DELIVERY AFTER PREVIOUS CAESAREAN SECTION

— R. Law —

I. Introduction

Thanks largely to the advancement in antibiotics, improved anaesthesia, and the availability of blood transfusion, Caesarean section is now performed with increasing impunity and frequency. Maternal mortality rate has fallen from a level of 75% at the middle of last century to less than 10% at the beginning of this one and at present the mortality is around 3.5 per thousand (England and Wales, 1968)

Subsequently, more and more pregnant women present themselves to our obstetrical clinics with a previous Caesarean section scar in their uterus, and the management of deliveries in these cases continue to be of special interest to obstetricians all over the world.

II. Once a Caesar, always a Caesar ?

This previously well respected dictum was challenged as early as 1930 by Williams, and subsequently during the last 40 years by various workers, more recent ones include Pauerstein (1966), Donnelly (1967) Pell and Chamberlain (1968), McGarry (1969) Kuah (1970).

The original reason for the avoidance of vaginal delivery following a previous Caesarean section is the probable rupture of the uterus through the previous scar with an associated maternal mortality of 50-70% and a fetal mortality approaching 100%. However, today, with most of our Caesarean scars being of the low, transverse type and the improvement in the technique of management as well as operation, rupture of the Caesarean scar has been low (table 1)

Table 1. Incidence of Rupture of Uterine Scar

Author	Incidence
Birnbaum (1956)	1.0
Browne (1951)	1.0
Chesterman (1953)	1.8
Chong (1968)	1.0
Douglas et al (1963)	1.1
Salzman (1964)	0.6
Kuah (1970)	1.1

Also, the maternal mortality rate from rupture of a uterine scar is reported to be 0.1% to 4.0% (Muller et al, 1961; Pauerstein, 1966). Thus the risk of a patient with a scar in the uterus losing her life in the process of labour is indeed small. In fact, the latter author concluded that the presence of a transverse lower uterine scar seemed to add little maternal mortality and fetal risk to that inherent in labour and vaginal delivery.

Further, Donnelly (1967) shows that in a series of 486 cases, the perinatal mortality rate was 2% among patients who has repeated sections and 2.4% among those selected to be delivered vaginally. Certainly, there was no indication that elective repeated Caesarean section guarantees a lower perinatal mortality rate than vaginal delivery of selected gravidas with previous section. Obviously with more careful selection of cases, perinatal mortality rate can still be lowered even further.

Thus in all the well-equipped obstetrical centres today, cases of previous Caesarean section are admitted before term for careful assessment and selected cases are allowed to deliver vaginally. (Table 2)

Table 2: Vaginal Delivery after Cesarean Section

Author	No. of Patients	Vaginal Delivery %
Cosgrove (1950)	500	35.8
Schmitz & Gajewski (1951)	448	32.6
Wilson (1951)	167	33.6
Lawrence (1952)	195	21.6
Lane & Reid (1953)	114	16.0
Riva & Teich (1961)	214	73.8
Allahbadia (1963)	565	53.3
Lawler et al (1966)	165	34.0
Chong (1967)	452	70.2
Kuah (1970)	454	55.3

Just as McGarry (1969) claimed that no more than 12% of patients required a repeated Caesarean section, in Kuah's series (1970) of 367 cases, elective Caesarean was done in 29%, and vaginal delivery was successful in 78% in the remaining cases. Such a result is indeed gratifying to both obstetrician and mother.

III. Management of Patients previously delivered by Caesarean Section

The following discussion assumes an up-to-date and qualified care from an obstetrical department.

Post-natal care after Primary Caesarean Section

Poidevin (1965) first put forward concrete evidence that hysterographic studies after Caesarean section provide quite an accurate assessment of the status of the uterine scar; and his view has been supported by various other workers (Pauerstein, 1966, Ruiz-Velasco, 1967).

However, in practice, this has not yet been a widely accepted routine for various reasons, the patient failing to return for investigation being one. This is indeed unfortunate as an immediate post-natal assessment of the uterine scar would provide valuable reference during subsequent pregnancy.

