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PRELIMINARY NOTE ON A TOURNIQUET METER,

by

Kenelm H. Digby and Lien Tsoong Kya.

The need for some method of measuring the pressure exerted on the limb by a tourniquet has long been recognised (1) and the use of an ordinary sphygmomanometer advocated (2).

The sphygmomanometer has two drawbacks:—its bulky nature and its unsterilisability. Some time has been expended in this Clinic in trying to provide a more suitable and equally safe tourniquet. A special narrow sterilisable pneumatic tourniquet with pressure guage has been devised, but the rubber, at least in a tropical climate, does not last well and the tourniquet is difficult to adjust to all sizes of limbs.

A steel strap tourniquet somewhat after the fashion of H. J. Godwin's tourniquet but with a spring pressure guage was tried out by my assistant Dr. S. T. Hsiu, but has eventually been abandoned as the readings involved complicated mathematical calculations. The apparatus was a little cumbersome and there was a theoretical danger of the narrow spring band being tilted in such a way that its edge might press unduly and cause damage. Moreover, changes in the shape of the limb during movements greatly varied the pressure exerted within a rigid circle.

More recently, in 1932, Messrs. George Salter & Co., Ltd., West Bromwich, England, prepared a light meter to my directions to be used beneath a Martin's bandage. This pattern has subsequently been modified in the light of experience and I am indebted to Mr. Weller and the Ho Tung Engineering Workshops for carrying out these modifications (principally the addition of hinged slotted flaps), and producing the instrument here illustrated. (Figure I). I am also indebted to Messrs. A. Fong for taking the photographs illustrating this note.

In our earlier cases we determined the maximum systolic pressure before operation. But it must be remembered that systolic pressure will rise higher during ether anaesthesia, that the pressure in the femoral artery is always higher than in the brachial, say 180 m.m. of mercury compared to 120 m.m. of mercury, and finally that when the patient struggles, muscular contraction and relaxation may alter the volume in the region included by the tourniquet and this affect the pressure exerted by the tourniquet.

It is our practice at the moment to apply a pressure equivalent to 200 m.m. of mercury for the upper limb and 250 m.m. of mercury for the lower limb, for nearly all cases in adults. These have been safely left on for an hour, and could possibly be left on longer without harm.

The meter consists of two flat plates of duralumin. To the lower plate is attached on each side a hinged flap. Each flap has two slots for the attachment of tapes. The lower plate is prolonged at one end to bear a vertical scale. Four vertical rods attached to the lower plate pass through holes in the upper plate. On these rods and between the plates are four metal springs, and between the plates also is situated the lever attachment from which the pointer passes to the scale. The four rods pass well above the plates and are covered by screw caps.

Before use the limb will, of course, be raised for five minutes, and if further bloodlessness be required the limb can be compressed by an elastocrepe bandage (or by a rubber Martin's bandage).

If used on the arm a double, or on the thigh a single layer of lint or wool is wound round the part and the tourniquet meter applied. (Figures 5, 6, 7, and 8). Three turns of a three inch wide Martin's rubber bandage will be sufficient to raise the pressure to 200 m.m. of mercury.

The upper plate of the tourniquet meter should be pressed down by hand once or twice as the bandage is applied to prevent any jamming. The turns are then fixed by a clip very similar to Makka's scalp clamp but with the ends blunt instead of sharp. (Figures 3 and 4). It is perhaps well to compress the main artery proximally during the few seconds that the three turns are being applied, so that a few extra systolic pumps of blood shall not enter the limb during the moments of adjustment.

For operations high up the limbs the meter is applied to the top of the shoulder or to the lateral aspect of the hip. The projecting ends of the four rods prevent the rubber bandage from slipping distally down the limb, and the meter itself is prevented from sliding by means of tapes passing through the slots in the side flaps. These should be knotted on the upper side of the side flaps. (Figure 2).

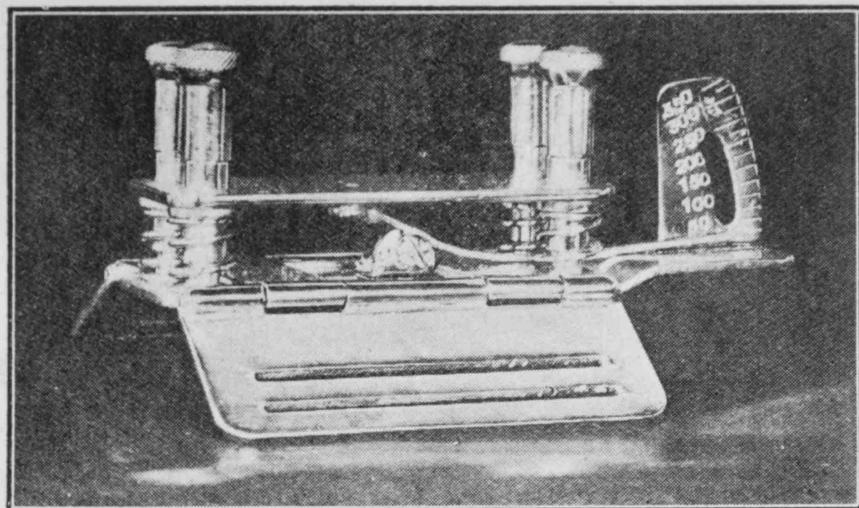


Figure 1. Tourniquet Meter.

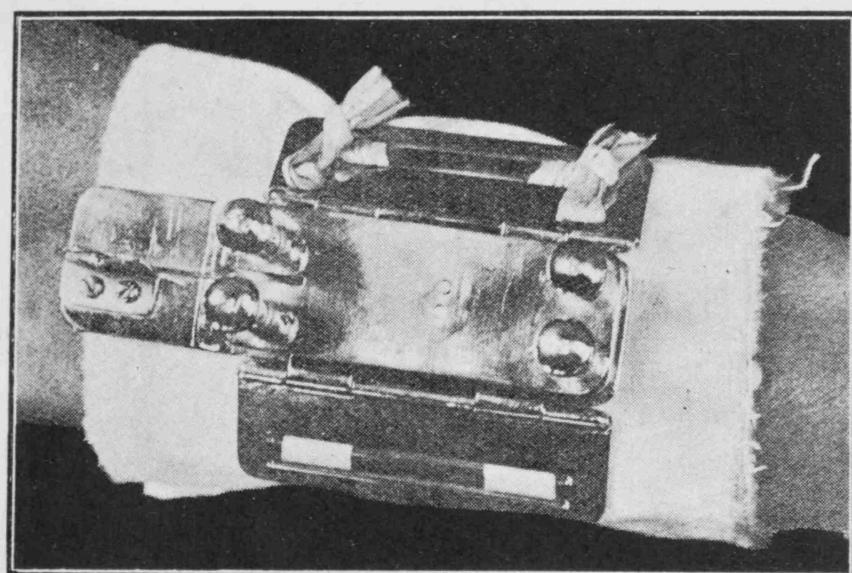


Figure 2. Tourniquet Meter with tapes.

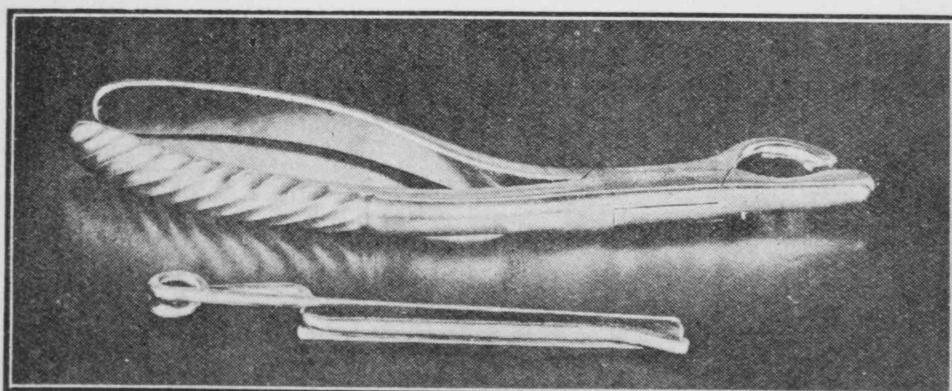


Figure 3. Forceps and clip for fixing rubber band.

