4 c.c. per 500 c.c. normal saline, is used instead of the saline drip, the rate being adjusted by periodical check of the patient's B.P. to maintain it at about 100 mm Hg. systolic. The patient should be kept warm but not hot, and pain should be relieved by moderate dose of pethidine or morphine, but not enough to obscure important physical signs. If one is certain there are no chest or head injuries, the foot of the bed may be elevated to help combat the shock.

An adequate airway must be assured. Oxygen is administered, and if there is impairment of the airway, or if the patient's tracheo-bronchial tree is wet, requiring frequent suction, a tracheostomy should be done.

Aspiration of the stomach by Ryle's tube is extremely important for successful management of patients with intra-abdominal injuries. It immediately relieves gastric dilatation, which frequently occurs in accident victims. Blood may be detected in the gastric contents and thus supply an early indication of gastric injury. If the stomach is ruptured, suction reduces the amount of leakage and resultant peritoneal soilage. Early aspiration also prevents distention of the stomach later on.

Catheter drainage of the bladder is of two fold importance: first, for the detection of haematuria and renal or bladder injury; second, for early appraisal of urinary output, a factor needed for the calculation of fluid and electrolyte requirements for the patient.

THE HISTORY:

With the pulmonary and vascular systems reasonably well under control and the initial treatment of shock under way, careful attention is directed to obtaining a history of the accident with particular attention to the type of trauma, the direction of the blow, loss of consciousness, presence or absence of nausea and vomiting, presence of pain, type of pain, time of onset of pain following the accident, time of accident in relation to meals. Much of this information may be obtained, while the patient is being examined, from the patient or a relative or a witness. All possible information with regard to disease existent prior to injury should be obtained at this time also.

EXAMINATION AND INVESTIGATIONS:

Although an intra-abdominal injury may be strongly suspected, the patient must be regarded as a whole until other and possibly more serious injuries have been eliminated. A meticulous physical examination should be

done. Particular attention should be drawn towards the detection of fractures, ecchymoses, abrasions, lacerations, subcutaneous emphysema, limitation of motion, muscle guarding, pain, rebound tenderness, rigidity, bowel sounds, fluid wave, shifting dullness and blood from any of the orifices. A rectal examination should not be omitted, to determine the presence of blood in the rectum or a bulging in the cul-de-sac.

A rapid X-ray survey is of great value in the final evaluation of the case, as well as being of great medico-legal value. In the presence of severe trauma, X-rays should be taken of:

1. The skull.
2. The chest, including the clavicle and diaphragm.
3. The abdomen, upright position, if the condition of the patient permits.
4. The pelvis.

Where X-ray facilities are readily available, to save an extra trip from the ward to the X-ray department and back, X-rays should be taken while the patient is on the way up from the Casualty to the ward.

When X-ray films are obtained, evidence of the following conditions is looked for:

1. Fracture of ribs, pneumothorax, pleural fluid, mediastinal shift, gas bubble in left side of thorax and upward displacement of cardiac shadow, indicating a herniation of the stomach through the diaphragm.
2. Free air under the diaphragm, in the upright X-rays or free air around the R. kidney; or, as retroperitoneal emphysema; or along the shadow of the R. psoas muscle.
3. Displacement of the colon; this may be displaced medially from either side, or downwards from above; such displacement indicates blood collected around a ruptured spleen.
4. Displacement of the stomach to the right or indentation of its greater curvature, indicating haemorrhage from the spleen.
5. Indefinite unilateral or bilateral shadows of the psoas muscle; indicating retroperitoneal haemorrhage.
6. Any unusual shadows or masses.

& 7. Abnormalities of the skull, vertebrae and pelvis.

DIAGNOSIS STILL UNCERTAIN:

If after these examinations, no definite diagnosis can be made, the patient is carefully observed; the B.P. and pulse are recorded every 10 minutes. Should these indicate a deterioration of the patient's condition or should the abdominal pain, tenderness, rigidity, nausea and vomiting continue, a ruptured viscus should be suspected and surgical exploration should be carried out. A laparotomy which reveals no pathology in the abdomen is relatively harmless, whereas, a delay in exploration for a ruptured viscus is disastrous.

30 Cases of Non-penetrating Traumatic Wounds of the abdomen 1952 - 1957

Organs	*No. of Cases*	*Treatment*	*Deaths*
Ruptured Spleen	15	Splenectomy	0
,, small intestine	5	Repair	1
,, Stomach	2	,,	0
,, Liver	3	Repair 2 No operation 1	0 1
,, Kidney	3	Nephrectomy	1
Injuries of more than 2 organs:			
Spleen, liver, kidney	1	No operation	1
Spleen, diaphragm and Bladder	1	No operation	1
	30		5

Of the 30 cases listed, only three were not operated on. These were cases which came to the ward in a moribund state and died shortly on arrrival. Among the 3, one was an extensive laceration of the liver, while the other two cases each received injuries to three organs. Post-mortem examinations of these cases confirmed our clinical impression that surgical treatment was futile.

In the series of cases listed, we have also omitted contusions of the abdominal wall; these recovered without any operative treatment.

Rupture of the Spleen

There were 15 cases of splenic rupture. The spleen appears to be the most common organ to suffer from non-penetrating injury, if contusions of the abdominal wall are excluded.

Sex and age incidence:

All except two were men whose ages were as follows:

Age	10 – 20	2 cases
	20 – 30	4 ,,
	30 – 40	8 ,,
	40 – 50	1 case

Perhaps the more physically demanding occupation and preoccupation of the male and the greater exposure to trauma of the young adult account for the sex and age distribution.

Associated Injuries:

Of the 15 cases, only 3 had associated injuries to other structures; in two there were multiple rib fractures; in one there was laceration of the lower lobe of the left lung and fracture of left femur. Tagart, reporting 16 cases of ruptured spleen seen during a 10 year period (Addenbrooke's Hospital), found that in none of the 16 cases was there an associated injury to any intra-abdominal organ. However, in common with other writers, Roettig, Nussbaum, Curtis & Parsons & Thompson, the most common associated injury involved the left kidney which was either ruptured or contused. They suggested therefore that no case diagnosed as a ruptured spleen should be operated on without the urine first being examined for the presence of blood.

Modes of Injury:

Seven cases of ruptured spleen were due to assaults, which include fist fights and direct blows on the abdomen by hard objects. *Five* cases were due to accidents, of which three were knocked down by car and two by bicycles. The injuries received by the latter two were rather mild. Some writers (Walderman, Pender & Tagart) have drawn attention to the fact that in children, relatively slight injuries may cause unexpected severe damage to the spleen. The remaining 3 cases of splenic rupture were due to falls from a height; the victims, landing on hard objects, received direct injury in their abdomen.

No less surprising than the mildness of the injury in some cases is the fact that, in more severe injuries, the spleen and no other intraperitoneal viscus is singled out for damage. In all 15 cases in the series, urine examination showed no evidence of the kidney being damaged. Wilson (1945) found that in a series of 63 non-penetrating abdominal injuries, damage to the spleen was almost as common as damage to all other organs added together. The susceptibility to injury of the spleen is of interest. One may presume that the liver being more friable, and presenting a larger surface, is more easily damaged. It is possible that some other factor as well as direct external violence is involved – perhaps as Tagart suggested, a sudden contraction of the splenic capsular and trabecular muscle in response to fear or anger.

Pathology:

Without exception, all the spleen removed were normal in size and gross appearance, apart from the rupture.

Spontaneous rupture of a diseased spleen has been described in a wide variety of illness such as malaria, typhoid fever, leukemia, hemophilia, splenic abscess; in fact, it seems anything which leads to enlargement or engorgement such as pregnancy, increases the chance of rupture. In our unit, however, we have not encountered any case of spontaneous rupture of the spleen. Susman contended that many cases in the literature reported as spontaneous rupture were probably those in whom preceding injury was overlooked.

DIAGNOSIS:

The diagnosis is usually simple, but the clinical picture may be very variable. In 14 cases out of 15, a correct diagnosis was made and prompt treatment by splenectomy was carried out. The only case in the series, in whom treatment was delayed was a 20 year old man who was struck on the left lower chest by firewood 3 hours before admission. He experienced immediate pain in the LUQ, worse on deep inspiration. On admission his pulse was 90/min. B.P. 90/60, Hgb. 11.9 gm%. There was bruising over the L.9th – 11th ribs. Muscle guarding and little tenderness were felt in the LUQ. X-rays showed no evidence of rib fracture. He was observed for 6 days during which the symptoms and signs rapidly subsided and he was discharged well. During the interval he had gone back to his usual work without any symptoms. Exactly 1 month later, he suddenly collapsed while in the toilet. On admission his pulse was weak, 150/min., B.P.80/40; the entire abdomen was rigid and there was marked tenderness in the LUQ. Free fluid was detected in the abdomen. Immediate splenectomy was done; the spleen was ruptured and there was a large subcapsular haematoma. Six pints of blood were removed from the peritoneum and used for autotransfusion.

