



MEDICAL STUDENTS' CENTRE,  
SASSOON ROAD,  
HONG KONG.

# Caduceus

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## EDITORIAL

### SENATE REPRESENTATION GRANTED

The granting of student membership of the Senate is really a milestone in the history of the University of Hong Kong. This clearly illustrates the slogan that union is strength. For only when the student body en masse stands firmly on any matter of principle, can it exert a strong influence.

In spite of student Senate membership having been granted, we feel that the University Authority has brushed off some of the items lightly. Evasive tactics serve no purpose as the underlying problems will still persist. We must stress that the achievement of any reform is not only of benefit to the student body alone, but also to the University. This can only be accomplished by mutual understanding and co-operation. Therefore the University should take a more enthusiastic attitude towards any reform aimed at improving the University.

On the other hand, we must be critical of the correct attitude of a student representative in the Senate. One must dedicate himself to the expectations of the whole student body. We disagree with Mr. John Lau's idea that the one so posted will merely sit as another "brain" in decision making. If such is the case, the whole purpose of student representation in the Senate will be defeated. We sincerely hope that the future student representatives in the Senate will act whole-heartedly, without reservation and fear, for the undergraduates of the University of Hong Kong.

Undergrad No. 10, 1969 (1st June), page 5.

### TUTORIAL AND FRATERNITY

We are glad to see that the Medical Fraternity Committee has organised tutorials for first year medical students. Though it is still too early to assess the value of such tutorials, we believe that this idea will be welcomed by most first year students. These tutorials are in fact more of the nature of guided discussion groups. The participating students can be benefited not only in the academic aspect but also in the aspect of having a more intimate friendship between the "junior" and "senior" students. We hope that the feelings of superiority complex or inferiority complex can be completely eradicated. May be it is some of these feelings that make some of the clinics or ward rounds so unbearable? After all, is it not that the idealism of fraternity is what we should be striving at?

### BLOOD DONATION CAMPAIGN

The Medical Society held a Blood Donation Campaign in co-operation with the Hong Kong Red Cross Bank on 6th June from 9.30 a.m. to 3 p.m. Forty students and members of the staff from all faculties came to Lok Yew Hall to donate their blood. Their good-will is well appreciated.

A second Blood Donation Campaign will be arranged in summer. It is hoped that it will be another success.

## Around the Campus

Dr. Frederick Peter Lisowski, L.M., Ph.D., L.R.C.P.I., L.R.C.S.I., has been appointed to the Chair of Anatomy from September 16, 1969, to succeed Professor K.S.F. Chang who will retire on September 15.

Professor P.H. Teng, C.M.G., O.B.E., M.B.E., B.S., D.P.H., has been re-appointed Professor of Preventive Medicine part-time to June 30, 1970.

Dr. R.E. Boden, Lecturer in Pathology, has resigned on June 1, 1969.

Professor J.P.M. Tizard, M.A., B.M., F.R.C.P., D.C.H., Nuffield Professor of Child Health at the Hammersmith Hospital, London, has been appointed External Examiner in Paediatrics for the

Final Examinations in January, 1970.

Professor T.A.J. Pranker, M.D., F.R.C.P., Professor of Clinical Haematology at the University College Hospital, London, delivered the Lo Yuk Tong Foundation lecture during his visit to the University as External Examiner in Medicine in May 1969. The title of the lecture was "The Red Cell."

A Digby Memorial Lecture has been instituted, to be given annually from November 1969 in the Department of Surgery.

The Li Po Kwai Prize in Surgery has been awarded to Dr. F.C.Y. Cheng for the best essay submitted.

## DO YOU KNOW —

FREDERICK PETER LISOWSKI

L.M. (Rotunda), Ph.D. (Birmingham), L.R.C.P.I., L.R.C.S.I.

Dr. Frederick Lisowski, Senior Lecturer in Anatomy at the University of Birmingham since 1964, has been appointed to the Chair of Anatomy from September 1969.