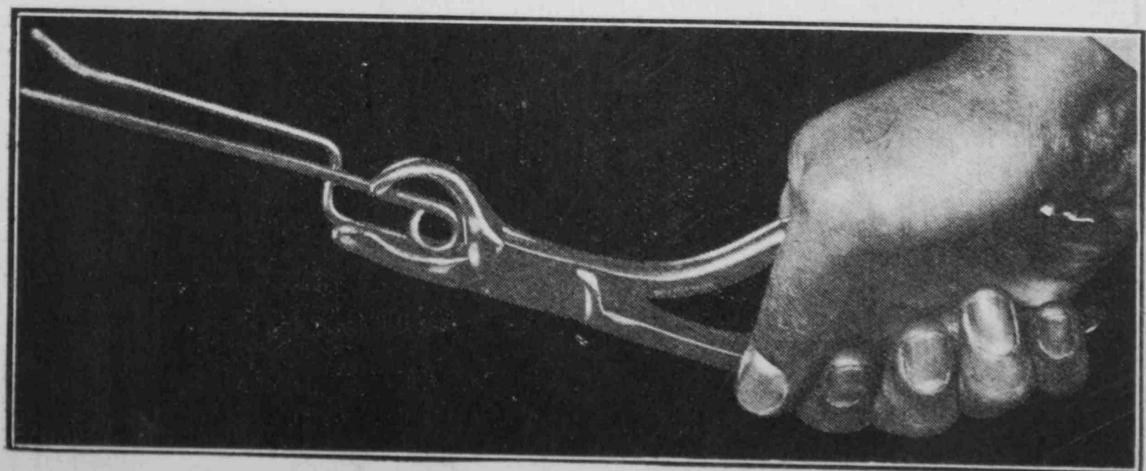


Figure 4. Forceps opening clip for application.

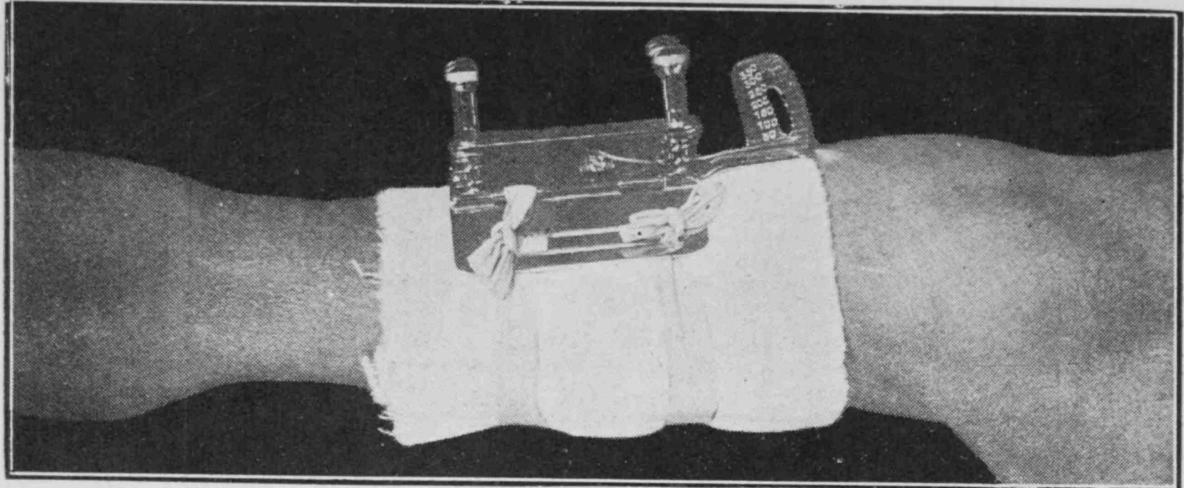


Figure 5. Tourniquet Meter secured with tapes to the arm.

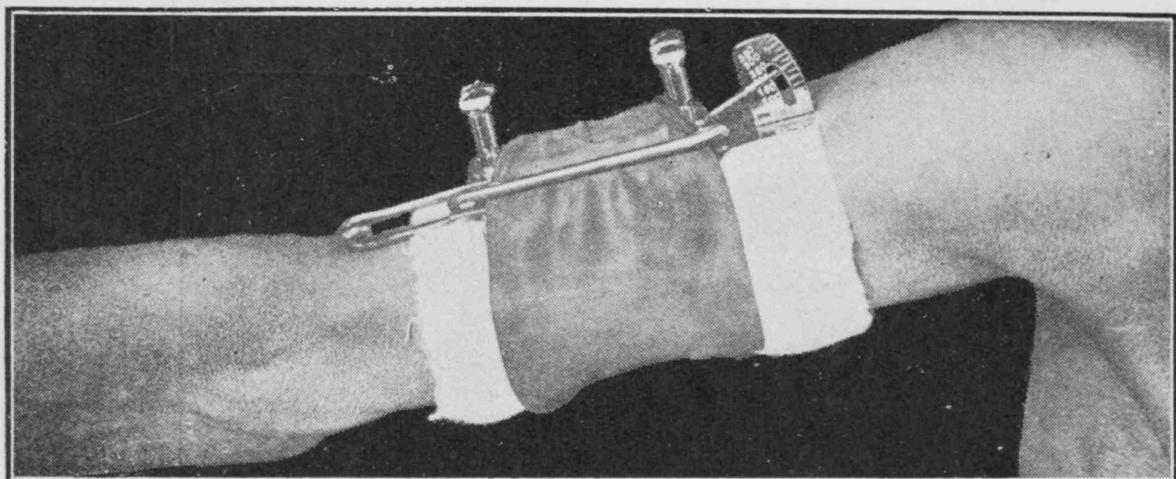


Figure 6. Tourniquet Meter on the arm with flat rubber band applied and clipped.

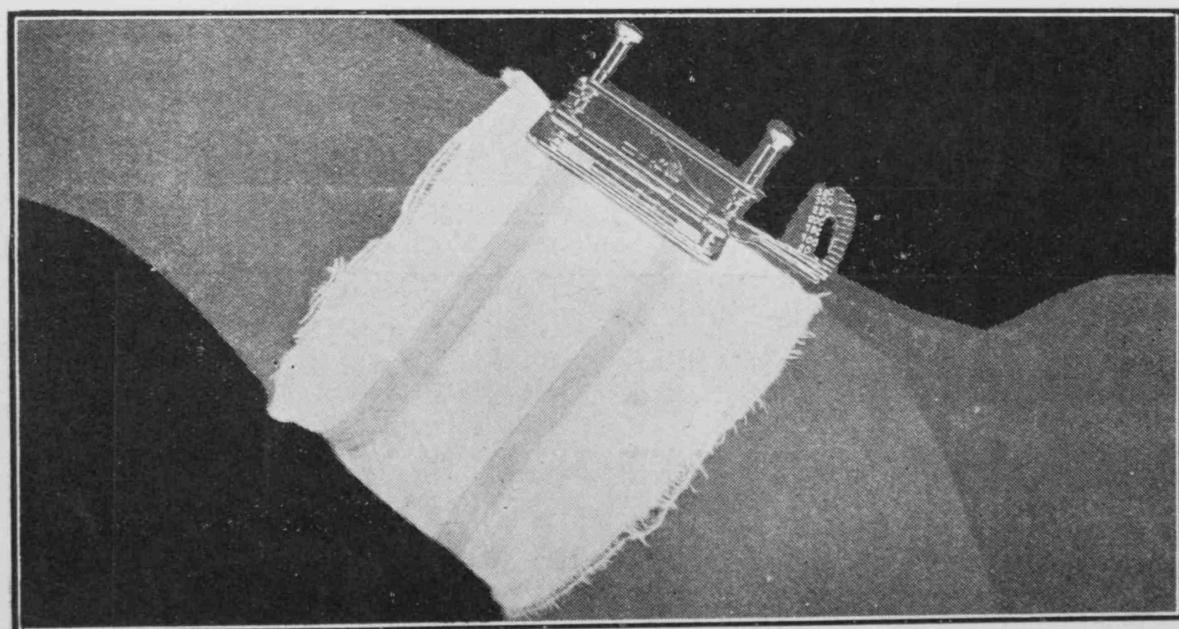


Figure 7. Tourniquet Meter secured with tapes to the thigh.