Antenatal care of subsequent pregnancy

Patients who were previously delivered by Caesarean section should be encouraged to present early during the prenatal period, when the obstetrician concerned should

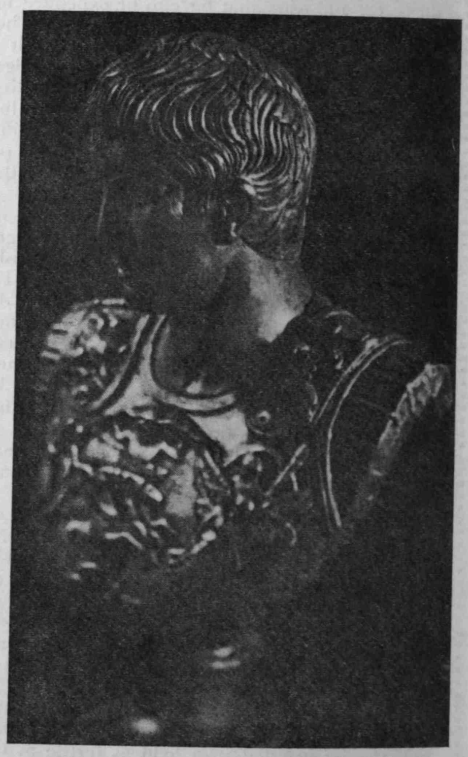
(A) find out the causes for the previous Caesarean section. The argument is that some factors may be recurrent ones (e.g. cephalo-pelvic disproportion, contracted pelvis) while others may not necessarily be present again, e.g. placenta previa, toxemia of pregnancy. Kuah's series (1970) revealed that only a small percentage of patients had a repeated operation when the original Caesarean section was performed for indications other than disproportion (table 3)

B) review the nature of the previous operation. Tracing the previous records will reveal whether it is a lower-segment transverse section or a classical section or may be even some other types. The surgeon's comment on whether there is any tear or difficulties in operation procedure (e.g. uterine muscle may be edematous from too long labour) should also be noted.

Note that a lower-segment scar usually heals much better than a classical one. Although in Browne and McGrath series (1965) of successful cases, 21 (among 386) of the patients delivered vaginally have had a classical scar, the obstetrician should be on his guard if he ever allows these cases to go into labour.

In any event, a hysterographic study record, if available, would be most valuable.

(C) find out any history of morbid pueparium in the previous section. It is generally taught that a weak scar



Julius Caesar . . . . . his birth and death being associated with the use of a knife.

Table 3: Indications for Caesarean Section

Indications	Primary C/s	Repeated C/s as for primary C/s	Repeated C/s New Indications
Prolonged labour	75	6	4
Cephalo-pelvic disproportion	58	39	2
Placenta praevia	51	1	6
Toxemia of pregnancy	35	2	3
Abruptio placentae	22	0	1
Fetal distress	21	7	11
Failed induction	18	3	4
Cord complications	11	0	1
Miscellaneous	75	10	15
Previous C/s + unfavorable factors, e.g. high head	—	0	91
TOTAL	366	68	138

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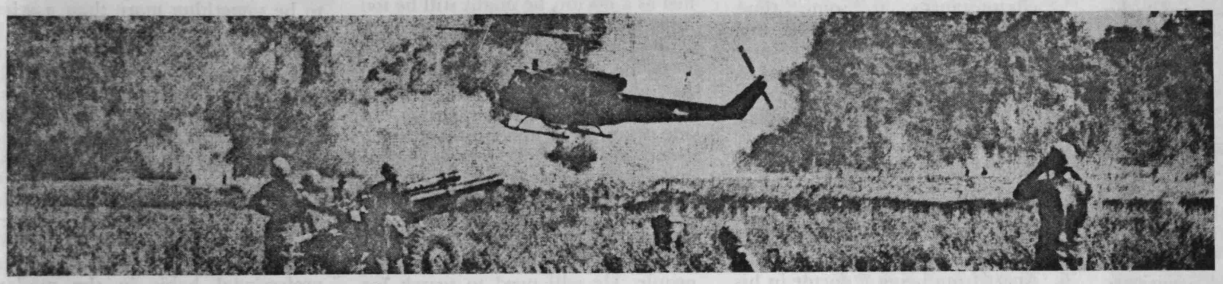
雨