SIGNS AND SYMPTOMS:

In general the clinical picture is the same as that produced by internal haemorrhage from any case. Laceration of the spleen will result in haemorrhage from the splenic parenchyma or from a tear in the vascular pedicle. The bleeding may be slow or rapid. If the tear is both capsular and parenchymal, there is rapid exsanguination. If the tear is subscapsular, the bleeding may be delayed. While the majority of our cases reported at the Casualty within six hours of injury, there were five cases which delayed, respectively, for 1 day, 2 days, 4 days, 5 days and 1 month after injury.

A 25 year old man who was knocked down by a car, developed pain in his left flank, which quickly subsided without treatment. He was well until 1 month later when he had sudden onset of LUQ pain referred to the tip of his left shoulder. At operation a subcapsular rupture was found. The spleen together with clotted blood under a recently torn capsule was about 3 times normal size. However when the clots were removed, the spleen was normal in size.

In a review of 171 cases of "delayed rupture" reported in the literature, Zabinski found them to constitute an incidence of 14% of all splenic ruptures. The latent period may be completely symptom free, or as is more frequently the case, symptoms are of such mild degree that they either go unnoticed or fail to cause alarm either to the patient or to his doctor.

THE HISTORY:

In most cases a detailed account of the injury was not obtained, the patients remembering only that they had received a blow in the abdomen. Three cases were admitted in a state of severe collapse, the only history given in each case was that the victim was knocked down by a moving vehicle.

1. *Pain in the left upper quadrant* appears to be the most common complaint.
2. *Kehr's sign* (pain referred to the region of the left shoulder) was present in 3 of the 15 cases. This sign when absent can be produced by placing the patient in a Trendelenburg position.
3. *Clinical sign of Haemorrhage:*
   a. *Pallor* was a constant feature in the cases of acute haemorrhage.
   b. *The pulse rate* – except for two cases in whom the pulse rates were 84 & 90/min. respectively, the remaining cases had pulse rates well above 100. In 7 cases the pulse rate exceeded 120.
   c. *B.P.* The B.P. in 12 cases was 90 mm. Hg. systolic or lower; in 2 cases readings of 50 were obtained.

ABDOMINAL EXAMINATION:

In acute cases examination reveals signs of peritoneal irritation in the left upper quadrant, tenderness and muscle spasm or rigidity. Shifting dullness was found in 11 of the 15 cases. *Balance's sign* (fixed dullness in the left flank, shifting dullness in the right) was present in 3 cases.

HAEMOGLOBIN ESTIMATION:

In only 2 cases was the Haemoglobin above 10 gm%. Even allowing for the lower baseline in Hgb. level amongst Chinese, averaging 11 - 12 gm%, any Hgb. reading

of less than 10 gm% appears to be a reliable sign of blood loss, particularly if successive readings should show any continued fall. We have, on many occasions relied on this sign of a falling Hgb. level to arrive at a diagnosis, in cases whose physical signs were otherwise equivocal.

The X-ray findings of splenic rupture are well known, and these include:

a. increase in the left upper quadrant density.
b. elevation of the left diaphragm with diminished motion.
c. downward displacement of the gastric bubble and splenic flexure.
d. Serration of the greater curvature of the stomach.
& e. reflex gastric dilatation.

In our cases, many did not have X-rays of abdomen taken primarily because the diagnosis and necessary form of treatment were clearly indicated on clinical grounds. X-rays of the chest proved valuable; a boy of 12 was knocked down by a lorry and was admitted in a state of shock; Pulse 140 B.P.90/40, Hgb. 7 gm.%. On physical examination there were guarding and tenderness in left upper quadrant; shifting dullness was present. There was dullness in the left lower lobe; the breath sounds were diminished and the respiratory rate was 60/min. X-rays of chest showed fracture of 8th and 9th ribs on left side, pleural fluid and increased density in lower lung field. The left diaphragm was depressed. A left thoracoabdominal exploration revealed splenic rupture at the hilum and ½ pint free blood in the peritoneum, and a complete rupture of the lower half of the left lower lobe with tension haemopneumothorax; 3 pints of blood recovered from the left pleural cavity were used for autotransfusion. The spleen and left lower lobe were removed and the boy recovered satisfactorily and on the 17th postoperative day was referred to Orthopaedic Unit for treatment of fracture of femur.

TREATMENT OF RUPTURED SPLEEN:

This should always be laparotomy and splenectomy. It is simple and safe. Apart from the certainty of arresting haemorrhage, free blood in the peritoneum is valuable for autotransfusion – valuable particularly here in our community where it is difficult or impossible to secure blood donors. In the absence of contamination from concomitant bowel injury autotransfusion is safe. In 10 cases more than 4 pints were recovered from the peritoneum; in 1 case 6 pints were obtained; the remaining 4 cases each provided 3 pints from the peritoneal cavity.

THE OPERATION:

A left rectus splitting incision or occasionally a left paramedian incision were used and proved most satisfactory. Using a sucker with numerous perforations the free blood is quickly aspirated, put through a gauze sieve, citrated and collected for autotransfusion. A sister or nurse specially assigned to this task proved most helpful. The neatest and quickest way to remove the spleen is to draw the spleen medially, dividing the lieno-renal ligament and securing the splenic and short gastric vessels, which are divided between a ligature placed proximally and a clamp distally. Massive ligature of the pedicle is fraught with danger, since a slip of the ligature leaves insufficient stump for satisfactory application of a pedicle clamp. In difficult cases, it is best to pull the stomach distally in the wound and proceed with division of the gastro-splenic omentum between clamps, and follow with ligation of the pedicle.

RESULTS:

There was no mortality. A prolonged low grade fever of up to 100°F. was noticed in 3 cases, lasting for up to 6 days. It may be due to absorption of breakdown products of blood, or may be due to thrombosis of the remnant splenic vein. Except for this complication all the patients recovered satisfactorily and were discharged from hospital on the 8th to 10th day.

Rupture of the Small Intestines

There were 5 cases in our series. They were all men of an older age group, only 1 was under 30; the remaining four were respectively 38, 46, 48 and 50 years of age. Two cases fell from a height of 10 feet; one landing on the buttock, was initially diagnosed as fracture of spine. Observed overnight, abdominal distension increased and signs of general peritonitis became obvious. He was explored and a 1½ cm.

perforation was found on the antimesenteric border of the ileum 2½ feet proximal to ileocaecal junction. The second case, who fell landing on the abdomen complained of desire but unable to urinate or defecate. Urinary retention was relieved by catherization, but signs of generalised peritonitis became only obvious 3 days after admission, at which time laparotomy revealed a laceration involving ½ the circumference of the terminal ileum. Two victims of ruptured small intestine gave a pre-existing history of reducible indirect inguinal hernia, and being struck on the groin, developed severe pain, first in the groin and later generalised throughout the abdomen. In both cases the history of the pre-existing herniae and characteristic signs of generalised peritonitis prompted immediate laparotomy and repair of laceration of terminal ileum. The fifth case, the only mortality of this group, a 48 year old man who was knocked down by a bus, was seen in casualty soon after, and sent home. He was apparently well; but after eating 2 bowls of rice, developed excruciating abdominal pain and became delirious. Five hours after eating rice and 14 hours after injury he was admitted in a moribund condition with frank generalised peritonitis. With a B.P. of 50/30, he was resuscitated and explored. The jejunum was found to be completely severed in two, 4 feet from the ligament of Treitz, and a large retroperitoneal haematoma was present. He died 3 hours after operation. At post-mortem there were fractures of 2nd to 9th ribs, fracture of T12 vertebra and petechial haemorrhages in the cerebrum. A delay in the diagnosis and treatment was responsible for this death.

The diagnosis of a ruptured small bowel is difficult; except for the 2 cases with a pre-existing hernia; the diagnosis in the remaining 3 cases was delayed, respectively for 14 hours, 24 hours and 3 days. The delay in diagnosis may be due to several factors:—

1. Shock, which is present in any case of acute haemorrhage, is not a prominent feature.
   The B.P. in 4 cases was initially never below 110 mm Hg. systolic. In the man who died, collapse may be explained by the blood loss in the large retroperitoneal haematoma.
2. Soiling of the peritoneum by small intestinal contents is chemical rather than bacterial at the onset, and therefore signs of acute peritonitis are not obvious.
3. In the normal state the small intestines are collapsed; little free air therefore collects under the diaphragm.

Convalescence following repair of small bowel lacerations is apt to be prolonged since these patients have to overcome their generalised peritonitis, only to have paralytic ileus which may persist for many days.