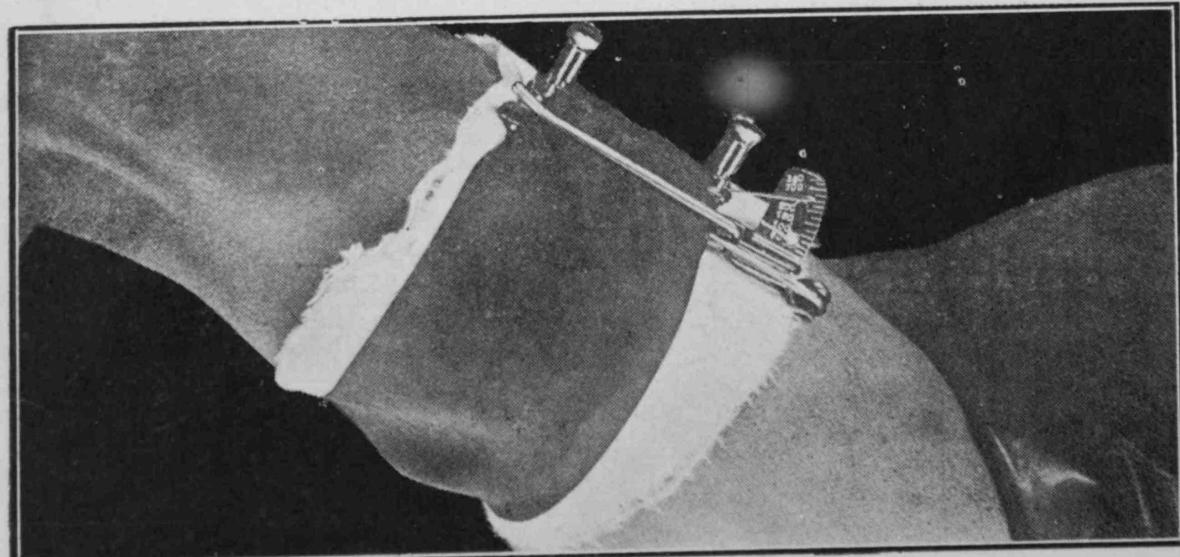


Figure 8. Tourniquet Meter on the thigh with flat rubber band applied and clipped.

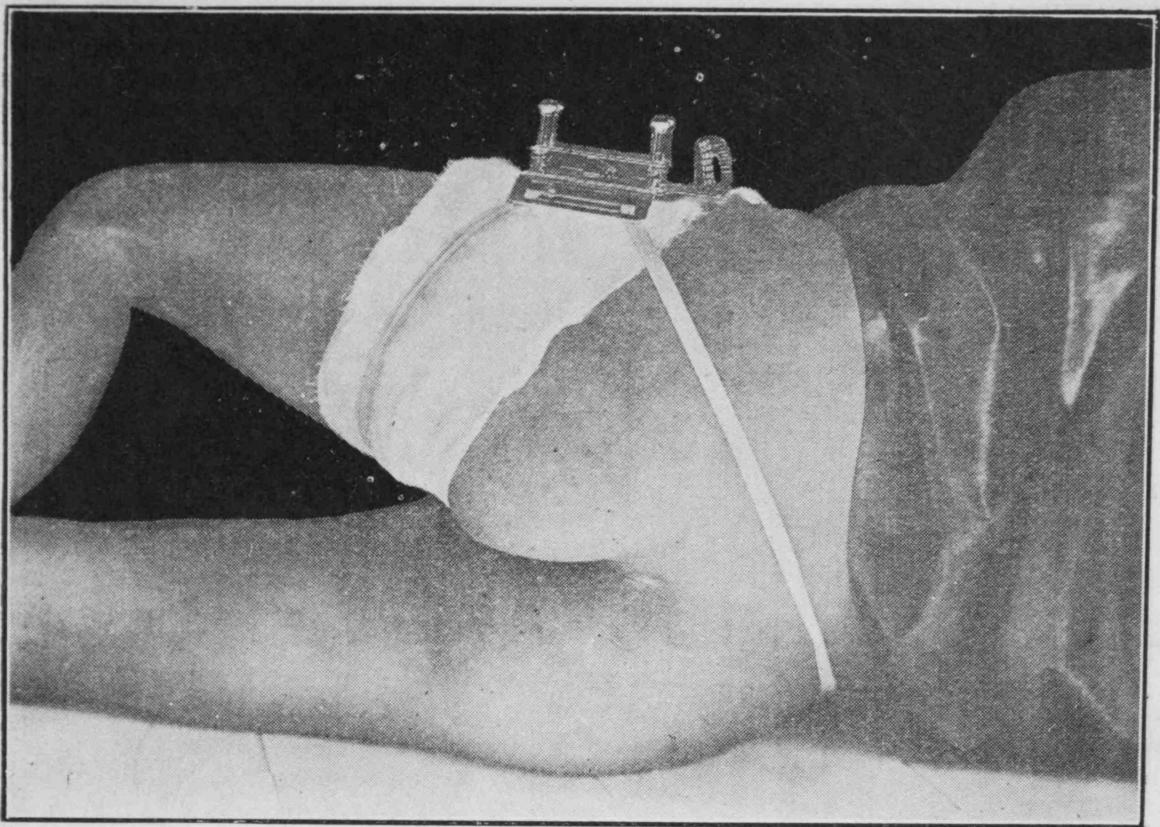


Figure 9. Tourniquet Meter secured with tapes to the hip.