南飛雁



雨，
我愛下雨，
愛在雨中漫步，
愛聽那大自然的脉搏——滴滴嗒嗒……。
愛着每一滴——造物主賜的，
雨。

×

但是，
曾幾何時，
雨，
一般兒的雨——天上下的，
四日四夜的雨；
落在秀茂坪的山坡上，
落在「安置區」，
轉瞬時間——
山泥！
木屋！
被「安置」的人——
你們在那兒？

×

一隻黃狗，
頭不見了，
尾巴在搖，
後腿在掙扎；
「把牠拖出來。」
是出來了，
但——
家在那裡？
主人在那裡
嗅嗅——。
聞不到？

×

家沒有了！
「不，你們可以再次被安置。」
「不去，我怕再……」
「這次不同了——
是安全的大廈啦！」
安全的大廈？？
爲何須經一場浩刼始獲安置！

×

半山，
旭和道，
十二層高的也倒了。
「這是上天的公平安排——
窮富一樣。」
但，
這「上天」到底是甚麼？
「百多人死啦，太慘了！」
是的，太慘了。
可是，
在那不遠的地方，
在這星球上——東南半島的一角。

×

雨，
是天上下的，
却非一般兒的雨。
十多年了；
你我都曾在電視機前嚷着：
「眞的！是眞的！」
那裡的雨沒停過，
有些直下，
有些橫行；
打在人身上——
人要躺下，
打在房子上——
房要破毀。

×

只見那，
穿了綠衣裳的人使勁的拖着另一個——
像我和你拖那黃狗一般。
慘嗎？？
「不一定，誰叫他們帶有武器？」
帶武器的不是人？……
眞的——
誰叫他們帶槍？
是誰？

×

不過，
沒槍的一樣，
雨仍然打下來，
誰也逃不了——
一個女孩，
拿着一片紙，
想把雨陣間的陽光擋住，
免得媽媽在雨後又遭太陽蹂躪，
媽媽再也看不到陽光——
媽媽却渴望陽光是永遠的！

×

雨，
還在下，
不論是窮的或富的，
不論是帶槍的或赤手的，
都一樣。
「這是上天的公平安排——
窮富一樣。」
但，
這「上天」到底是甚麼樣？

×

還是愛下雨——
天上的一點一滴，
請不要用別的東西使它蒙羞！

七二年六月雨夜。

The Editorial Board wishes to thank the special support of Glaxo, Hong Kong, Ltd.

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TO BE A-DOCTOR-AND-A-MAN

dent a goal which he must strive to reach. That picture was upheld to the physician of ancient Hellas in the so-called 'Hippocratic Oath'. It was natural to link it with the name of Hippocrates, for he 'will ever remain the type of the perfect physician.' . . . It is only, however, in modern times that society generally has acknowledged in the medical profession such a standard of professional behaviour as the Hippocratic Oath demands. The brilliant dawn of Greek medical science was soon overcast, and succeeded by the 'cloudy and dark day' of superstition and barbarism."

To make a point further, it might seem appropriate here to suggest that to be a doctor does not necessarily equate with to be a specialist of some kind. He is not educated to pursue after honour or prestige (and, of course, money, too.) He needs not be a Nobel prize winner, not even a MRCP or FRCS before he can do something. As long as he is a doctor, he is already entitled, or perhaps privileged, to make good service to people. I never mean a doctor should not be a specialist, but he never, I think, need to be one with a long list of professional titles.

Somehow, it has to be admitted that a doctor may think too much in terms of himself, too easy to be satisfied in a vertical pursue. He may be too ready to forget his responsibilities toward his people in a horizontal direction. He would have been ignorant of the fact that the people outside have been paying a large stake on the doctors and medical students on training, hoping that someday the younger generation of graduates may bring life and happiness to the living of the people. Yes, a doctor should be, and should remain to be, a doctor of the people. He should meet the needs of the people, not those of himself, for the people themselves are the objects of all trained people eventually.

My last words are: never be a trained doctor, who could have been so easily replaced by a machine or computer of diagnosis, for what distinguishes a doctor from a machine is his individuality with distinct judgment and personal understanding, of the needs of his fellow-men, who are men and not machines.

"May I never see in the patient anything but a fellow creature in pain.

Grant me strength, time and opportunity always to correct what knowledge I have acquired, and always to extend its domain. For knowledge is immense and the spirit of man can extend infinitely to enrich itself daily with new requirements. Today he can discover his errors of yesterday and tomorrow he may obtain a new light on what he thinks himself sure of today."