Rupture of the Stomach

Traumatic laceration of the stomach may be suspected from the site of the blow, blood from gastric aspiration, pain, rigidity, tenderness in upper abdomen and the presence of free air under the diaphragm.

The two patients in this series, aged 25 and 33 years respectively, were victims of a fall from the 4th floor, and steering wheel injury. In both the physical signs obviously pointed to a rupture of a hollow viscus, and the patients were promptly subjected to exploration. In both cases there was extensive soiling of the peritoneum by food; both patients had a full stomach. The patients recovered from repair of stomach lacerations satisfactorily.

Rupture of the Liver

Injuries to the liver produce pain in the epigastrium and right upper quadrant, tenderness and muscle rigidity, and are therefore difficult to diagnose accurately.

There were two cases of liver laceration.

The one survivor, a women of 22 who was hit by a block of wood 4 hours before admission, presented a picture not unlike that of a ruptured spleen. With this pre-operative diagnosis she was explored and was found to have a 2" laceration on the posterior border of the right lobe of the liver and a retroperitoneal haematoma of about 300 c.c. The laceration was repaired and the patient recovered.

The fatal case was a man of 54, who fell 15 to 20 feet while working aboard ship. He was brought in to hospital in a moribund state and succumbed shortly afterwards. At

post-mortem multiple extensive lacerations of the liver were found.

Extensive injury to the liver as a rule is associated with extensive injuries to other parts of the body; the prognosis therefore is poor.

Rupture of the Kidneys

Traumatic injury to the kidney is not uncommon. Haematuria is the primary symptom and may persist for many days. Anuria and reflex paralytic ileus may be present. In those cases in whom the haematuria is not profuse, treatment should be conservative. All specimens of urine are kept. Clearing up of the urine is an indication of healing of a contused kidney. An intravenous pyelogram some two weeks after injury will provide a clue as to whether healing has been satisfactory.

In severe injuries, where haematuria is initially profuse, and continues, exploration should be carried out and the ruptured kidney removed.

There are three cases of ruptured kidney in this series. The two survivors, both men, aged 27 and 30, were respectively involved in a truck accident and fights, and received blows directed on their flanks. In each case there was frank haematuria, severe pain and tenderness and muscle rigidity in the affected loin. Prompt exploration and nephrectomy resulted in satisfactory recovery of both patients. The third case, a man aged 57, was admitted 1½ hours after he was knocked down by a bicycle. There was mild pain in the abdomen and back and he vomited. The B.P. was 80/60, Pulse 80/min. The right upper quadrant was rigid and tender, and a vague mass was felt in this region. The urine which initially was bloody, became clear.

Subsequent examination revealed that the mass was no longer felt, but signs of a ruptured viscus prompted exploration. At laparotomy a large retroperitoneal haematoma was found, and all viscera in the peritoneum were intact. The abdomen was closed with drain. Two days later, the temperature rose to 101°F., the haemoglobin dropped from 11 to 7 gm.%, the abdominal distension increased and X-rays examination suggested intestinal obstruction. The mass in right upper quadrant and flank reappeared, now even larger. The right kidney was explored and found to be completely ruptured in two, at its middle, buried in a large retroperitoneal haematoma. The kidney was removed. On the 3rd day uraemic symptoms set in; there was urinary incontinence. Blood urea rose to 342 mg%. The patient became comatosed and died 6 days after the second operation. At post-mortem examination there was right upper lobe pneumonia. The aorta and valves were atherosclerotic. The cortex in the left kidney was thin and flabby.

This case died because the diagnosis was missed and effective treatment was carried out too late in a 57 year old man who suffered from atherosclerosis.

Lacerations of Multiple Organs

Two cases were brought to the wards in a moribund state and died shortly after admission despite active resuscitation. Post-mortem examination revealed in one case lacerations of spleen, liver and kidney, and in the other, spleen, diaphragm and urinary bladder.

The severe nature of these injuries is such that any treatment will prove futile.

CONCLUSIONS

Prompt recognition and treatment of non-penetrating abdominal injuries are essential and the results are gratifying.

The spleen is the organ most commonly ruptured in non-penetrating abdominal injuries. Fifteen cases are presented. There is no mortality following splenectomy. The diagnosis is simple but the clinical picture is variable, and a delayed rupture is not infrequently encountered. The treatment for suspected rupture is laparotomy. Splenectomy is the treatment of choice. Autotransfusion is a valuable form of treatment, attended by little risk and is easily carried out.

Rupture of the small intestine was found in five cases. The diagnosis is more obscure and may not be evident until bacterial peritonitis sets in. There was one death due to a delay in diagnosis and an ill-advised consumption of a large meal.

STOMACH:

Rupture of this organ usually occurs when

it is filled with food and is directly injured. The diagnosis is not difficult and treatment of 2 cases by repair is followed by satisfactory results.

LIVER:

Minor lacerations can be satisfactorily repaired. Extensive injury of the liver is usually associated with severe injuries to other parts of the body and therefore carries a grave prognosis.

KIDNEYS:

Contusions are not uncommon. Watchful waiting and observation of the urine is all that is necessary in the majority of cases. Persistent and frank haematuria with falling haemoglobin level are indications for exploration and nephrectomy is done for rupture. Two cases promptly treated by nephrectomy survived. In a third case, death occurred because the diagnosis was missed and treatment was delayed.

Injuries to more than two organs are not compatible with life. The dictum "Prevention is better than cure" holds water, and efforts should be directed towards improvement of traffic safety.

Acknowledgement:

The author wishes to express his thanks to Professor F. E. Stock and other members of the Surgical Professorial Unit for the use of clinical records of some of the cases.

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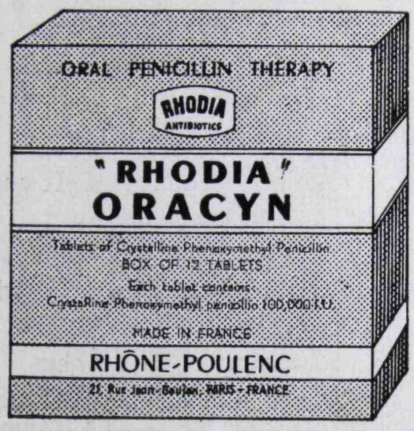

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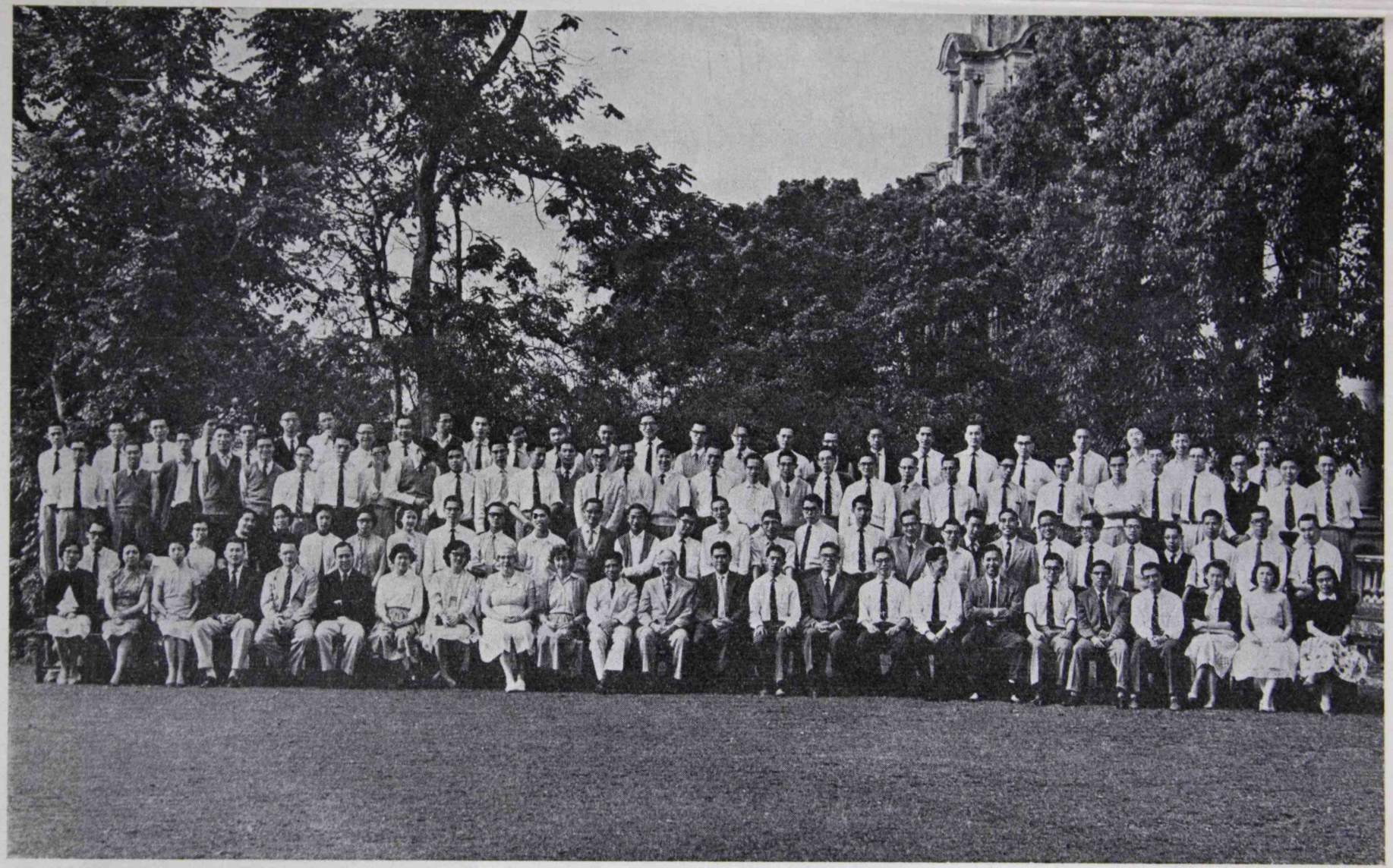