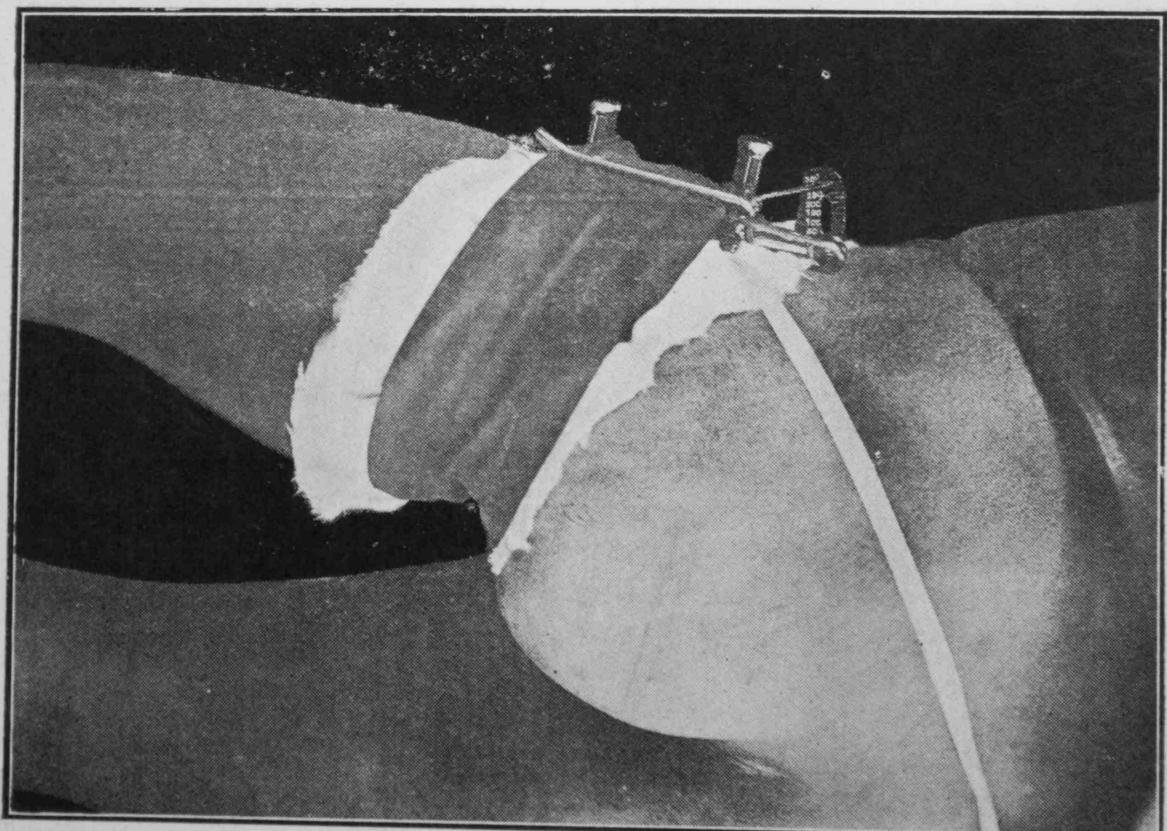


Figure 10. Tourniquet Meter on the hip with flat rubber band applied and clipped.

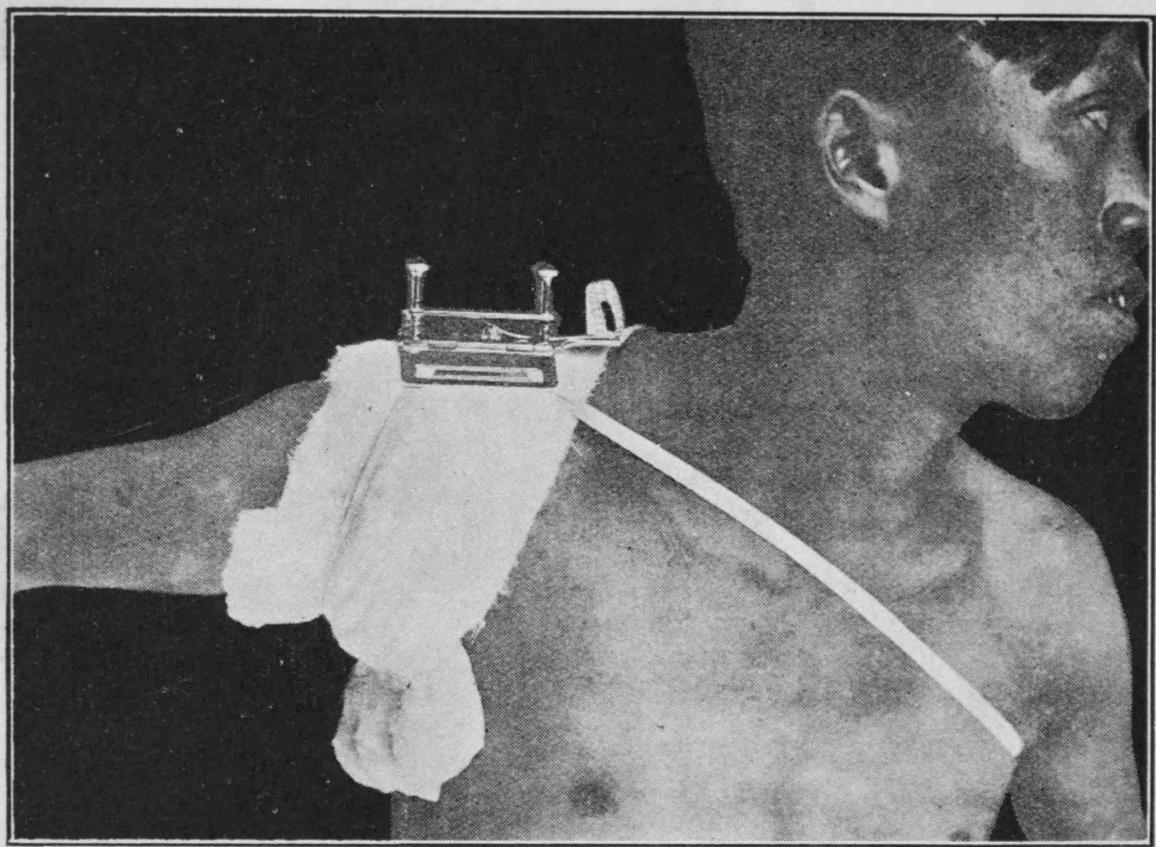


Figure 11. Tourniquet Meter secured with tapes to the shoulder.

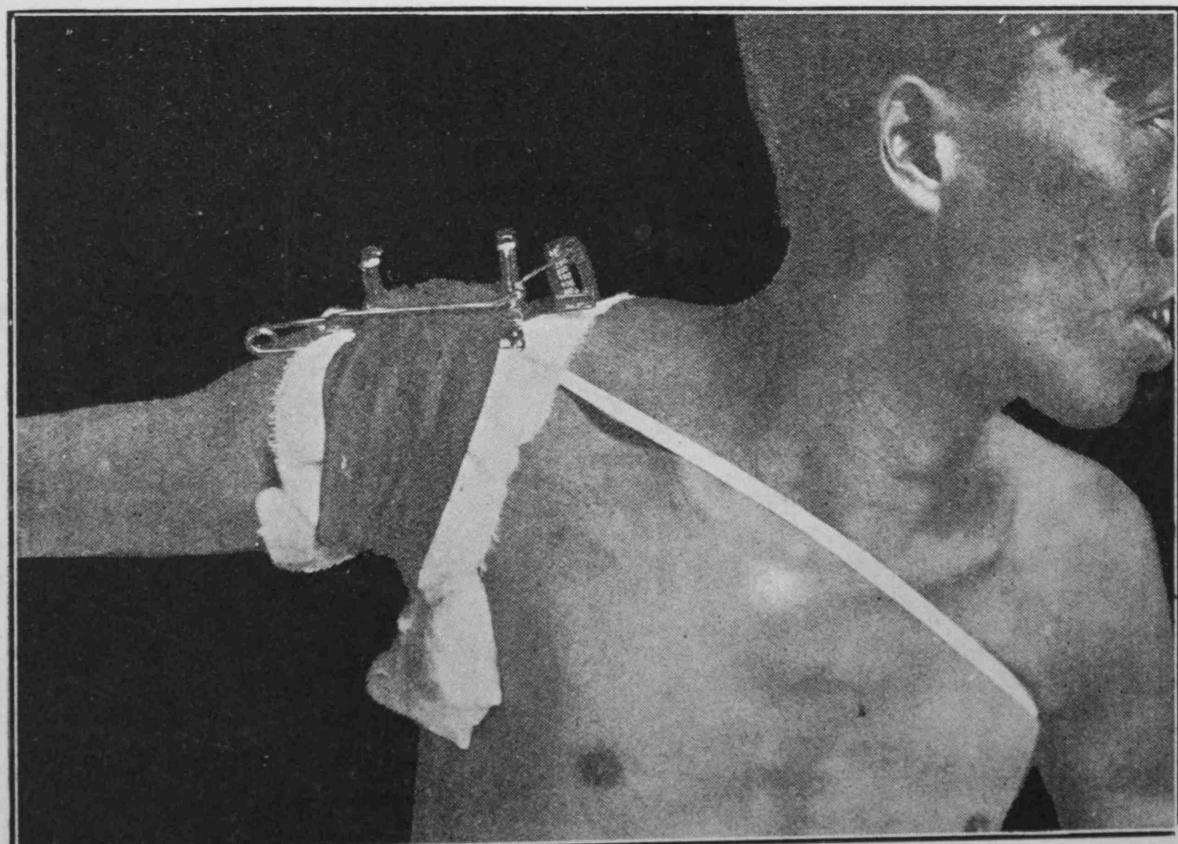


Figure 12. Tourniquet Meter on the shoulder with flat rubber band applied and clipped.