Of Irish nationality Dr. Lisowski graduated with distinction from the Royal College of Surgeons in Dublin in 1947. Thereafter he worked as Demonstrator of Anatomy, first at Trinity College, Dublin, then at the University of Liverpool, before being appointed Assistant Lecturer at that university in 1953, and in 1954 Lecturer in Anatomy at the University of Birmingham. He was awarded the Ph.D. degree of the University of Birmingham in 1963 and was pro-

moted Senior Lecturer in 1964.

From 1965 to 1968 Dr. Lisowski was seconded by the University of Birmingham as an Associate Professor to the Haile Selassie I University in Addis Ababa, where he was instrumental in setting up a Medical Faculty and in particular a Department of Anatomy. During this time he was a founder member of the Ethiopian Biological Association and a member of the Ethiopian Medical Association. Dr. Lisowski's research has

been largely in the field of comparative morphology and human biology. He studied anthropometric techniques under the late Dr. J.C. Trevor at the Duckworth Laboratory at Cambridge in 1951 on a grant made to him by the Egypt Exploration Society, and has since become an international authority on matters relating to comparative osteology and the diagnosis of human remains. In this connection his specialist knowledge has been brought to bear on investigations of the findings of archaeological excavations in many parts of the world.

Dr. Lisowski is a Fellow of the Royal Anthropological Institute of Zoological Society of London, as well as being a member of several anatomical, anthropological, and medical societies and associations. He is a former member of the Committee of the Birmingham Branch of the British Medical Association, and has represented the University of Birmingham on the Association's Full-Time Medical Teachers and Research Workers Committee.

### STUDENT REPRESENTATION ON SENATE

By a decision of the University Council, student representation on the University Senate was accepted. The Council met on May 29, and it was decided that six students would be allowed to sit in the Senate. One student is to represent the Student Union itself. The remaining five come from the five dif-

ferent faculties and each represents his or her own faculty.

During the Extraordinary General Meeting of the Students' Union held on Feb. 27, provisions were made concerning the duties and election of student representatives to Senate. These representatives will be elected in the near future accordingly.

### Results Of The Final Examination

The results of the final examination was out in May. The following students have graduated. They are now having their hard-earned holiday before taking up their internship.

ALI, Mohammed Bin; CHAN Chin Pang, Ronnie; CHAN Ki Wing, Patrick; CHAN Lai Man; CHAN Man Cheung; CHAN Siu Hung; CHAN Shu Kai; CHOW Chung Wo; CHOW Hing Ping; CHUNG Chak Man; CHUNG Siu King, Helen (Miss); DIU Kai Cheung; FUNG Mei Ling, Betty (Miss); HSU Chung, Anthony; HSU Hing On (Miss); HUA Su Ping, Andrew; HUNG Chee Keong, Roger; IP Yuk Ming; KONG On Tai; KWOK Yue Kit, Irene (Miss); LAM Chuen Bik (Miss); LAU Chor Kin, Stephen; LAU Chuen Ping; LAU Kin Sang, Kenneth; LAU Man Chiu; LAU Tai Kwan, James; LAW Chiu Lai (Miss); LEE Cho Hung; LEE Kee Shing; LEE Kwok Wing; LEE Yok Yee, Anna (Miss); LEUNG Kim Pong; LEUNG Kwok On; LEUNG Lit Hung; LEUNG Ping Ki; LEW Kin Kwok, Clement; LIM Thuan Lok; LO Chuen Mai, Teresa (Miss); LUI Yiu Shing; LUK Kwok Fai; MOK Bor Ling; Margaret (Miss); NG Cheuk-Him; NG, Ronald Paul; SHE Siu Yam, Dominic; SHUM Ping Shiu; SO Sing Cho; SO Wing On; TAAM Chi Woon; Vivian (Miss); TANG Nim Cho; TAO Siang Kuo, Billy; TENG Chong Shing; TONG Yau Kan, Kevin; TSAI Beh Yui, Vera (Miss); TSAI Tsang Wing; TSANG Shiu Chung, Jeffrey; TSANG Wing Keung; TSE Kin Chuen; TSE Ng Kan; TSOI Kwei Sang; TSOU Sheung Mei, Gloria (Miss); WAN Ho Hee, Horatio; WONG Ho; WONG Tak Cheung; WONG Yeung Chi;

WOO Chi Pang, Cleophas; WOO Wing Hung, Edward; YEUNG Chak Ming; YEUNG Kai Tai, Patrick; YEUNG Kung Ming; YOUNG, Lawrence; YU Ho Yam, Henry; YUEN Wing Hung, William; YUNG Ming Tung; YUNG Yue Hung.