Medical Society Group Photo 1957 - 1958

MEDICAL NIGHT

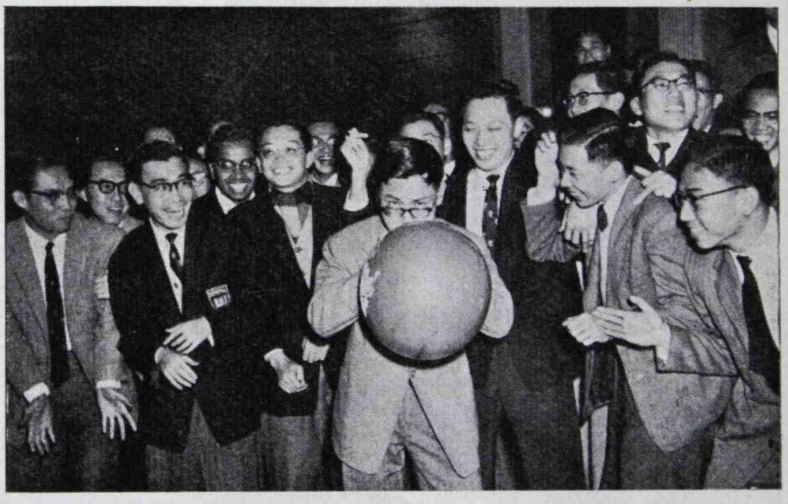
The Medical Night was held in conjunction with the farewell dinner to Dr. Stephen Chang, in Loke Yew Hall on 22nd January, 1958.

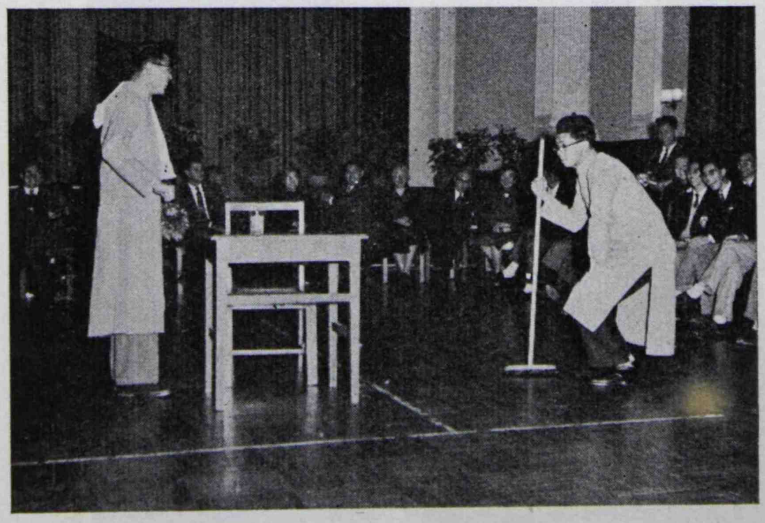
The function was excellently attended by many professors, postgraduates, and students.

After the dinner, each class representative presented their gifts to Dr. Chang.

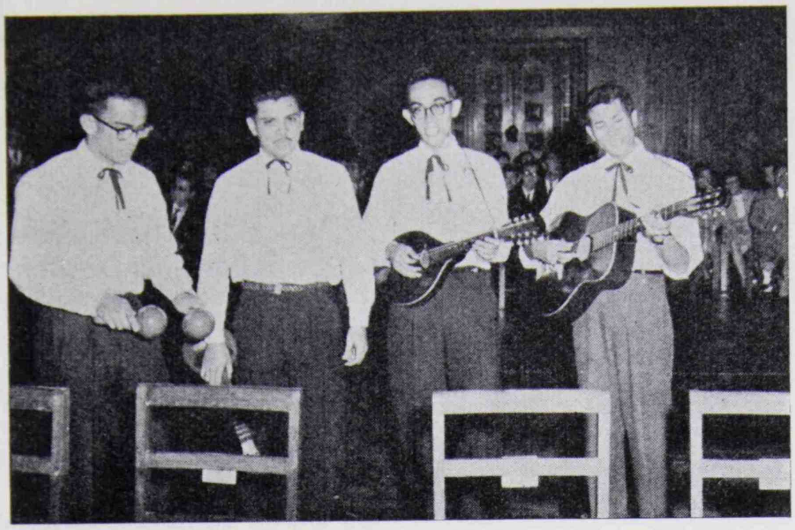
The latter part of the evening was filled with laughter, songs, short plays, and was ended up with Auld Lang Syne to mark this memorable event.

Eh, it is going to burst!





"Close the door from behind"
— 5th yr's performance.



Rondo and his Quartet

Too big !

"The President" and the Bouquet

Annual Report of the Medical Society 1957-58

Our first social function of the year was the Medical Night which took place in Loke Yew Hall on the 22nd of January. This year, the Medical Night was held in conjunction with a Farewell dinner to Dr. Stephen Chang. The function was excellently attended by many professors, postgraduates, and students. The evening was started off with speeches, followed by a dinner. After the dinner, representatives of each class presented their farewell gifts to Dr. Chang. The latter part of the evening was filled with laughter, songs, short plays, and was ended up with Auld Lang Syne to mark this memorable event.

During the Christmas season, we organised a campaign to raise funds for Christmas gifts to be distributed to the sick children in Queen Mary Hospital and the Children's convalescent home in Sandy Bay. As this was the first time that the Society had done anything of this nature, we tried it out on a small scale. The response to the appeal was very encouraging indeed. Everyone of the sick children received a food parcel and a toy.

The Christmas cards, sold at one dollar per dozen, had a sale of several thousands.

The Presidential Address was delivered by Dr. Kenneth Hui on the 10th April on 'Nonpenetrating Injuries of the Abdomen.' Tea was provided on the lawn in front of the Chemistry Building. The annual group photo was taken immediately prior to the address. The lecture was very interesting and informative. The large audience enjoyed it very much.

We were fortunate to have Professor P. C. Hou give us 'A Brief History on Department of Pathology of University of Hongkong' in the new Pathology Building on 25th April.

Earlier in October Professor Rex L. Dively from Kansas University gave a lecture on 'The Diagnosis and Treatment of Low Back Pain.'

Starting from March we have been having weekly film shows in the Anatomy Lecture Theatre. Among the films shown are; 'Skin Graft,' 'Sterility,' 'Anaemia,' 'Coarctation of Aorta,' 'Patent Ductus Arteriosus,' 'Nutritional Aspects of Tropical Diseases,' 'Syphilis,' 'Resuscitation of Cardiac Arrest,' 'Surgical Anatomy of Female Pelvis,' 'Endotracheal Anaesthesia,' 'Paediatric Anaesthesiology,' 'The story behind the doctors' prescriptions.'

The Annual Medical Dance took place at the Penninsu'a Hotel on the 13th of June, (a Friday). Presumably a Black Day, the superstition did not work on that day, for the gathering enjoyed themselves tremendously. The party had to be extended to 2 a.m. before the thought of going home occurred to them.

The committee wishes to take this opportunity to express a vote of thanks to all those who have contributed to make this a successful year.

LEUNG DING BONG
Hon. Secretary,
Medical Society,
Hongkong University.