In the case of the shoulder (Figure 11 and 12), one tape is secured around the opposite axilla, and another round the arm on the side to be compressed. A pad of wool is required between the anterior and posterior folds of the axilla on the side to be compressed, so that the projecting folds do not shelter the artery from the general pressure. In the case of the hip (Figures 9 and 10) one tape is tied round the opposite hip midway between the greater trochanter and the crest of the ilium, and the second tape encircles the top of the thigh. A small pad may be used over the trigonum femorale if there is definite concavity.

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THE TREATMENT OF OTORRHOEA IN GENERAL PRACTICE,

by

Li Shu Pui, M.B., B.S. (H.K.), F.R.C.S. (Edin.).

From the outset let me state that Otorrhoea is not a disease per se, but rather a sign indicating discharge from the ear. Besides suppurative otitis media, which is the most common cause of this condition, external otitis, eczema, furunculosis, septic granulomata, carcinomata may also give rise to otorrhoea. In rare cases even pus from suppurative parotitis may find its way into the external meatus through the two fissures of Santorini, which are found normally in the anterior portion of cartilage of the meatus. It is therefore very necessary that in treating a case of Otorrhoea, one must first of all find out the underlying cause.

A history should be carefully taken, paying particular attention as to deafness, pain, fever, previous attacks, if any, nose and throat conditions and general health especially in regard to syphilis and tuberculosis. As a routine, the unaffected ear should be first examined. On the affected side any tender areas or swellings are to be noted. Unless the discharge is too thick and tenacious it should be mopped dry with cotton wool "pencil" instead of syringing. As regards syringing I would like to sound a note of warning here that under no circumstance should an ear be syringed in acute suppurative otitis media. The reason is, that when fluid is forced into the middle ear by syringing, the return flow of the fluid may be obstructed by a flocculent mass at the tiny perforation, the middle ear is there distended and as a result, intense pain is produced.

When the external meatal canal has been cleansed and dried, any swelling or tender area should be noted. Unless the meatus is excessively narrowed down by oedema or boils, the tympanic membrane should be examined. If there is a perforation, its situation, and size, the length of the long handle of the malleus, polypus, granulations or cholesteatoma, if present, should be carefully observed, in view of their importance in regard to prognosis and the particular form of treatment to be advised. Finally, any septic focus in the nose or throat such as chronic sinusitis, septic tonsils and adenoids, caries teeth should not escape attention. Because of the limited time at my disposal this evening, I can only deal with the treatment of the two most common causes of Otorrhoea, that is, external otitis and suppurative otitis media, the latter forming the majority of cases.

External Otitis.

I. External otitis consists of two forms, Viz:—(a) the diffuse and (b) the circumscribed. The diffuse form includes eczema and the so-called "tropical ear." The circumscribed form is represented by furunculosis or boils.

(a) *Diffuse Otitis.*

It is interesting to note that in 1930 H. Neumann (1) declared that *Bacillus pyocyanus* is the cause of diffuse otitis. The affected individual carried the bacilli in the axillary, or the popliteal regions or the anal folds. The frequent recurrence is due to scratching and reinfection of the itching area left behind after the first attack of otitis. He advised light packing with 3% solution of silver nitrate, and for the relief of the intense itching 1% menthol in liquid paraffin. This form of diffuse otitis may complicate a mastoid operation. The best prophylactic treatment after the operation is therefore painting of the meatus with a silver nitrate solution.

The condition popularly known as "tropical ear" needs an explanation. The term was suggested by Forsyth in 1924, for it is found in all tropical and subtropical regions. It is variously known as "Singapore ear," "Calcutta ear," "Hong Kong ear," "bather's ear," etc.

The causal organisms are said to be either mycoses or bacteria. This condition is generally prevalent in Hong Kong during the swimming season and it appears to affect Europeans especially. Many of these cases are however traceable to the rubbing of the aural meatus with a towel or the irritation of a piece of rubber called "ear drum protector for swimmers." As a result of the irritation from the plug, the wearer may so forcibly rub the meatus that the epidermis is denuded leading thereto dermatitis and infection.

The best treatment I find so far is a combination of Mercurochrome and local ultraviolet light therapy. The ear is first mopped dry and then on patient lying down on the sound side, a solution of 2½% of Mercurochrome is dropped into the ear. The solution is allowed to act for ten minutes, after which the ear is mopped dry. The Auricle is then exposed to a Kromayer lamp for three minutes, at the distance of 2½ inches and finally the meatal canal is exposed through a 2½ inch quartz rod for another three minutes. Usually one treatment is sufficient. However without the ultraviolet light, the mercurochrome alone may achieve the result, but is slower and requires a number of treatments. The principle objection to this form of treatment by the patient is that the staining of the surrounding skin by the mercurochrome. I find dilute hydrochloric acid removes the stain most effectively.

Like dermatitis elsewhere, soap and water may aggravate the skin condition, therefore the patient should be warned against this use. Light packing with 10% Glycerine-Ichthyol is also effective, but it takes a longer time to obtain a cure.

(b) *Circumscribed Otitis (Viz: furunculosis or boils).*

Boils give rise to aural discharge only when they burst. The first feeling which is noticed in the ear, is that of intense pain. At its early stage, sometimes it is quite impossible to locate the lesion, because the epidermis in the meatus is tightly bound down by the perichondrium. The sign of swelling and redness therefore may not be seen in its early stages. Hence in a case of otalgia, when one fails to find any cause in the adjacent areas, such as tonsillitis, a caries tooth, inflammation of the temporo-mandibular joint, one should not definitely say, that there is nothing wrong with the ear. A blunt probe is often useful in locating a boil in the meatus. Whenever in doubt treat it as a case of furunculosis, but the patient must be asked to return the following day. One often finds that the boil has visibly developed by then.

I find that 10% Glycerine-Ichthyol is useful in these cases. A small loosely rolled piece of cotton wool is used to dip into this Glycerine mixture and apply lightly to the meatal canal. Any tight packing will tend to produce unbearable pain. Another piece of cotton should be applied on the concha so as to soak up the excess of the solution. Internally for fever and pain either Aspirin or Veramon is helpful. Stannoxy 4 c.c. intramuscularly or six tablets by mouth daily is useful in addition.

When a boil is definitely defined, the usual text book teaching is to incise it. I must say that the incision of boil in the meatal canal without anaesthesia is so painful that the operation should not be lightly undertaken, but as usual, patients will object to incision even with a general anaesthetic. They would prefer to bear the pain of the furuncle than the horrid thought of the incision. In order to overcome the prejudice, I find the best procedure, is to hasten spontaneous rupture by touching the most prominent part of the boil with pure carbolic acid on a wooden stick or probe. This has the effect of producing a local necrosis of the epidermis through which the boil will most probably rupture. Usually it takes one application daily for two days before it bursts by itself in this way. If the application of Glycerine-Ichthyol is continued, the discharge will soon cease and the boil will heal usually in a few days. To prevent recurrence injections of Staphylococcal Vaccines are advisable.

II. Suppurative Otitis Media.

(a) Acute suppurative otitis media;

Unlike that of chronic otitis media, most authorities agree on the general principles of treatment in acute otitis media. Before the

perforation of the tympanic membrane, the patient should be confined to bed.

I find that the ice bag is often a more soothing application than a hot poultice and that aspirin is useful for the relief of pain. Locally a warmed 1-2% carbolic acid in glycerine should be instilled into the ear; because carbolic acid is an antiseptic and an analgesic, while glycerine is a hydroscopic.