Maimonides (12th century Physician and Rabbi)

Fight, Fight, Fight and Fight to be an ordinary doctor with a successful career.

TO BE A-DOCTOR-AND-A-MAN

BERNARD LAU

A man is a creature that can walk and talk, take and give, smile and lie, and love and hate.

A doctor is one who is expected not only to restore a normal life to those who are suffering, physically or mentally, but also to give JOY to the suffering lives.

A-doctor-and-a-man is a man who stands among the people as a doctor.

To be a-doctor-and-a-man, I further imply:

1. A doctor is not just a computer nor a machine for diagnosis. He is also a man and similar to any other man in any aspect. He should be able to talk, read, appreciate and so forth, like an ordinary man.
2. He would not take his patients as mere patients, something or someone to be repaired here and there. Rather he sees and treats them as men, for he himself is also a man.
3. Sometimes it would seem advisable to transform the doctor-patient relationship into man-man relationship in order that the patient may be at ease or feel free to talk. For that matter, the doctor has to be a 'man' in the eyes of the former.
4. A doctor may wish to be a man, an ordinary man only, in some circumstances at some time, rather than a doctor, one supposed to act or speak in some particular way. In this connection, he has to be always ready to be a man. A kind of dissociation, you may presume.
5. A doctor, as we all know, cannot be perfect. He has weakness both in body and soul, like a man, which every doctor should admit.
6. Apart from being a doctor in his hospital or clinic, he still assumes a man's responsibility in his family, society and country.
7. To be a doctor is his way to stand among and serve people, and to be a man is his aim in life.
8. One is not born to be a doctor. He is born first of all to be a man.

In a word, he cannot be a good doctor without being a good man. A-doctor-and-a-man is more complete in every way than a doctor. In fact, for all the fact that he is qualified as a doctor, he might still be too immature to stand like a man against reality.

To be a doctor is relatively easy. As long as he studies hard enough for the qualifying examination, no one can prevent him from becoming a doctor. In contrast, to be a-doctor-and-a-man demands a great deal of effort on his own part. He has to make ways into the horizons of other fields. He must try to get in touch with the core of life of other people. He will need to search for himself and meaning of his life.

Let us recall a passage from 'The Genesis of the Physician's Ideal' by Bishop Hensley Henson (B.M.J., 1930):

"The physician in modern society holds a very high place. He is generally regarded with respect. It is not merely that his distinctive service is indispensable, and is universally required, but also that he commands the public confidence in a very notable degree, and has behind him a tradition of professional behavior which is generally admired. It is assumed that he will be adequately trained; that he will be entirely honourable; that he will be patient, considerate and assiduous; that he will be generous and even-minded, giving his service as frankly and fully to the poorest as to the richest of his patients; that he will be, in a quite astonishing measure, disinterested. We expect the doctor to be something more than a scientific specialist, skilled in his specific branch of work. We look for education and good manners. He must be welcome in society for his own sake. No doubt there is a measure of idealising sentiment in this conception of the physician; but it is near enough to general experience to maintain itself in the teeth of all individual contradictions, and its existence is not only a remarkable evidence of the high level of medical professional habit in the modern world, but also a precious possession of the medical profession itself. The ideal has, of course, never been realised fully in any individual . . . But the combination in a single picture sets before every medical stu-

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DELIVERY AFTER PREVIOUS CAESAREAN SECTION (con't)

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results from pyrexia and wound infection at the time of the primary operation, but Douglas (1967) denies that this is so. Nevertheless, most obstetrician would be more on the alert in this sort of cases.

In addition, during the antenatal course, the uterine scar should be closely monitored. The patient must be reminded of the importance of immediate reporting of any untoward symptoms. And during each visit the scar should be palpated, any progressive weakness would be significant and any tenderness would be a warning signal of immediate rupture.

Management of Near Term

All patients with one or more Caesarean section scars should be delivered in a hospital with facilities to perform immediate Ceasarean section.