THE SEVE S O

(W EARE)

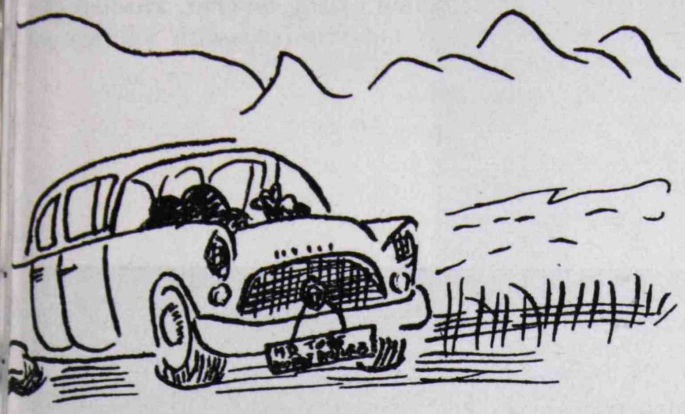
All doctors are sages,
And all students merely followers;
They have their Gray's and Conybeare
And each one in his time 'mug' many books,
For this course – 6 years. At first the green-horn,
Dogfish and frogs are his favourites.
And then the real Medical, facing vivas
With Parkinsonean face, feel 'damn sore'
For certainly he fails. And then the 2nd M.B.
Terrifying 'like hell', with a woeful regret
Made the wrong choice to be a Med. Then 'floke' through,
Full of new hopes, and adorned like a doc
Proud and glorious, sudden and quick in romance;
Prizing himself with the stethoscope
In front of the fair damsel's face. And then the Clinic
With clever eyes and polished tongue at start,
Heart beating fast, and the once cleaned specs steamed;
Full of wise words, but glossus paralyticus;
At length his ear torment'd. The next stage shifts
Into the Blood Bank, with a cup of coffee prize
The tourniquet 'round arm and needle I.V.,
His hands turn cold, well wett'd, a world too much
To take from him for he's underweight,
Turning up he thinks he has saved a life, while
He himself, ? prognosis. Last scene of all
Ends this worthy tenure in Queen Mary —
Final M.B.B.S., he dares not foresee, 'cause
Sans faith, sans hope, sans luck, sans everything.

— A.Y.M.B.—

". . . . . And then the 2nd M.B."

S OF LIFE

EARE)



". . . . . Sudden and quick in romances;"

" Sans faith, sans hope, sans everything"

" At length his ear torment'd . . . . . "

FAREWELL TO STEPHEN

Members of the Medical Society said farewell to Dr. Stephen Chang on (Jan. 22nd, 1958). Although in many ways the occasion was a sad one it was not unmixed with jollification as can be judged from the photographs.

He speaks . . . . .

"Hot air" ?

The Gifts

Everybody sings

A toast

"He entertains"

Auld Lang Syne

Recreation and the Student

by Dr. S. M. Bard.

The object of this short article is to emphasise the value of recreation in student's life and the role it plays in general education. Majority of the students who join this University had to compete hard in the matriculation examinations and they are usually determined to study hard in the course they chose. They probably know the value of higher education, and regard, quite correctly, acquisition of knowledge, as their main object in the University. Few, however, realise the importance of recreation. Many times I have asked a newly-joined student what recreational activities he or she was going to take up in the spare time, and got the same reply:—"Now that I am in the University, I shall be too busy for anything except my studies". I believe that the University in addition to imparting knowledge has another function to perform which is – to build student's health and character, and in this function recreation plays a vital part.

The word "recreation" is often given many meanings and is used to cover many activities some of which are pleasant and relaxing, but are purposeless. People need these from time to time, as they need rest and sleep; it is good, once in a while, to flop into a comfortable armchair and read the silliest little novel which happens to be within one's reach. This is not, however, the recreation which I have in mind. The one I have in mind can be described as a pursuit of wholesome leisure-time interests, always containing an element of achievement and purpose. The pursuits can be physical or mental, cultural or social, undertaken alone or in company. Games, sports, art, music, chess, science and many other activities are all recreative activities when they do not represent one's principal occupations.

For many students, physical activity, and sports in particular, is the main recreation, but recreation is much broader than just a sport's programme. Various pursuits which collectively make up recreation should, of course, be based upon freedom of choice and should be available to all.

All will agree that the object of good education is to produce good people, who possess not only the skills and abilities in their professions, but who can also take their places as responsible citizens in their community. Recreation contributes to this object in many ways, few of which may be mentioned here:—

It provides —

1. Students with an opportunity to learn how to live in harmony with other people and to appreciate value of desirable social contacts with other people.
2. Opportunity to find and develop new interests and broaden the scope of activities.
3. Opportunity to participate as a responsible citizen in social and economic problems of own community.
4. Opportunity to understand and enjoy literature, art, music and other cultural activities.
5. Opportunity to attain a satisfactory emotional and social adjustment, through organised activities such as sports, dances, concerts, plays.
6. Opportunity to develop constructive thinking in management of clubs, writing plays, etc.

Recreation has a very important part to play in building up the health of the student body and is therefore of particular interest to the Student Health Service. The World Health Organization's definition of health is as follows:—"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." One of the objects of Student Health Service is to create a healthy environment and atmosphere in which students may develop these attributes of health. The value of recreation to the Health Programme lies in the fact that recreation promotes a feeling of well-being, and the student soon begins to realise the therapeutic value of exercise, value of relaxing leisure, and satisfaction of sharing it with others.

Viewed from a narrower angle, recreation is needed as a balancing factor in a student's heavy schedule of work. In the tension of

present-day life one realises more and more value and necessity for relaxing. With greater competition in the world today, more is required from students, and the tension which students show at examinations is more evident today. Recreation helps to relieve physical and emotional tension and to build physical and emotional fitness.

An investigation, among newly joined students, into their recreational activity before they joined the University showed the following picture:—

Recreational activities

	Regular	*Occasional*	*Never*	*Total No. of Students*
Physical	83	139	51	273
Cultural and Social	47	58	168	273

These results showed that a high proportion of students had little opportunity of taking up recreational activities especially in the cultural and social fields; or possibly little attempt was made to encourage them in this direction.

University can play a very important part in making recreational facilities available to all students and encouraging students to participate in them. In fact, a great deal is being done. Compulsory residence in the Halls allows students to live and mix together and develop common interests. Numerous students' clubs, societies and groups are all actively encouraged by the University with the same aim in mind. Physical education has now an official standing as a University Department with a full-time Director in charge. A place for it may well be made in the educational programme. Can anything more be done in the direction of other recreational facilities? I believe it can, by planning recreation for students as a programme at a staff level. While it is possible for the students to run a bridge club or a badminton club, it may need more organised effort and help from the staff, to establish, say, an Orchestra or a Choir, or a Dramatic Society. Naturally, in all these activities the participation of students is the real measure of success, and the real problem is how to get students interested in them.

A glance at the freshman's guide to the Students' Union activities will show a large number of students' societies, embracing among them, most of the recreational activities that are likely to interest an average student. I am sure that every student will be able to find among these activities some pursuit, a hobby or an interest which will enable him to experience a real sense of achievement and to enjoy self-expression. I am also sure that, as his activities develop and change and his understanding grows, he will become a better student and a better individual.



WRITE

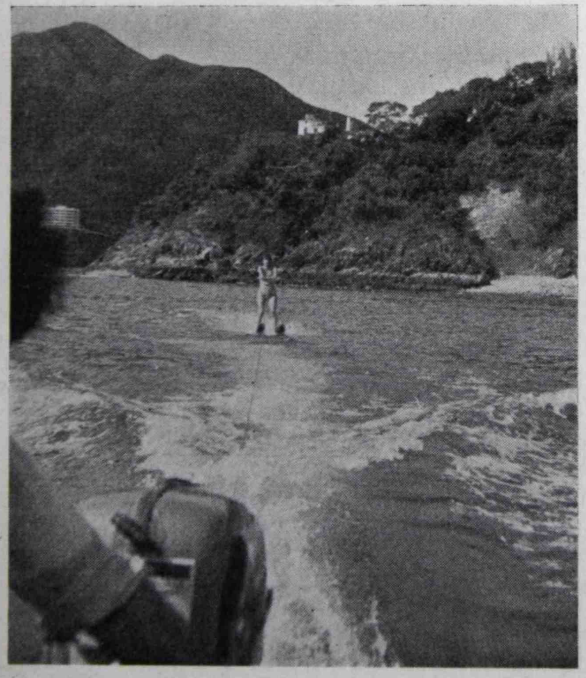
FOR ELIXIR ! !

ARGUE IT OUT !