If acute rhinitis is also present, 1% menthol in liquid paraffin as nasal drops is a valuable adjunct. The constant blocking of the nose is best relieved by ephedrine jelly.

Paracentesis of the tympanic membrane is indicated when there is either bulging of the tympanic membrane or that the intense pain has not been relieved by medical treatment. I may mention that paracentesis of the tympanic membrane is seldom practised in this colony; firstly, because the lay public thinks an incision in the ear drum would lead to permanent deafness, which of course, is not true; secondly, because in almost all cases where paracentesis is indicated, the drum would rupture spontaneously; thirdly, because no medical practitioner would guarantee complete recovery particularly as regards discharge and hearing after the myringotomy.

When the ear drum has been ruptured or incised, the usefulness of carbolic-glycerine is ended. The pain due to the tension from the collection of pus in the tympanum having been released, the use of any analgesic medicine is unnecessary. Again the hydroscopic value of glycerine in the presence of a free flow of pus is uncalled for. In fact, carbolic-glycerine may do more harm, than good, as by its use, it prevents free drainage on account of its viscosity.

A better hydroscopic effect is obtained by the use of magnesium Sulphate crystals, as first introduced by Watson-Williams in 1931 (3). The effect of the crystals is to relieve local congestion and to produce a thinner discharge. Before its use, the meatus should be mopped dry. The magnesium sulphate crystals are then poured into the meatus filling up to the concha, and is then covered by a piece of cotton wool. The process is repeated every four hours when the discharge is free. Later on, this may be done twice a day. The method is simple and can be carried out readily by the patient or members of his own family. There is no fear of caking the discharge as the crystals dissolve in the discharge easily.

With this method of treatment the discharge will usually become less and less and will finally stop. One should never accept the patient's statement that there was no discharge. The ear should be mopped dry with cotton wool and examined before we can say the ear is really dry.

Should the discharge persists after three weeks, Suzberger's iodized powder is worth trying. It is a 0.75% iodine in boric acid powder, and is prepared by rubbing down resublimated iodine gr. 3.6 with a few drops of rectified spirit and gradually incorporating with it, one oz. of finely powdered boric acid. This should be kept in a brown ground glass stopper bottle to prevent volatilization of the iodine. This powder dissolves readily in the discharge and does not cake. The stimulating effect of the iodine is most useful in chronic cases. In fact, Scott Stevenson (4) claimed that it cures 95% of cases of chronic middle ear suppuration. The powder may be poured into the ear or blown in with an insufflator which is preferable. Again I wish to emphasize the importance of mopping dry the ear before insufflating the powder.

B. *Chronic Suppurative Otitis Media.*

(1) Besides the above the other form of treatment in chronic otorrhoea is zinc ionization which was first popularized by A. R. Friel. To-day many clinics are adopting this procedure as a routine. But the results published in the last few years are most misleading. I must say that favourable results are obtained only in selected cases. The greatest advantage in this form of treatment is that healing can be obtained in one or two sittings. But at least two requirements must be fulfilled. The first is that there must be a large perforation through which the solution may gain access to the tympanum. The second requirement is, that the infection must be confined to the tympanic cavity only. This is shown by the absence of disease of the attic, mastoid, nose and tonsil and by the absence of polypi, granulations, Cholesteatoma and caries of the ossicles.

The technique of zinc ionization (5) briefly is this, that the ear is first cleansed and filled with a weak solution of zinc sulphate.* The negative or indifferent electrode is attached to the patients leg or arm and the positive zinc electrode is placed in the meatus. The current is turned on gradually up to 3 ma., and if there is no complaint of giddiness or pain, the current is allowed to flow at this rate for ten minutes. But if the patient can only stand 2 ma. the current should be allowed to flow for 15 minutes. The current is then slowly turned down to the zero point. With a suitable case the result is little short of a wonder. I recall a case of chronic otorrhoea of eleven years standing, who was treated in various places in Europe and China without result. Seeing it was a suitable case, I gave her this treatment. I saw her again not long ago, and I was glad to find that her ear had been dry during the last three years.

* Zinc Sulphate	5 grms.
Glycerine	60 C. C.
Aqua	1,000 C. C.
Dilute with equal quantity of warm water.	

(2) Hydrogen Peroxide : This agent has been used by the medical profession for a number of years. It is efficacious in that, owing to its oxidization property, ozone, being an antiseptic, is set free when it comes in contact with disintegrated tissue. Moreover the bubbles of gas by virtue of its active movement remove pus and debris from the depth of the ear. The present concensus of opinion of most otologists however, is to condemn its use, on account of its irritating effect on mucous membrane, as external otitis are produced in many cases. Its use during the acute stage is objectionable in that it may carry the virulent organism into the attic or antrum. Nevertheless, I have found it useful in subacute and chronic cases of infants and adults among the poor classes. In infants and children mopping of the ear cannot be efficiently carried out by their parents and hydrogen peroxide treatment would render this unnecessary. In patients of the poorer classes when economy plays an important part, hydrogen peroxide drops answers the purpose well. In regard to the strength of the solution I find $1\frac{1}{2}\%$ is sufficient and not too irritating. In favourable cases the aural discharge will stop after they having used about one oz. of the Solution.

A word may be said here about syringing, which is commonly known as the "wet" method. Its use should be confined to the chronic cases. If the discharge is free, two or three syringing may be required daily. The drawback of this method is, that one cannot leave the patient or his family to do the syringing. This treatment is best carried out in the hospital, as good and satisfactory results cannot be expected in the outpatient clinic.

(3) Spirit drops are often prescribed by otologists. I find that even in diluted solutions not many patient can stand the burning pain after its instillation.

(4) Now let us consider the most puzzling part of the treatment of otorrhoea. The question is what are we going to do with cases which do not respond to the treatment which I have just outlined? I must say at once that these cases of otorrhoea are almost invariably due to complications. For example locally there may be mastoiditis, granulations, polypi, cholesteatoma, caries of ossicles, septic tonsils and adenoids. In other cases the otorrhoea may be a local manifestation of a general infection of syphilis or tuberculosis. Cox and Dwyer (6) found that 15% of chronic discharge from the children's ears is due to tuberculosis. A local treatment alone in a general infection is therefore a futile procedure. In regard to septic tonsils and adenoids, it is advisable not to remove them earlier than six weeks after the acute infection, because firstly, any septic area left behind after the operation may prolong the infection in the diseased ear; and secondly, the early operation tends to restart an acute infection in the ear.

The presence of mastoiditis, granulations, polypus, cholesteatoma, caries ossicles in chronic otorrhoea according to modern teaching, usually requires modified or radical mastoidectomy. The main objects of operating in my opinion are:—first, to avoid intracranial complications, secondly, to stop the discharge, which may be undermining the health of the patient, thirdly, to preserve or to improve the hearing. Complications of Sinus thrombosis, meningitis, and cerebral abscess are fatal conditions and may not at all be amendable to treatment. Fortunately such complications are very rare in China. In fact James Maxwell (7) wrote that “Sinus thrombosis, meningitis, and cerebral abscess the result of such infections are almost unknown.” But such complications do occur is unquestionable. Even to-day I have under my care in the Yeung Wo Hospital a case of septic meningitis complicating otitis media. However, the chance of getting intracranial complications in a case of chronic otorrhoea in China is a very remote one. As for the discharge, “dry ears” after the modified operation is 50% and after the radical operation 70% (8). Hearing is improved 78% of the cases after the modified operation. Judging from these results and facts, mastoid operation may not be advisable in cases of chronic mastoiditis, with the presence of granulation, polypi, or cholesteatoma, even after a prolonged conservative treatment. On the other hand, mastoid operation should not be delayed in the presence of symptoms of intracranial complications, such as headache, vomiting, rigors, etc. For all other cases, however, we have to rest content with our medical treatment such as cauterization of granulations, removal of polypi, cleansing out of cholesteatoma.