Anderson Memorial Gold Medal

— So Sing Cho

Proxime Accessit Medal

— Ronald Ng

Chan Kai Ming Prize

— So Sing Cho

C. P. Fong Gold Medal in

Medicine — Ronald Ng

Gordon King Prize in Obs. &

Gyn. — Diu Kai Cheung

Honour Student

— So Sing Cho

### MEDICAL FRATERNITY COMMITTEE TO SPONSOR TUTORIALS FOR 1ST. YEAR

The Medical Fraternity Committee is arranging a serial Summer Vacation Tutorial Scheme for the 1st. year students. There are about 80 1st. year students, arranged into 6 groups, and 48 3rd. year student-tutors taking part in this scheme.

The Tutorials will be conducted in 8 Sessions. The first 5 will be on Physiology while the last 3 will be on Biochemistry. Each Session of each group will be conducted by a different tutor and by doing so, it is hoped that the 1st. year students may get the best benefits.

### MEDIC BALL

The Medic Annual Ball was held on the 7th June. The Ball was honoured by the presence of Professor and Mrs. Gibson, who kindly helped to give away the

prizes, and other staff of the Faculty. Music, dinner, dances, and raffle draw were the highlights of the evening. Everybody had an enjoyable evening.



# 2nd M. B. ACT I—EPILOGUE

# Medicine Today

VOICE

## THE WITHDRAWAL OF A MEASLES VACCINE

Though we can now sit for examinations in the Loke Yew Hall without green gowns on our backs, our troubles do not end there. You must not have the notion that you can now go anywhere you like with a clean shirt, a neat tie, decent trousers, socks and polished shoes. There are still times when you will meet unexpected interference. Not too long ago, some students taking borderline vivas were reprimanded for not putting on a jacket. We never expected a hearty welcome with open arms or a red carpet but such an opening slap is really too much for one under tension. To be challenged by such a viva is torment enough by itself. If such attire is good enough for the Loke Yew Hall, it should also do for vivas. It is in every way respectable. The university authorities should define what is acceptable for examinations — written and viva. It is unfair to leave the decision to individual lecturers who may well happen to be in a

nasty mood. We are attending pre-clinical vivas, not the governor's garden party or the Annual Ball. All these don't apply to the females who may dress like Paris models and yet never picked upon. Would you still say they are the inferior sex?

On the whole, the examination questions this year are quite reasonable. At least there are no major shock surprises like Mathematics papers. Some questions are godsend to those who depend on fluke. Some questions are so difficult to interpret that they make the English Language much more difficult than it really is.

Most of the 3rd year students who survived the examination are busy finding recreation or at least giving their poor brains a hard-earned rest. A few who would tolerate no disruption of their routine life are still digging their way into their

books every minute of the hour, every hour of the day, every day of the month and every month of the year. Some junior surgical clerks are racking their brains trying to figure out some way to kill the hours. They simply have too much time at their disposal — in contrast to the pre-examination period when they wished that they could do away with sleep (which some students nearly accomplished).

As is universally known, the Thursday clinic is packed with thrills, suspense, fun and excitement but do you know that its very name has a greater impact than a Japanese alarm-clock? There is a chap who used to be so reluctant to get out of bed that nothing short of a needle prick will bring him to his feet. However, he admits that there is a sure-fire way of doing it — just whisper in his ears "Young man, its Thursday!" This will make him leap sky high.