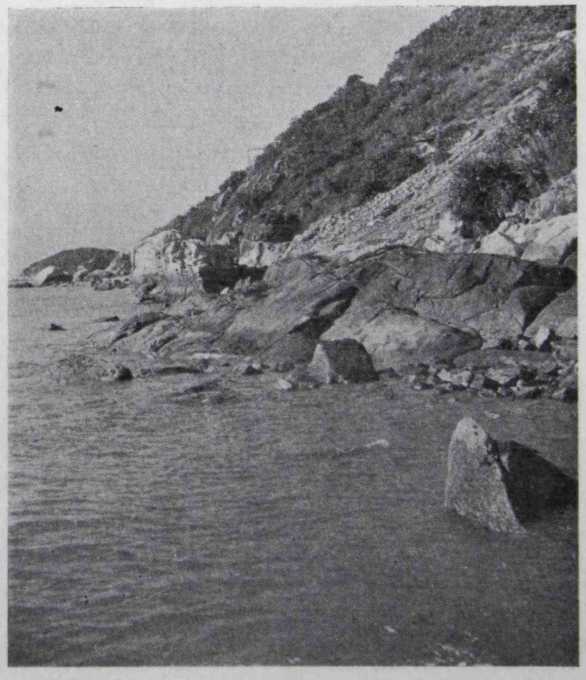
The Director of Physical Education challenges you!

Where were the photographs taken? . . . . Don't worry about the sport . . . . Don't worry about the faces (Who would, anyway?)

On the site of a building donated by you . . . . ?



If only she would move her head and would be easily recognised.



This is visible from afar.

HEALTH IN THE WESTERN PACIFIC

By I. C. Fang, M.D. Regional Director
WHO Western Pacific Regional Office.

The Western Pacific region has a wide divergence in cultural, economic and social patterns. Within its boundaries there is a sharp difference in the standard of public health development and progress in health services. The health needs of countries vary greatly; the health services of governments in the region range from those which have been firmly and soundly established for many years to those which have been started only recently and those which have been initiated on a sound administrative and technical basis within the ten-year lifetime of the World Health Organization. And although there are very few health problems in the world which are not to be found in many parts of the region, there is no common outstanding health problem for the entire Western Pacific. The region is, indeed, one of those parts of the world where the past meets the present and where the varying degrees of development in many phases of life are somewhat sharply defined. However, during the years following the establishment of the World Health Organization, there has developed a common denominator to the health progress in the region. That common denominator is, taken altogether, the increased awareness in health and health work, the stimulation and encouragement of governments to promote and protect health and the acceptance by all of the concept that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Progress in health work within the Region must be taken within the context of the overall governmental programmes, taking special note of the changing attitudes of governments with respect to those health projects. It is particularly important to mention that the attitude of governments with regard to WHO assistance has considerably improved; the advisory role of WHO personnel is now more understood and appreciated. The idea that WHO assistance and training is paving the way for national staff to take over control of those projects is gradually taking root. This welcome attitude may well be reflected in the many requests received by WHO from governments for the expansion of existing programmes and assistance in new projects. Since the inception of WHO, there has grown a noticeable change in the thinking of Member-Governments in so far as a re-examination of their health needs and health problems are concerned. Looking back at the years after the Second World War and following the establishment of WHO in the Western Pacific, one is heartened by the big stride in the march of health. Ravaged by war and beset by disturbed conditions and a multitude of post-war headaches, many governments of the Western Pacific countries nevertheless rallied on and continued with their work of nation-building. In that painful task of rebuilding from the ruins of war, the World Health Organization can claim a share, a duty fulfilled, which it sweated for with much the same zeal and enthusiasm.

It should be remembered that assistance to countries in the Western Pacific did not start with the opening of the regional office. Joint WHO/UNICEF projects were being directed from Geneva before the office could be set up and because of the close contact necessary between Member-Governments and WHO in carrying out the expanding assistance projects, the need for a regional office became urgent in 1950.

A basic purpose behind all WHO assistance is the strengthening of national health services. While in the early days WHO-assisted projects principally were in the form of control measures against communicable diseases, this basic aim was always part of the programme. Gradually, emphasis shifted to the training of personnel and in a region where the dearth of adequately trained staff has more than once threatened to arrest progress in health work, the shift in stress was indeed a very wise one. This emphasis in training has led to the realization by

Member States that regional facilities should be utilised as much as possible in the training of personnel, taking into consideration the similarities in health problems which exist in various groups of countries. This inter-regional training scheme is a departure from the former practices in the Region and is helping shape new approaches to health problems common to some countries in the Western Pacific.

The stress in training programme has led to an increase in the number of projects requiring assistance to educational institutions which were accomplished through visits of short-term consultants, seminars, exchange programmes, visiting lecturers, and the provisions of medical literature and teaching equipment. As the number of trained workers in the Region grows, more intensive courses could pe organized so that the level of training could be gradually raised until the desired standard is achieved. And with the upgrading of the standard of health workers the strengthening of health services of the various countries would move nearer to complete realization.

Among the earliest activities of the Regional Office were those directed to the control and eradication of communicable diseases such as malaria, yaws and tuberculosis. If any highlight is to be singled out in the continuing fight against malaria it is the expansion of control programmes into malaria eradication campaigns. Governments have particularly been alerted to the difficulty they would encounter should the anopheles mosquito develop resistance to insecticides and a change in strategy has been adopted in China and in the Philippines to meet this eventuality. In the same manner, countries in the Region have become aware of the common dangers posed by malaria, particularly in areas where there are common national boundaries. This awareness has led to inter-country programmes, two of them now in operation. These are the Anti-Malaria Co-ordination Board with representatives from Burma, Cambodia, Laos, the Federation of Malaya, Thailand, and Viet Nam and the Borneo Conference covering Brunei, North Borneo and Sarawak.

A highlight of the continuing fight against *malaria* is the expansion of government control programmes to malaria eradication campaign. An example of an effective malaria eradication programme is in Taiwan where assessment of the programme showed

" The treatment for this condition will be . . . er . . . free? . . . no Sir, I mean bed rest . . . tonight? . . . er . . . I mean high protein diet . . . "

that malaria transmission has been interrupted in most parts of the island after two consecutive annual residual sprayings. I am happy to report, for instance, that whereas in 1951 1,200,000 cases of malaria, resulting in 12,000 deaths were reported in Taiwan, in 1956 only 492 cases with no deaths were reported. As you can see from these figures *we are making progress*. In the Philippines, malaria has also ceased to be a major public health problem in many of former hyperendemic areas and efforts are now aimed at the eradication of the disease. In view of the emphasis given by the Ninth World Health Assembly, and the WHO Executive Board, governments have been particularly alerted on the need for pursuing the goals of malaria eradication and have been warned of the difficulty they would encounter should the anopheles mosquito develop resistance to insecticides. In general, anti-malarial efforts in the Region have been handicapped by two main problems: namely, the lack of sufficient number of trained malaria-control workers, and the lack of funds for supplies, equipment and other expenses needed in an intensive anti-malaria campaign. A third problem also exists in some countries and it is the need for studies to determine whether malaria transmitted by the local mosquito vector could be effectively and economically controlled by the modern anti-malarial techniques.

Some significant results of WHO participation in yaws control in the Region have been the stimulation and encouragement of further interest of governments to improve the health conditions of the rural areas, the greater readiness of health personnel to undertake work in rural areas after their experience in control projects and the stimulation of the people to want improved health conditions for themselves. The yaws endemic areas have been drawn, or are being drawn, into a regional wide programme. The disease, which has persisted in a number of countries for many years and which is a major public health problem in some areas, may eventually bow out of the scene.

In the field of tuberculosis, programmes have been limited to BCG campaigns during the early years. Gradually, the concept of tuberculosis as a public health and not a clinical problem is being accepted in many countries: techniques, methods, supplies, equipment and recording of results have been standardised. With the award of fellowships to train medical officers and nurses, tuberculosis control services are being improved. A significant trend which has been encouraged by the Organization is the increasing emphasis on overall tuberculosis control projects in which BCG will be an integral part.

The incorporation of health education in many WHO-assisted projects was a major development that helped shape a new philosophy of health among the peoples of the Region. In some countries, this has led to a different concept of health work and increased participation of the community in health education in some aspects. There is no doubt that the emphasis given to health education in some field projects, notably in the Schistosomiasis Control Pilot Project in Leyte, Philippines, is helping establish a firm foundation for health in the grassroots level. Where health work was mainly on the preventive side, the participation of the community for health betterment has touched off a new consciousness; thus people in those areas are now aware of the value of health. The urge to better their station and to work for cleaner surroundings have been kindled and it would be safe to say that in those areas where the projects have gained headway, the people have now realized that they can better their lot through means within their reach and capacity. There is the snowballing interest in environmental sanitation and the role it plays in improving the health of the population. Coupled with this is the fact that governments are realizing that foundation of sound environmental sanitation programmes rests on the provision for sufficient numbers of well-trained and qualified professional and subprofessional workers in the field. The prognosis is that for the next five years more significance gains both in magnitude and quality will take place in the field of health education because the inertia of acceptance of new ideas has been overcome.