The usual practice is that the patient was admitted at 38 weeks (some would admit cases of classical scars at 37 weeks). Pelvic assessment (usually already done at 36-37 week) and size of baby reviewed to exclude any cephalopelvic disproportion which is the most common recurrent indication for repeated Cesarean section. New indication (table 3) should also be sought and if found the patient be subject to Cesarean section again. If everything is satisfactory, which is by far the majority (greater than 2/3) of cases in modern obstetrical practice, the patient would be allowed for vaginal delivery.

Induction of Labour

Previous Cesarean section alone does not preclude the use of induction of labour (McGarry, 1969). However, this should be used with much caution and close observation by the obstetrician is required.

Management in Labour

During trial of labour for cases of previous Cesarean section, the patient should be given bed rest, nil by mouth, and closely watched. Cross-matching should also be done in case any emergency may arise.

The progress of labour should be closely watched in case any indication, e.g. fetal distress and uterine dysfunction, may arise for a repeated Cesarean section. The uterine scar should also be closely watched for any signs of weakening or tenderness. In this respect, the use of caudal block analgesia is debatable, as it will mask this sign of scar tenderness.

Mode of Delivery

Most cases would be delivered spontaneously, although low forceps or vacuum extractors can be used. Any manipulation, e.g. internal version, however, is best avoided.

Pueparium

Generally pueparium is uneventful: Allahbadia (1963) and Klinges and Gaubrell (1967) both reported a low incidence of morbidity in patients with uterine scar and delivered vaginally, although Kuah's series (1970) shows a higher incidence of blood transfusion after repeated Cesarean section whether elective or following trial of labour.

Before discharging, careful explanation regarding importance of hospital confinement and probability of further successful vaginal delivery should be done by the obstetrician to the patient.

Future Pregnancies

Whereas a successful vaginal delivery does not guarantee similar success next time, a repeated Cesarean section also does not preclude possibility of vaginal delivery next time (Camillen and Busuttil, 1968). These workers based their argument on the established fact that hysterographic studies porvide a reliable guide to the integrity of the uterine scars. Their analysis of 58 cases shows good results (i.e. satisfactory scars) in 72% and they also claimed that the margin is good if (1) both sections were carried out after onset of labour and (2) interval between the 2 sections exceeds 2 years. But in any event, the obstetrician should judge each individual case on its own merits rather than adhering to some fixed rules.

Multiple Cesarean Sections

Just to make the discussion complete, mention must be made of the safety of multiple Cesarean sections. In the literature, up to 14 successful deliveries by Cesarean section have been performed on the same wound. Cosgrove as early as 1952 has claimed that there should be no limit to the number of Cesarean provided that the integrity of the uterus is maintained.

Piver and Johnstone (1969) studied 123 women who individually experienced 4 to 8 Cesarean deliveries and only 1 neonatal death and no maternal death. Three uterine ruptures occurred, all in classical section scars. Nine of the 14 eventual Cesarean hysterectomy were performed for thin scars which would doubtlessly have been repaired.

Although all these figures support Cosgrove's claim, in practice, sterilisation is usually done after about 3 or 4 Cesarean sections either on advice of surgeon or will of the patient (or may be even earlier if circumstances are compelling). Further, in places where obstetrical care is not adequate, repeated Cesarean sections may prove dangerous.

IV. CONCLUSION

In spite of the occasional antagonist, vaginal delivery after Cesarean section is gaining wide support. The practice, if carried out in a good unit with careful supervision, incurs little extra risk for the mother or infant.

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訪香港戒毒會石鼓洲康復中心後記

本年六月二十四日，香港大學醫學院學生會舉行了一項訪問活動，目的地爲石鼓洲康復中心，參加者爲醫學院各年級學生，共二十人，筆者亦爲其中之一。

是日中午，各同學齊集港外線碼頭，乘搭直航小輪往長洲，既登長洲碼頭，即見此行領隊之湯主任，在其指引下，轉乘康復中心專用之小輪，直向目的地駛去。

船行約二十分鐘，即抵達石鼓洲，由碼頭沿一小徑步行片刻，即爲康復中心總辦事處，夾道滿種美麗花卉，鳥語花香，景色怡人。

在總辦事處會客室內，得見院長 Dr. J. B. Hollinrake，林副主任與駐院醫生Dr. Mak，他們均先後發表談話，尤其在述及吸毒者戒毒的過程，我們最感興趣，對此問題，詢問甚詳，以下是談話的主要內容：