As regards to medical treatment the iodized powder is advantageously prescribed for prolonged home treatment. Even without medical treatment one is surprised to find that most of the neglected cases of suppurative otitis become dry at intervals, especially when the patients are in better health. I am convinced that cod liver oil, iodides and iron are useful in all these cases and they are particularly helpful in preventing further recurrent attacks of otorrhoea.

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- (5) A. R. Friel; Notes on Chronic Otorrhoea 1929.
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- (7) James Maxwell: Diseases of China 1929.
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Review of Books

The Chinese Medical Journal. Vol. XLVII, Nov.-Dec. 1933.

This issue of the above journal is a special parasitology number dedicated to the famous German parasitologist Professor Friedrich Fülleborn whose death last September deprived medical parasitology of one of its most prominent leaders.

The number contains some twenty-nine articles most of which are original communications on various aspects of helminthic and protozoan infections. A paper by R. Hoepli on parasites and tumour growth provides an interesting review of the subject together with a most extensive bibliography. There are several papers on the histological changes in parasitic infections, including two on experimental leishmaniasis. A paper by L. C. Feng on Microfilaria malayi records a detailed study of this human parasite, the occurrence of which in South China was recorded last year by the same author. The several taxonomic papers on nematodes should be of value to helminthologists.

Space does not permit of a more detailed mention of the various contributions, but is hoped that sufficient indication has been given that this memorial number with the numerous excellent papers emanating from the laboratory of Professor Hoepli forms a very fitting tribute to Friedrich Fülleborn whose pupil he was.

L. J. D.

"Cholera, a Manual for the Medical Profession China."

By Wu Lien-teh, J. W. H. Chun, R. Pollitzer, and C. Y. Wu.

Shanghai: National Quarantine Service. (Pp. 197; illustrated. Sh. \$5.)

This volume is issued as the English supplement to the current series of the National Quarantine Service and is intended to be the first of a number of practical manuals on the commoner epidemic diseases in China.

The book consists of four parts and an appendix. The first part, by Dr. Wu Lien-teh, is devoted to a survey of the historical, geographical and epidemiological aspects of cholera. The second part by Dr. R. Pollitzer, comprises an account within the compass of some sixty pages of the laboratory aspects of the disease. It contains a description of the usual bacteriological methods of diagnosis, and of recent work on the bacteriology of cholera together with a useful bibliography. The third part by Dr. J. W. H. Chun deals with the clinical aspects of the disease. In the nineteen pages devoted to treatment the whole therapeutical armamentarium is surveyed ranging from Chinese treatment to bacteriophage. With such a diversity of therapy to choose from, the reader will hardly be impressed with the efficiency of any

one method by the statement on page 142 that ". . . almost anyone can be saved from cholera. It is merely a matter of good nursing and careful attention to the details of treatment. . . ." The fourth part of the book by Dr. C. Y. Wu deals with education and propaganda. It affords an insight into the methods adopted by the energetic public health authorities in Shanghai and elsewhere in their efforts to instill a consciousness of sanitation into the mass mind. Their efforts range from lectures to the distribution of pamphlets by aeroplane. A page is devoted to the scenario of a cholera film produced by the Chinese National Quarantine Service in 1932. The captions suggest an entertainment less banal and certainly more instructive than many emanations from Hollywood. The book concludes with an appendix by Dr. C. Y. Wu on the spread and control of sea-borne cholera.

It is felt that the value of the book would have been enhanced had it been written in somewhat more critical spirit. For example, the figures set forth on pages 161, and 162 in support of anti-cholera vaccination are in the opinion of the reviewer without statistical significance. Again on page 81 the statement that "the value of anti-cholera vaccination is demonstrated not solely by statistical evidence but proved also by experimental results and the blood changes observable in the vaccinated" does not in the opinion of the reviewer rest on a solid foundation of fact. Although there is general agreement concerning the probable value of prophylactic vaccination in raising the herd immunity, a carefully controlled experiment conducted on a large scale would provide results of definite worth in assessing the value of this measure.

One would have wished for a more detailed discussion concerning the vexed question of bacteriophage in prophylaxis and treatment. In this connection there is urgent need for carefully controlled large-scale experiments, and for an unbiased critical examination of the results.

The book is well got up and printed. It is interesting and easy to read. It should be of value to medical men faced with the task of opposing an epidemic of cholera in China.

L. J. D.

TWO TEXT BOOKS OF SURGERY.

It is interesting to have for review at the same time two modern text-books of surgery, an English one from London and an American one from the Harvard Medical School.

The fourteenth edition of "Rose & Carless' Manual of Surgery" edited by Cecil P. S. Wakely and John B. Hunter was published in August last year. This work has long been a favourite with English

students. The present edition shows several advances upon the previous one. The paper, printing illustration and binding are excellent.

Amongst other sections showing additions to, and improvements on the previous edition may be mentioned the description of the sympathetic system and thoracic surgery. Bohler's methods of treatment of fractures which have recently come into fashion are described. The account of surgery of the sympathetic system is, however, still scanty: perhaps this is justified on the ground that so much of it is still sub-judice. The surgical advances which owe their origin to the United States are adequately dealt with. The reviewer has been unable to find a single fault in the index. It may be mentioned that Rose & Carless' *Surgery* is the text book of choice for the undergraduates in this medical school.

The second edition of Homan's "Text-book of Surgery" was published in October 1932. It represents the teaching of the Harvard Medical School. It is a most able and interesting work. Tumours of the brain, the pathology of the pituitary gland, the surgery of the sympathetic system, adenomas of the islands of Langerhans, and other subjects, to which recent American research has contributed so richly, are, as one would expect, exceptionally good, and reflect the brilliance of American surgery; and even—may we say it?—a slight weakness in anatomy (see figure 432 showing a double foramen epiploicum) is not entirely false to the impressions of a visitor to the United States.

It is rather piquant to note that this text book of a Republican country devotes three historical paragraphs to "touching for the King's Evil" pp. 661 and 662.

It is of great value to those who have been nourished on the English teaching to read a text book which reflects the slightly different angle of view of American surgery, and we strongly advise all those interested in surgery to have this volume on their bookshelves.

The paper and printing are of very high standard. Twelve hundred and thirty-one pages with stout covers form a thickness of less than 2 inches—one and seven-eights, to be precise.

There is a bibliographical index as well as a subject index. The latter presents the page numbers in thicker type where an illustration occurs. And here one may insert a word of praise for the excellence of the numerous line drawings.

Carcinoma, sarcoma, etc. do not appear in the index under C or S, etc. but under T as a subheading of "tumours" which is not a very scientific word itself. We could not find "oesophagus" at first until we happened to see it under E.

In both text books, English and American, one would have liked to have seen a definition of surgery and its scope.

Rose & Carless Surgery; 14th Edition; Pp. X 1547, 8 black and white plates, 721 illustrations. Balliere Tindall & Cox, London, England. Price :—£1—10s.—od.

A text-book of Surgery; Homan's; 2nd Edition; Pp. X 1231, 517 illustrations. Charles C. Thomas, Baltimore, Maryland, U.S.A. Price :—G\$8.00.

K. H. D.



CORRESPONDENCE.

To the Editor of the Caduceus,
Hong Kong University.

Dear Sir,

Allow me to express my warm appreciation of Dr. McAll's comment (Caduceus, November 1933) on my paper, 'The Pathology of Acute Haematogenous Osteomyelitis.' I must remind Dr. McAll and other readers that my paper could be worth very little and was merely a 5th year student's attempt on a subject of which he has naturally had very limited experience. In fact I considered it too audacious for me to attempt to write any scientific essay but one of my teachers was kind enough to prompt me to write one and so I chose as the subject of my paper the disease that first interested me when I began the study of surgery.