In the field of nursing, there was a great disparity in development among many countries in the Region; while some had progressive nursing standards and a corps of qualified nurses, many countries had no

nursing service, so to speak of, in the years immediately after the Pacific war. There were various causes that accounted for the dearth of nursing personnel, chiefly due to the complexity of factors related to the economic, cultural and social patterns existing in the countries concerned. In many areas, nursing was generally confined to menial tasks or acquisition of certain skills to assist the doctors. Outside of these, there were certainly no incentives for the growth of the nursing service. However, during the period 1950 to 1957, WHO assistance in nursing and midwifery education was given in almost every country and territory in the Western Pacific. The field projects that were carried and still are being carried on were particularly concerned with the improvement of the quality of the nursing practice. Now programmes in basic nursing have been established and programmes for preparation of nurses and midwives at the professional and auxiliary level have been strengthened. The years slowly evolved a 'new look' for the nursing profession: nurses began to take increasingly active part in professional problems and new legislations controlling the nursing and midwifery education, practice, registration and examination have been passed in many countries; in others, existing laws have been revised while in a few countries such laws are under review and revision. The different attitude to nurses which developed as a result of these projects augur well for the further improvement of health services in the Region. The fact that, for the first time in the history of some countries, nurses have been appointed as directors or assistant directors of schools of nursing and nursing services and that nurse representation at national government levels have been set up show that within the span of a few years, WHO helped raise the profession into a much higher status.

The same disparity in development exists in the field of maternal and child health and in many countries the lack of qualified personnel hampered the growth of services in this phase of public health. The need for improving maternity care services is a very real one in many parts of the Region, especially where a high proportion of births are still attended by untrained persons. In addition, to assisting countries to increase the number of trained professional and auxiliary midwives, WHO and UNICEF have also helped to develop training programmes to improve the services of traditional birth attendants. This serves as a double purpose as it is an interim measure to provide better care at the time of delivery until sufficient trained staff are available and it also provides a useful link between the health services and the community where the traditional birth attendant often holds a position of considerable prestige and influence. This programme has a very laudable effect on the public health structure of the country; it reaches to the remote corners of rural areas and in communities where trained personnel are not yet sufficiently attracted to for the practice of their profession. The traditional midwives are effective transmitters of the 'new' concept of health to the mothers in the villages and areas where health education and some elementary forms of hygiene are still wanting. It has the effect of creating a wider base for a health education pattern, at the same time achieving the goals of improving maternity care.

A general review, however, of the maternal and child health situation in the Region would reveal many needs still unanswered: more well-trained paediatricians are urgently required; there is a dearth of maternal and child health administrative units at national levels; nutritional problems have as yet received insufficient attention and the development of sanitation services are still inadequate although they are of primary importance to child health. But to give specific instances of progress in this field, programmes in some countries could be cited. Specialised programmes for the care of premature infants and for handicapped children have been developed during the past five years by the Government of Japan. In the Philippines, a domiciliary premature infant care services, associated with the domiciliary obstetrical service in Manila has also been jointly assisted by WHO and UNICEF. Many more of these specific projects could be cited and it would be readily noticeable that steady progress has been made to overcome the major problems in this field, with the assistance from WHO and UNICEF playing a major part.

There are other problems such as Mental

Health that are receiving the attention of the governments of the Region. Progress in this field continues to be hampered in the Region by the lack of trained personnel at all levels and the reluctance of graduates to seek service in this particular field. To solve this problem the World Health Organisation has helped to provide opportunities for training personnel through fellowships. At this moment a WHO consultant is helping the Government of the Philippines in the task of modernising the country's mental health services.

At the outset of this article, mention has been made of the common denominator to the progress of health work in the Region and that outstanding feature became more clear in the development of the health services that were mentioned. There is, however, another equally significant step that WHO has made over the years. Through its sponsorship of seminars, conferences, study tours and visits concerning almost all phases of health problems, there has gradually developed a kinship, if we term it that way, among the health officials of countries in the Region. Where before each country worked in a vacuum, there now exists a working relationship; where each country before had its own standard of health practice, there is now a common pattern and system being followed. There is a gradual outflow and intake of scientific information, working method as well as improved practices from one country to another; knowledge, indeed, is pooled and is made available to all. Over and above these are the lasting personal contacts that result from the meetings of health officials, thus bringing about the foundation of all the efforts of WHO as well as the United Nations and all its other agencies.



THE SIXTH INTERVARSITY GAMES

The Malayan University team, led by their president Rahim Kadir, arrived on June 12th. Throughout their stay they played four official games and attended a number of functions and outings.

Here are some of the highlights:

June 14th—Hockey

The visitors were just too fast and strong for us, beating us by 7 - 0. They played an aggressive game, while their defence was equally good.

June 17th—V C's Cocktail Party

Drinks and cocktails mixed freely with guests and hosts and a very enjoyable time was had by all.

June 18th—Chancellor's Tea Party

A very refreshing tea amidst exceptionally fair weather, as the whole Malayan Contingent and many of our players enjoyed themselves in the company of His Excellency the Governor, Lady Black and Miss Barbara Black.

June 21st—Tennis

Playing an all-round game, the local boys were too good for the visitors who, however, put up a stern fight especially in the doubles.

June 26th—Badminton

There was no doubt about the outcome of the match. The Malayan team won all their matches beating us 7 - 0. In addition they had a Thomas Cupper, Lim Say Hup, who gave us some brilliant play in the mixed doubles and doubles matches.

June 29th—Soccer

At half time, HKU led by 2 - 0. Then MU's goalkeeper scored an unexpected goal and their centre-forward equalised the score. However, an excellent 'header' by Rondo Bernardo saved the day for HKU.

July 1st—Farewell Dinner

This took place at Winner House. Trophies were presented to the winning teams, while the two presidents both exchanged addresses and pennants. Departure took place on the following day.

PARKINSONISM ?

Apologies to all medical students who have made or will make their brilliant stand in the siege of the Thursday morning clinics!

NOTES AND NEWS

PERSONALIA

Professor Daphne Chun was appointed by by University of Malaya to be External Examiner in Obstetrics and Gynaecology and visited there in December 1957.

Professor L. G. Kilborn was appointed by the University of Malaya to be External Examiner in Physiology and visited there in March 1958.

The degree of Doctor of Philosophy has been conferred on Dr. Lillian S. C. Pang, Demonstrator in the Department of Pathology, and British Empire Cancer Campaign Research Fellow, by the University of Leeds.

APPOINTMENT

Dr. Lillian S. C. Pang, B.S., M.D. (Shanghai), PH.D. (Leeds), Demonstrator in the Department of Pathology, to be Assistant Lecturer in Pathology from January 1, 1959.

GIFTS

A sum of U.S.$15,000 has been given by the China Medical Board of New York, Inc. for the purchase of equipment for the teaching of experimental pharmacology.

A sum of £1,540 has been given by the British Empire Cancer Campaign for Cancer research in the Dept. of Pathology.

British Empire Cancer Campaign Research Fellowship. Dr. Lillian S. C. Pang has been appointed to the Fellowship for one year from January 1, 1958. The Fellowship has been instituted in the Dept. of Pathology with the gift referred to above.

PUBLICATIONS

Professor Daphne Chun: "Endometriosis, Adenomyosis and Pregnancy", *The Journal of Obstetrics and Gynaecology of the British Empire*. Vol. LXIV, No. 5 (Oct. 1957).

Professor P. C. Hou: "Malignant Tumour of the Liver, Extra Hepatic Ducts and Gall Bladder," *Cancer* Vol. II, Chapter 10 (Batterworth & Co., London, 1958, pp. 168-185).

Dr. T. B. Teoh: "Epidermoid Carcinoma of the Nasopharynx among Chinese: A study of 31 Necropsies", *Journal of Pathology and Bacteriology*. Vol. LXXIII, No. 2 (1957, pp. 451-465).

UNIVERSITY REPRESENTATIVE

Professor P. C. Hou, at the Seventh International Cancer Congress in London from July 6 to July 12, 1958. Professor Hou has been invited to be a co-chairman of the section meeting on Tumour-Host Relationship.

VISITING EXTERNAL EXAMINERS

Professor B. H. Sheares, of the University of Malaya, for the Degree Examinations in Obstetrics and Gynaecology, in May 1958.

Dr. H. Brown, M.D., U.S.O.M. to Thailand, for the Degree Examinations in Medicine, in May 1958.

Professor G. S. Yeoh, of the University of Malaya, and Professor J. Bruce, of the University of Edinburgh, for the Degree Examinations in Surgery, in May 1958 and May 1959 respectively.

UNIVERSITY REPRESENTATIVE

Professor Daphne Chun, on the Nursing Board for a further term of three years from May 1, 1958.