本港的吸毒者爲數甚多，尤以二十五歲以下的青年人佔最多數，而絕大部份的吸毒者所吸食的毒品是海洛英（俗稱白粉），原因有三：

（一）海洛英售價較鴉片等其他毒品便宜，

（二）吸食海洛英可以得到較多的刺激性快感，

（三）吸食方法簡單方便：可以不用烟槍、烟燈等器具。

然而吸食海洛英遠較吸食其他毒品危險；因爲吸食劑量必定與日俱增，吸毒者初時可得到快感，漸漸快感消失，代之而起是肉體上的痛苦，這時吸毒者吸食海洛英不再是爲了尋求快感，而是爲了減輕痛苦。隨着吸食份量的自然增加，吸毒者的經濟負担也就愈來愈重，以致貧病交煎，無以爲生，被迫鋌而走險，做出非法的事，墮入罪惡的深淵。據統計，已經上癮的吸毒者，平均每日畑耗費二十五港元購買毒品，吸毒消費如此昂貴，實非一般吸毒者所能負担。

石鼓洲康復中心，係專爲男性志願戒毒者而設，戒毒過程分生理治療和心理治療兩大部份：

（一）生理治療：

所有戒毒者須在康復中心內的醫院接受至少兩個星期的治療，治療原理甚爲簡單，所用的主要藥物名叫 Methadone，服用這種藥物可減輕毒癮發作時的痛苦，但服用的劑量須按日遞減，一個星期後，便要停止服用，否則戒毒者會將毒癮轉移到這種藥物上去。此時戒毒者將接受其他藥品的治療，通常經過兩個星期之後，毒癮已可戒除，但身體虛弱的戒毒者，多已患有咳嗽、氣管炎或慢性肺病等病症，須留院繼續接受治療。

疾病痊癒後出院的戒毒者，仍須在島上居住約二十個星期，在這一段時間內，戒毒者所接受的是工作治療：所有已出院的戒毒者，被編爲若干工作小組，每組設一組長，領導各人工作，目的在恢復戒毒者對工作的信心，並藉此增强他們的體力，作爲日後到社會工作的基礎。

（二）心理治療：

戒毒者因曾受毒品的刺激，故情緒甚不穩定，動輒大發脾氣，甚至出手傷人，所以在戒毒過程中，加設心理的治療，由輔導組人員負責，戒毒者在醫院接受藥物治療時，這些人員會去開解和安慰他們，出院之後則作爲他們的顧問，協助戒毒者解決各種困難，直至戒毒者有能力到社會工作爲止，輔導組人員工作的繁重，由此可見。

談話完畢，我們一千人等離開會客室，前往康復中心的建設部參觀，這個部門負責爲戒毒者作工作治療，工作種類有園藝、耕種、手工藝等，間中會籌劃大規模的建設工程：如建築花園、球場等，島上的足球場即爲戒毒者的輝煌工作成果。工作勤勞而行爲良好的戒毒者可獲得特別獎勵金。

建設部之毗鄰即爲醫院，設有病床約百張，並有小型外科手術室，醫院內不論日夜均有註冊醫生及護士輪流當值，看護戒毒者。

由醫院正門步出，乘車約五分鐘，即抵達位於半山之戒毒者宿舍，宿舍共有六座，其中五座是獨立的，只有一座在膳堂樓上，每座可容七十餘人，宿舍內設備相當完善，地方亦頗爲整潔。每一座宿舍有舍監一人，負責管理一切事務。宿舍附近環境幽美，極目所見，遠山青翠，綠水如鏡，視野遼濶，海風迎面輕拂，令人胸懷開暢，眞是理想的居所。

宿舍的附近，有一座大禮堂，可供戒毒者休憩與運動之用，堂內有乒乓球桌，羽毛球場，健身操器械等設備，戒毒者工餘時候，可往此處舒展身心。此外，禮堂又可用作各類文娛活動，盛大表演和招待大會的場所。

我們參觀完畢，仍坐原車回到碼頭，與康復中心各人員握別，乘船離開石鼓洲。我們都覺得這個小島，是戒毒者的天堂，但願本港的吸毒者，都能夠猛醒回頭，在康復中心戒除毒癮，重過有意義的人生。

康復中心正門內望

ALL ABOUT THE MEDIC LIBRARY

Pothead

For months on end the Medical Library has not been properly air-conditioned. Now that the extension to the Medical Library has been in service for more than a month, the initial hope that good air-conditioning will come after all the construction work seems groundless. With the present hot spell, it is virtually impossible to study in the Medic Library. The air inside is hot, humid, stagnant. Something must be done about it.