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## FOR STUDENTS ONLY

Many a time medical students have been assaulted and trodden down by remarks manufactured by their tutors. They have been variously described as a herd of swine, poker-face, rubbish, hopeless lot and what-not. In fact, every witty remark under the sun has been thrown at us. Mind you, they are not compliments. However, unlike UFO's in the OT, words seldom inflict physical injury especially when they are hurled at a hundred-odd students. In general, the more authoritative the manufacturer is, the more generous he is in showering names on us. You know what I mean? You follow?

A very famous saying goes like this: The rarest thing in a medical student is common sense. This may have some sense in it but there is no shadow of doubt that it applies only to students. Once he matures into a surgeon, he may be drowned in an ocean of common sense. Physicians, however, are on the safe side.

We have always been taught to be brief and up-to-the-point when answering questions. Naturally enough, we put that into frequent practice, especially during ward rounds, so much so that it looks as if we need to be prodded into action. When we do utter something, we finish that off with a few words. After all, the more one says, the more nonsense one vomits out. Somehow, certain tutors have apparently acquired hypersensitivity (or more appropriate — idiosyncrasy) and probably think that we are just too miserly. Thus originated the remark "Cable and Wireless". On the other hand, when we don't know anything, we naturally don't say anything. Then we are rewarded by being described as chicken laying eggs or chicken drinking water. Very vivid description!

# MEDICAL GIRLS ELAINE

"In medicine," one lecturer is reported to have said to a group of girls embarrassed by a joke he had made in somewhat dubious taste, "in medicine there are no girls". If he was referring to feminine modesty and coyness, he would probably prove to be correct, for these are qualities medic girls can well do without in their future profession. However, medic girls apparently suffer more than merely these shortcomings, in the eyes of most medic boys, and one can frequently come across boys who seem to have nothing but contempt for their female colleagues.

This article is written with the aim of defining the male attitude, as well as to present the views of some of the girls in the faculty. The writers apologize for the use of the crude and unscientific methods in obtaining their facts, but they feel that more often than not, these serve their purpose. The results of a questionnaire circulated to boys of the first, second and third years are presented for what they are worth, together with analytical remarks where possible, for frequently, opinions wander into the field of psycho-analysis, and appear quite beyond us.

## What The Boys Think

### The Questionnaire

1. Do you object in any way to girls studying medicine? The majority answered No to this question but the percentages showed this curious fall from the first to third years:

First Year	: 78%
Second Year	: 70%
Third Year	: 50%

**Analysis:** In their first year, boys enjoy studying in a class with girls, many of the boys having come from schools with boys only. There is no significant change in the second year, but in their third year boys become embarrassed by the presence of girls in the wards.

2. Do you think men make better doctors than women? The majority of boys in each class answered Yes.

First Year	: 78%
Second Year	: 90%
Third Year	: 88%

**Analysis:** Since the second year girls have as yet no chance to show their clinical abilities, the boys must have made their judgement on intelligence alone, whereas both these factors must have influenced the third year boys. This is borne out by the next item on the questionnaire, which was to give reasons for the choice.

First Year:	
Greater dedication to their work	35%
Greater physical endurance	35%
Second Year:	
Superior intellects	33%
Greater Physical endurance	30%
Third Year:	
Great Physical endurance	25%
Superior intellects	23%
Greater dedication to their work	23%
More trusted than women doctors	23%

3. Do you think girls spend more time on their studies than boys? The majority answered Yes, having observed this to be a fact.

First Year	: 78%
Second Year	: 60%
Third Year	: 75%

**Inference:** The girls of the second year are obviously the least hard-working among those of the first, second and third years.

4. All the boys felt that Surgery and Orthopaedics are the most unsuitable fields of medicine for girls to take up. Some of the reasons given are listed below:

- lack skill,
- physically inadequate
- too timid
- too hysterical, often slow and clumsy

Paediatrics: become bored with babies, no more wish to marry.

Medicine: illogical way of reasoning, poor memory, no intelligence to apply knowledge.

Psychiatry: Psychologically unstable themselves illogical can't cure, can only worsen patients' condition.

**Analysis:** We feel that most of the reasons given for surgery and orthopaedics are true, but as for the rest, they can be ignored.