PRIZES

The following prizes and medals have been awarded on the results of the Degree Examinations held in May 1958:

Faculty of Medicine

Anderson Gold Medal: Mr. Patrick Wei Tze Him, *Ho Fook and Chan Kai Ming Prize:* Mr. Patrick Wei Tze Him, *C. P. Fong Medal in Medicine:* Mr. Patrick Wei Tze Him, *Digby Memorial Gold Medal in Surgery:* Mr. Patrick Wei Tze Him, *Gordon King Prize in Obstetrics and Gynaecology:* Mr. Patrick Wei Tze Him.

APPOINTMENTS

Dr. David Todd, M.B., B.S. (Hong Kong), M.R.C.P. (Edinburgh), Assistant Lecturer in Medicine, to be Lecturer in Medicine for three years from the date of his arrival in the Colony.

Dr. Rosie T. T. Young, M.B., B.S. (Hong Kong), to be Assistant Lecturer in Medicine from the date of Dr. Todd's new appointment.

LEAVE OF ABSENCE

Dr. Joseph Y. C. Pan, Assistant Lecturer in the Department of Medicine, has been granted six months' paid special leave for postgraduate study in the United Kingdom.

Dr. K. K. Chow, Assistant Lecturer in Obstetrics and Gynaecology, has been granted six months' unpaid leave from August 1, 1958, to undertake higher studies in the United Kingdom.

Dr. Rosie T. T. Young, Assistant Lecturer in the Department of Medicine, has been granted one year's unpaid leave from September 1, 1958, to enable her to take up a Sino-British Fellowship Trust Fellowship for study in the University of Glasgow.

Dr. C. T. Huang, Lecturer in Bacteriology, has been granted an extension of leave for a further twelve months from October 1, 1958 to enable him to take up a Sino-British Fellowship to continue his work at the University of Leeds.

HONORARY RESEARCH FELLOW

Dr. Kwok-Kew Cheng, M.B., B.S. (Hong Kong), Ph.D. (London), has been appointed Honorary Research Fellow in the Department of Obstetrics and Gynaecology.

GIFTS

A sum of US$9,000 has been given by the China Medical Board of New York, Inc. for the purchase of equipment and supplies for use in the research programme of the Department of Anatomy.

DEPARTMENT OF PHYSIOLOGY

D. E. Gray and S. M. Loh: "Metabolic Effects of Alpha-Tocopheryl Acetate. I. Influences of Alpha-Tocopheryl Acetate on some Lipids and Nitrogen Compounds of Plasma in Human Subjects", *Canadian Journal of Biochemistry and Physiology* (1958, 36, 269-273).

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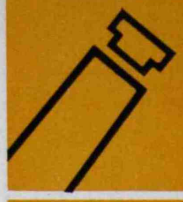

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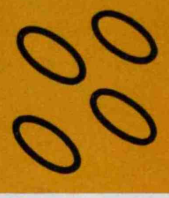

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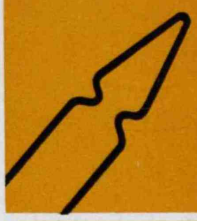

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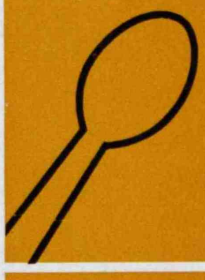

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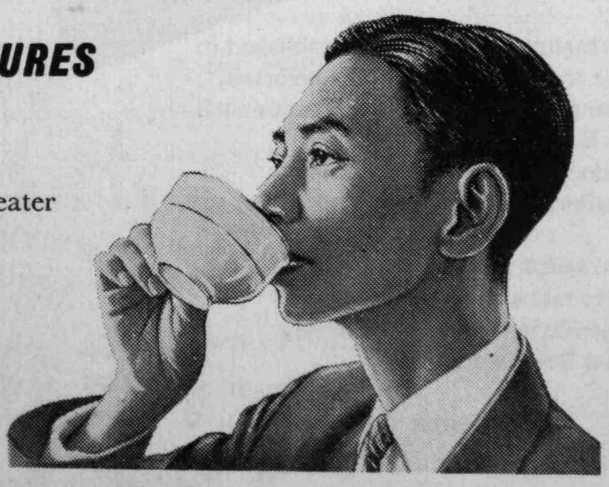

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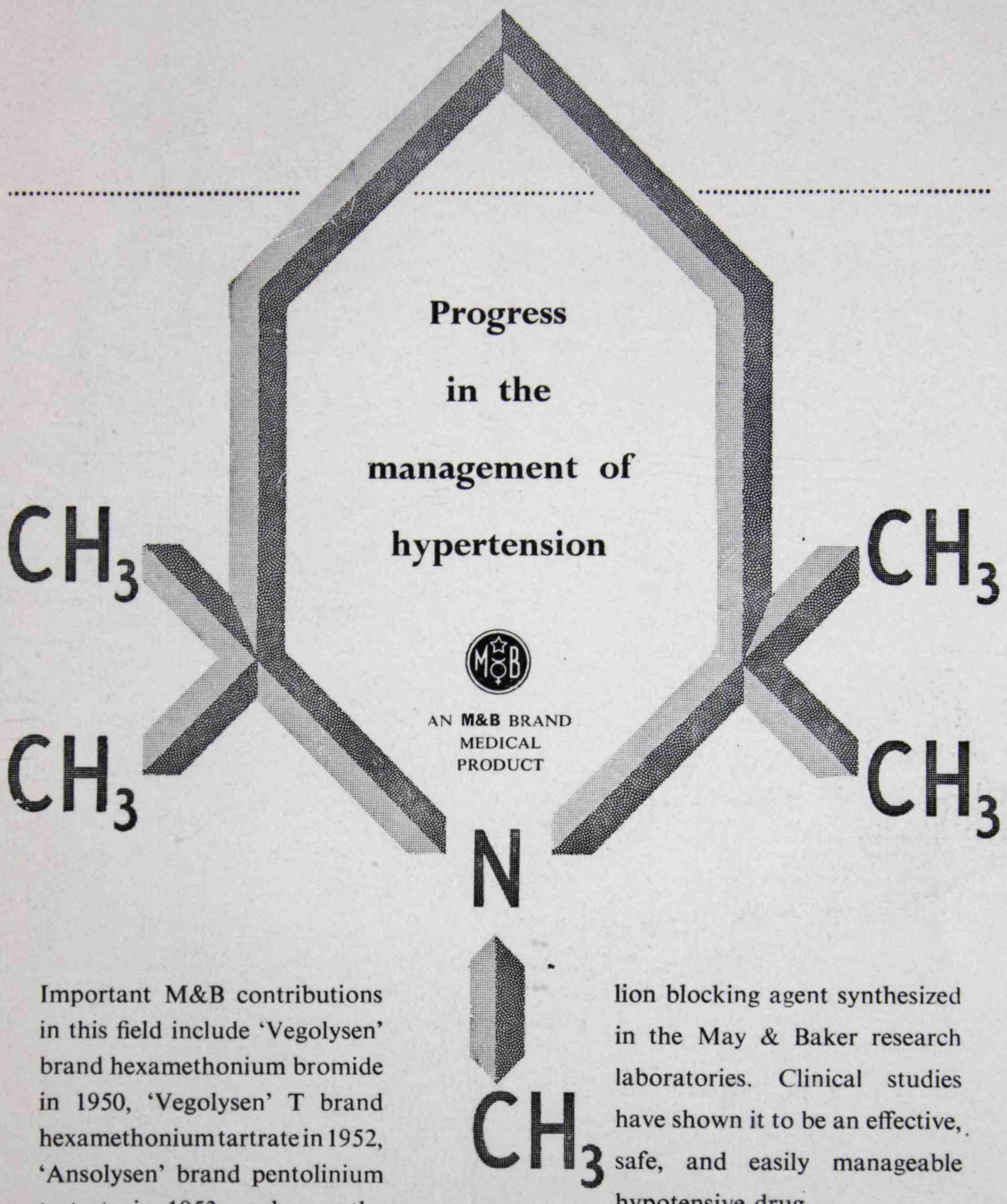

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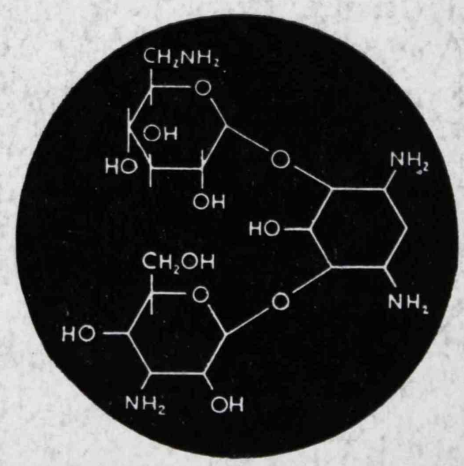

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