Someone from the Education Department must come here and have a good look at the state of lighting here at night. Particularly in the Ground Floor, even in daytime, certain parts have very bad illumination, which makes reading harmful to the eyes, and perhaps even more important, makes you even more sleepy.

Though the professors may be happy about it, certainly many medics feel differently. The new entrance to the Library makes it indeed a long walk to the canteen, whereas before you can slip into the canteen in no time and hang around for a couple of minutes of obscenities and false hilarity. Life has indeed been getting difficult.

It seems that one has always to come to it sometime. It is the lavatory. Maybe the architect is a firm believer in walking for good health. In addition to keeping the lavatory out of the Library, he has made it so remote that you can just make it.

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啟思

指甲與疾病

明德

手相學可以分爲八部份：（一）手形，（二）姆指，（三）手指，（四）手爪甲，（五）手紋，（六）掌中之丘，（七）手指之關節，（八）掌紋，而現在筆者所談論的對象是手爪甲或指甲。

指甲是從皮膚內生長出來的，從肉眼來看，它是一片薄硬的角質物體，但在顯微鏡下，它是由無數細微的髮狀纖維互相重疊而構成。它是能反映人們健康的狀態，設健康一旦發生障碍時，指甲的纖維便呈異狀，而其滑面也發生凹凸，或出現溝紋，同時其全體形狀因此也發生變化，所以前島雄吉謂：「指甲可以作爲疾病的正確的指示人」。

「次論指甲，屬筋之餘，志之主，乃肝所出，胆所附也。」這幾句說話是記載在神相全編中的，可知中國人很久以前亦已明白到指甲與健康的關係。

從觀察指甲的形狀及甲底的血色，我們可知：

（一）疾病有否在進行中，或者更可預測某種疾病在進行中；

（二）在一個健康的人來說，我們可以看出某人的疾病傾向，而作出適當的保健行動。

甲的形狀與疾病

A、健康甲——甲面約佔第一指節之一半，質硬兼帶有彈力，外面光滑而無凹凸，橫斷面畧帶彎曲，同時甲底的半月形約佔全甲面的五分之一，表示元氣足，健康良好。（見圖一）

B、心臟弱甲——甲面整齊而端方，面積較小，（見圖二），如果甲底的半月形很小，甚至沒有，表示心臟力弱。甲色青者心臟病尤爲嚴重。如婦女的甲異常短，主生殖器官有缺陷，主不育。

C、咽喉弱甲——甲長及大（見圖三），主易患鼻咽喉，支氣管等病。或似扁桃形（見圖四），橫斷面彎曲，主肺弱，有咽喉疾病，氣喘，氣管，傷風等傾向。

D、肺結核甲——甲成球形，橫斷面成一彎曲線，指端圓形（見圖五），這表示肺結核或罹癆癥症。甲色淡青者尤爲確實。

E、腎病甲——甲長形（見圖六），橫斷面成一特別彎曲線，主易患腎病。

F、癩痺症甲——甲端濶而甲底窄，狀似貝殼（見圖七），表示有癩痺症的傾向。如指甲的基底部很尖而形似三角形，表示很危險的癩痺症迫於眉睫（見圖八）。

G、脊髓病甲——甲細長，橫斷面狹窄，主脊柱骨弱，易於傾向屈曲（見圖九）。

H、神經衰弱甲——開始時，甲面出現多數白點，滿佈全甲，最後則變成無數溝紋（見圖十），這都表示神經衰弱在進行中。如甲質變成脆硬，橫斷面成爲特殊彎曲，主病情已至嚴重地步，若不事先預防，恐有半身不遂之虞。