5. What is the relationship with the girls in your class?

	1st Yr.	2nd Yr.	3rd Yr.
a. very friendly	2%	2%	13%
b. friendly	35%	50%	13%
c. indifferent	50%	45%	60%
d. hostile	10%	2%	12%

**Analysis:** The figures speak for themselves.

In what ways could this relationship be improved?

#### By more friendliness on the part of the girls

First Year	50%
Second Year	50%
Third Year	20%

#### If medical girls made themselves more attractive

First Year	35%
Second Year	35%
Third Year	50%

**Inference:** Third Year girls are the least attractive though the most friendly of the three groups.

6. What do you think motivates a girl to take up medicine?

50% of the boys feel that this is because of the narrow field of choice at the University, so that there is nothing else for the girls to do.

30% feel it is for pure academic interest.

20% think it is a means of getting rich.

Other assorted reasons given were: to get a doctor husband to show themselves superior to other girls to compete with boys to gain fame & prestige

8. Do you think women doctors can be average housewives?

70% of the answers of each class was No.

**Analysis:** Most of the boys are immature, since they still hold with the view that working women cannot make average housewives. For their information, 70% of the working women continue with their careers after marriage or else resume it some time after marriage.

9. What are the chances of your marrying a woman doctor.

	good	average	poor
First Year	2%	5%	77%
Second Year	2%	20%	70%
Third Year	10%	10%	80%

10. The most varied response was obtained when it was asked to list one problem peculiar to girls studying medicine. However, the following two reasons cropped up most frequently:

- a. Difficulty in getting a husband because they get too old after 5 years.
- b. They embarrass male patients.

The various other reasons given which are printable were:

- too aggressive
- too dependent on the gentlemen's help
- too sissy, can't make good doctors
- spend to much time studying, no time for parties
- spectacled
- think they are superior to other girls but actually are not
- delay in establishing a family
- great competition in a world of men.

## What A Girl Thinks

In a field of work that is mostly for boys, member of the opposite sex may cause some conjecture on the part of the boys. They may try to guess what problem the girls will face, what are their motives etc. Let us see how one of the members of the fair sex looks at the matter.

1. Do you think a girl studying medicine sacrifices a lot?

Yes, in the undergrad years. We have to sacrifice a lot. e.g. social and sports activities. It's all due to heavy schedules. We tend to be narrow minded, since we really have very little time for other things. Even before I enter university, I had noticed such a possibility, but it is really so tough. It is quite a surprise.

2. What sacrifices do you expect after graduation?

May be having difficulty in finding a good and understanding partner. Personally I prefer to have a doctor as a future partner, since we can discuss cases together. For people outside the medical field, the chance is less, I think, since there will be no understanding.

3. The answer in the questionnaire showing that medic boys do not like taking medic girls as wives. What do you think are the reasons?

Perhaps they do not want to take their work home, and want to have supreme respect from the other side. Also he may not be always with his wife if she is also a doctor.

4. How would you compare boys and girls as doctors?

In ability, it depends on devotion. The more devoted one is, the more capable one will be. Physically there is really a difference. Girls may have less endurance. In work, it depends on their field of activity. Girls may show greater aptitude in gynaecology and paediatrics. I think however surgery is not suitable for girls, since it will need quite a lot of physical endurance.

5. Do you think patients will prefer a man doctor to a woman doctor?

I think prejudice on the side of the patients do exist. It again depends on the particular field of work one is engaged. Patients would prefer to have woman doctors in gynaecology and paediatrics while in general practice, patients may treat man and woman doctors alike.

6. Do you think this career will affect the family life of a girl?

In fact any career may affect family life, e.g. even in girls taking up teaching as a career. In medicine, it again depends on the field of work of the girl. In some cases e.g. medicine, paediatrics paraclinical subjects like pathology there will be less hindrance, on the other hand as a general practitioner, one will have to answer night calls and this may affect family life.

7. How about the question of bringing up children?

For this, it requires great planning. Anyhow one can manage if one thinks carefully. Even girls without a career may not bring up their children well or give them adequate care if she is careless and with a lot of children to look after or if she is too devoted to mahjong.