I、脫腸症甲——從甲側面來看，中間細微凹陷，主罹脫腸症（見圖十一）。

J、痔瘡甲——從甲側面來看發現凹陷，主罹痔瘡病（見圖十二）。

K、寄生蟲甲——甲端脆薄而生變化，主腸內有寄生蟲（見圖十三）。

L、烟草毒甲——甲面發現溝紋而含有粒狀（見圖十四），主因酷嗜烟草，以致腸胃被尼古丁所傷。

溝與白點

A、溝——指甲上有很深的橫溝時，表示由於疾病而令神經組織受到危險。由甲底至甲端，其間交替過程，在發育旺盛的人，大約需要六個月，在相當年紀的人，則需要九個月。所以，若橫溝出現於甲底，我們可以斷定他在一個月以前發生疾病；倘使在甲端的，就可以推斷他在六個月或九個月以前已經生病了。若甲面的上部比下部光滑，同時下部出現無數溝紋，主疾病的發生，係由神經衰弱所致（見圖十五）。

B、白點——指甲上有白點時，表示身體薄弱。指甲全面到處有白點點綴着時，表示神經組織全體不健全。

月白——出生日期的指示與及心臟健康的關係

A、出生日期的表示——月白之大小普通以佔全部指甲四分之一爲正常，最大不可超過三分之一。在出生於月滿的望日的人，我們可以看到不但兩個姆指之月白大，就是其餘八個指甲之月白也特別顯明，如出生在月初，月白則會很少或完全沒有，上述這些觀察最大的原意非在估計某人的出生日，原因請看後述。

B、與心臟之健康關係——不論長短形之指甲如無月白，表示心臟衰弱逐年增加，預防貧血。月白大者表示心臟强，血液循急還速，過大者血行過盛，要注意勿受刺激，否則腦溢血或者心臟突然停止。由前面我們知道月白與出生日是有關係的，所以在斷定某人是否心臟衰弱或者過强，我們需要知道這人的出生日。如月初出生月白小或完全沒有時，不能確定他是有心臟病的傾向，而應配合掌紋來分析，但如出生在月初，而月白過多時，則我們才可以推測其爲高血壓的傾向，相反如在月滿日出生而沒有月白那就應注意養生以防心臟衰弱了。

結　語：

指甲大約可分四種，各指示出不同的疾病傾向：

一、短四方形	心臟
二、貝殼形	癩痺性
三、長形	咽喉、氣管炎、肺
四、細長形	脊髓

在推斷某人的疾病傾向時，我們應該結合掌紋來推論，這樣的準確性是會更高及更爲詳盡，在某些情形下，疾病發生的日期亦可以推算出來呢！

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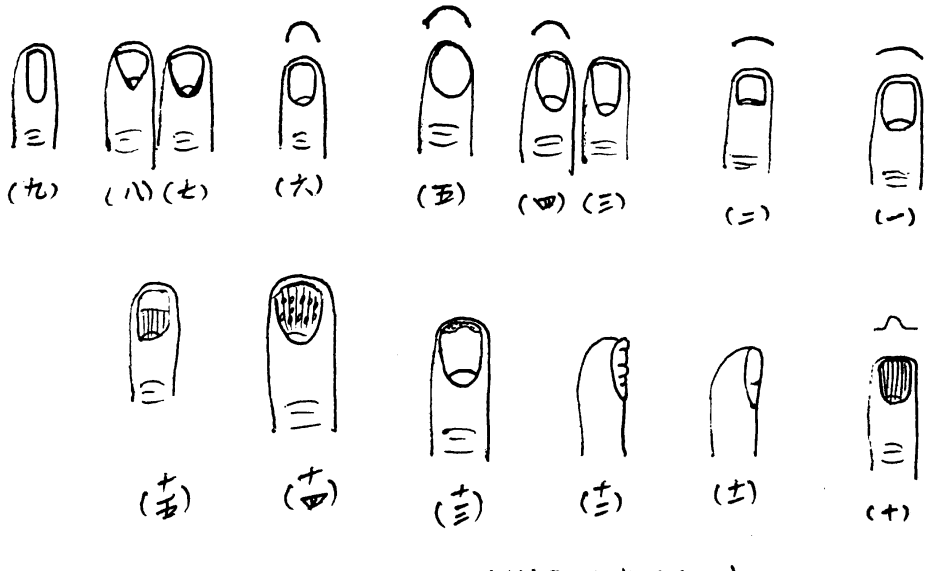

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