8. What is your motive for studying medicine?

To serve the sick. Others may have a pure academic interest or a desire for knowledge. Others may be just following their family trade. But I think very few would be just for a few dollars more. They may change their motive but that nobody will know. Some may be studying because they worship the idea of being a doctor.

9. What will you do after graduation? I don't know. It depends, but I think surgery is least likely.

10. What are your personal interests besides studying?

Ball games, netball, lacross, etc., in other words, outdoor games. That includes swimming. As regards reading, I read mostly religious books, some newer love novels and for magazines, readers digest. I seldom go to the movies or watch TV.

11. How many books which is not related to medicine do you read in a month? About 4-5 including magazine.

12. Do you have any other interest e.g. in fine arts such as painting, music?

No, I do not play any musical instrument, but I like to listen to records. I also like making dresses, household work and cooking.

13. Any comments on medic boys? They do not like girls to be superior to them in any way.

## Angiography

Angiography is a radiological technique which has only recently come into general use. Now, almost all the organs of the body are accessible to study by this new method of radiological exploration.

In recent years, technical advances in radiological equipment have completely transformed the practice of angiography. It is now regarded as old-fashioned and dangerous to perform cardiac catheterisation in the dark with only the dim light of the conventional fluoroscope. The use of image intensifiers and close circuit television links, as well as the mechanization of couches and accessories, not only make it possible to work in conditions of strict asepsis but also to protect the operator from radiation.

To study the heart and blood vessels the patient must be moved about a good deal to vary the angle from which the vessels and the heart are viewed. The usual couches are designed mainly for investigation of the alimentary tract with the X-ray tube movable only length-wise. This led to the idea of arranging mobile apparatus around the patient. As the picture (figure 1) shows, the X-ray tube is at the lower end of a semicircular mobile arm, and the image intensifier, video camera and cinecamera are at the other end. The arm can be moved round the patient in any plane, all the movements being controlled by a simple keyboard. The couch itself is transparent.

W. L. Ng



Fig. 1. Apparatus for cardiovascular angiography, on the right, the television screen.



# COLON MUCOSAL POLYPS: THEIR CLINICAL SIGNIFICANCE

DR. R. E. BODEN

Mucosal polyps of the colon are common neoplastic lesions and are found in approximately 20-25% of all autopsy cases. They are in general a lesion found in adults, and are most frequent in the recto-sigmoid region. During life these lesions can be symptomatic and the usual clinical history is one of fresh blood noted with bowel movements. Because of their location, they can often be seen and totally removed at sigmoidoscopy. For the 5% of the polyps which are located proximal to the sigmoid colon, a laparotomy is required for removal, either by simple polypectomy or segmental resection of the colon.

Two major forms of mucosal polyps have long been recognised. One is called an adenomatous polyp and consists of a polypoid lesion composed of atypical mucosal glands with a slender stalk forming the attachment to the colon wall. The other type is a papillary or villous polyp and is a papillary lesion with a broad base of attachment to the colon wall without a stalk. The adenomatous polyp is much more common than the papillary form. In a series compiled by this writer reviewing all of the mucosal polyps submitted for pathologic examination in a large hospital over a 10 year period, 203 polyps were the adenomatous form and only three were papillary. It is well established that the papillary polyp is often associated with carcinoma of the colon, and in 50% of these uncommon polyps an area of adenocarcinoma can usually be identified.

The evaluation of adenomatous polyps, however, has become controversial. The view has been widely held that they represent a pre-cancerous condition and should be so treated. In addition, it has been claimed that most colon carcinomas arise from previous mucosal polyps. During the past few years this view has been firmly challenged, primarily by the pathologists Professor Benjamin Castleman and Professor L.V. Ackerman. The basis for challenging this view rests on a number of grounds. The distribution in the colon of polyps and carcinomas is not the same, though both are most commonly found

in the rectosigmoid. Furthermore, in carcinomas of the colon one rarely finds any evidence of a remnant of an adenomatous polyp, even in very small early carcinomas. It is true that an area of adenocarcinoma is sometimes found in the tip of an adenomatous polyp. Interestingly, however, these focal areas rarely progress and act like a carcinoma. Prior to 1962, there was no reasonably documented case in the literature of an adenomatous polyp with an area of carcinoma producing a metastasis. Since that time this has been reported and well documented and about five such cases are now known. Nonetheless, it can be stated that this is a relatively rare occurrence.

The significance of the problem of adenomatous polyps and cancers lies of course in the treatment of the patient. If these lesions are pre-cancerous, then complete removal of all adenomatous polyps if possible is indicated whenever and wherever in the colon they are found. In addition, patients with adenomatous polyps would then require adequate annual or biennial examinations including sigmoidoscopy and barium enema of the colon to detect any recurrent lesions.

One would expect that if adenomatous polyps are either a pre-cancerous lesion themselves or if they indicate an increased neoplastic malignant potential of the colon mucosa, then patients with these lesions should show an increased incidence of carcinoma of the colon. Adenomatous polyps are a neoplastic condition

in themselves and as we know colon carcinomas also arise from the mucosa and are gland-forming carcinomas. This writer undertook to locate and obtain a medical history from 135 patients who had a previous adenomatous polyp of the colon. The interval since the polyp was removed was a minimum of 12 to a maximum of 23 years. In the 135 patients during this interval of time 5 developed carcinoma of the colon. Statistical analysis of these findings was done and the incidence of colon carcinomas found in the studied group was compared to the known incidence in the general population for the same age groups, race and sex. No difference was found. Other similar studies, covering a shorter interval of time, have also been reported and show a similar lack of any increase in colon carcinomas in patients with a history of colon polyp. A well recognised exception to this should be mentioned, which is the disease familial polyposis of the colon. It is well documented that patients with this disease have a markedly increased incidence of carcinoma of the colon. No such patients were included in the studies referred to.

The following conclusions can be currently drawn from the available evidence:

- 1) Most carcinomas of the colon arise *de novo* from the mucosa and not in a pre-existing lesion.
- 2) Most mucosal polyps of the colon are adenomatous polyps and are benign lesions. Occasionally a focus of adenocarcinoma may be present in the polyp but this rarely produces metastases.
- 3) The patient with an adenomatous polyp does not have an increased likelihood of developing a carcinoma of the colon. The exception to this, as previously mentioned, is the familial disease, multiple polyposis of the colon.
- 4) A papillary or villous polyp of the colon is to be distinguished from an adenomatous polyp. The papillary form is uncommon. At the time of diagnosis 50% of papillary polyps contain an area of adenocarcinoma which behaves like any other adenocarcinoma of the colon, and will progress and metastasise if not treated by adequate surgical resection.
- 5) From the standpoint of clinical practice, adenomatous polyps can be treated by conservative simple removal if symptomatic, whereas papillary polyps should preferably be treated by radical surgery as carcinomas. The accepted treatment of multiple polyposis is also radical therapy, with a total or subtotal colectomy.

# 啟思

香港大學醫學會  
第一卷第六期  
一九六九年六月十五日

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Now in its second decade of world-wide use—with no kidney damage, no teeth mottling, no liver impairment, no blood dyscrasia, no neurotoxicity, no photosensitivity, no bone-marrow depression—Erythrocin continues to prove itself a potent weapon in the everyday fight against a wide range of bacterial infections. Complete details available from your Abbott representative.

## Erythrocin® ERYTHROMYCIN STEARATE

100 mg. and 250 mg. Filmtab® tablets in packages of 12, 25 and 100. Also available in pediatric and injectable forms.



## The Microbe

The Microbe is so very small  
 You cannot make him out at all,  
 But many sanguine people hope  
 To see him through a microscope.  
 His jointed tongue that lies beneath  
 A hundred curious rows of teeth;  
 His seven tufted tails with lots  
 Of lovely pink and purple spots,  
 On each of which a pattern stands,  
 Composed of forty separate bands;  
 His eyebrows of a tender green;  
 All these have never yet been seen.  
 But scientists, who ought to know,  
 Assure us that they must be so.  
 Oh! Let us never gaze at him,  
 What nobody is more afraid of!