I should like to thank Dr. McAll for pointing out a sequela of osteomyelitis i.e. overgrowth of affected bone, which I omitted in my paper but of which I was aware at the time. This sequela definitely occurs in some cases but is uncommon and rarer than the opposite sequence i.e. shortening of affected bone (Beekman), although even the latter is not of very frequent occurrence. Speed (Journ. Surg., Obstet., and Gyne, 1923) has attempted to explain the mechanism by which overgrowth of affected bone is brought about. He states, "An irritation of required character (nature unknown) applied to the medullary cavity of a bone or to the periosteum at a distance from the epiphyseal cartilage may induce overgrowth and hypertrophy with lengthening of bone. This irritation must be indirect; if the cartilage cells are directly stimulated and irritated we are more likely to find death of cells and stoppage of growth." Lack of use of bone or rather freedom from weight-bearing is also mentioned causal factor.

Thanking you for the valuable space in the Caduceus,

I remain,

Yours sincerely,

P. P. CHIU.

The Editor,
"Caduceus."

Sir,

Kindly accept my heartiest congratulations for the most worthy work done by the Medical Society in putting up a bust in memory of one, whom we all love, respect and admire.

Looking at him from my angle, Professor Wang was outwardly the cold, gaust ascetic, who haunts rather than attends medical meetings. He was probably the last man in the world whose back you

would like to slap however intimately you may have worked with him. But behind that cold mask, there was a passionate, almost apostolic fervour. He worked very hard, in fact too hard, doing much more than his share, deficiently supplied in many necessary things, but he loved his work. Not that he was a mystic in worldly things. Few men have achieved such a dispassionate sense of hard truth, nebulous thought and nebulous speech were anathema to him. During all the years he was with us, he worked almost entirely behind the scene, teaching, suggesting, criticising and researching. Professor Wang might hate the limelight, but certainly we could not be induced to shut it off.

Dr. Lim Gim Kheang in his speech at the unvielling ceremony for reason known to himself, suggested that the Vice-Chancellor was the originator of the idea to have the bust. As a matter of fact it was a spontaneous cry from many of Professor Wang's students, past and present, which gave birth to it, an idea inspired by gratitude, respect as well as a great admiration. Undoubtedly we owe the Vice-Chancellor a great debt of gratitude for his generous support and permission and Dr. Lim for his fitting tribute.

I am sorry to learn from the last issue of Caduceus that the Society is still in need of funds to cover the cost of the bust. However, this we know is not due to any lack of sympathy on the part of those who knew Professor Wang, but rather to the lukewarm, slow, and above all timidity on the part of those responsible persons who ought to know better and to have been more awake.

Then, it is my humble opinion that the ugly fireplace at the dark corner of the Medical Library is no place for such a worthy bust. Could not the Society find a better place? It would have been only proper and fitting to have the bust put on a decent stand in front of or at the entrance to, the Pathology School, the place Professor Wang loved so well. Surely the Pathology School is proud of its Father or Founder. The least that we can state of Professor Wang was that he gave his life to the school and the work he began there. Had he been another, perhaps our University would have acclaimed him as a martyr to Science for we believe that he succumbed to an illness he worked to combat for the blessing of Mankind. He died from Tuberculosis and he got the infection from his laboratory.

Indeed I was much impressed and inspired when I walked round the compound of the famous Charité Clinic in Berlin, where I saw in front of practically every building a bust of the distinguished founder of the clinic. Now let us move Professor Wang's bust to the front of the Pathology School, where medical students can pass daily drawing inspiration from a great teacher and a devoted scientist.

With best wishes for a greater and grander Caduceus,

Yours, etc.,

T. P. WU, M.B., B.S.

Acknowledgements

1. Revue de L'Universite de Lyon. (February, 1934.)
2. Birmingham Medical Review Vol. IX, No. 1.
3. Medico Surgical Suggestions Vol. III, Nos. 1, 2 and 3.
4. Reports National Quarantine Service. Series IV.
5. Journal of Bone & Joint Surgery Vol. XVI, No. 11.
6. Post Graduate Medical Journal Vol. X, Nos. 101 and 102.
7. Medical Journal of Australia Vol. I, Nos. 7, 10, 12, 13, 14 and 15.
8. Tohoku Journal of Experimental Medicine Vol. XXIII, Nos. 1 and 2.
9. D. H. Medical Journal Vol. XI, No. 3.
10. New Zealand Medical Journal Vol. XXXIII, No. 174.
11. Fukuoka-Ikwadaigaku Zasshi Vol. XXVII, Nos. 3 and 4.
12. Chiba-Igakkai-Zasshi Band XII, H.K. 3, 4.
13. Okayama-Igakkai-Zasshi Jg. 46, Heft 3, 4.
14. Institute Portugues de Oncologia Vol. 1, No. 1.
15. Queen's Medical Magazine Vol. XXXI, No. 4.
16. Revista de la Facultad de Medicina Vol. 2, No. 5.
17. Manchester University Medical School Magazine Vol. XIII, No. 3.
18. St. Bartholomew's Hospital Journal Vol. XII, No. 6.
19. Middlesex Hospital Journal No. 214.
20. Der Volksgezondheid in Nederlansch-Indie Vol. XXIII, No. 1.
21. Puerto Rico Journal of Public Health & Tropical Medicine Vol. IX, No. 2.
22. Medical Magazine of Orient Vol. XII, Nos. 1 and 2.
23. Far East Medical Journal Vol. II, No. 12 and Vol. XII, Nos. 1 and 2.
24. Diagnose and Therapie Vol. VI, No. VI.
25. University College Hospital Magazine Vol. XIX, No. 1.
26. Journal of Shanghai Science Institute Vol. I, Section IV.
27. St. Mary's Hospital Magazine Vol. XL, No. 1.
28. Medical Press Vol. CLXXXVIII, No. 4953.
29. Bulletin of University of Georgia Vol. XXII, No. 1.
30. St. Thomas' Hospital Gazette Vol. XXXIV, No. 7.
31. Nippon Fujinkagakkai Zassha Vol. XXVIII, Nos. 8 and 14.
32. Bulletin of New York Academy of Medicine Vol. X, No. 2.
33. Academic Royale Serbe No. 1.
34. Japanese Journal of Experimental Medicine Vol. XII, No. 1.
35. The Hospital Vol. XXX, No. 3.
36. The Fourth Annual Report of the Wusueh Methodist General Hospital 1933.

ANNUAL GENERAL MEETING.

The Annual General Meeting of the Hong Kong University Medical Society was held on the 28th of March 1934 at 5.15 p.m. in the Union Assembly Room, with Dr. Lim Gim Kheang in the chair.

The minutes of the 1932 Annual General Meeting were read and confirmed.

The Annual Report of the Society submitted by the Hon. Secretary for the session 1933-1934 were read and approved.

The Accounts for the year 1932 and 1933 were passed.

The following gentlemen were returned office bearers for the session 1934-1935.

President :—Prof. L. J. Davis.

Chairman :—Mr. Ong Ewe Hin.

Hon. Treasurer :—Dr. K. D. Ling.

Hon. Sec. :—Mr. K. L. Leong.

Committee Members :—Dr. G. K. Lim.

Mr. S. H. Sung.

Mr. A. K. Nagalingan.

Mr. E. Gasano.

Mr. W. Heng.

Mr. V. Sorokin.

Mr. S. C. Tan.

A vote of thanks was passed on the retiring Committee and the Chairman stressed on the point of more co-operation among the members.

ONG EWE HIN,

Hon. Sec.

ANNUAL REPORT OF THE HONG KONG UNIVERSITY
MEDICAL SOCIETY 1933-34.

Report of the Hong Kong University Medical Society for the session 1932-1933 as presented by the Hon. Secretary Mr. Ong Ewe Hin at the Annual General Meeting held on 28th March, 1934 at the Union Assembly Room.

Mr. Chairman, Ladies & Gentlemen,

On behalf of the Committee of the Medical Society I beg to present to you the report of its activities for the session 1933-34.

The Society has had quite a successful year so far as its activities are concerned. There were more lectures delivered this session than before besides we were able to hold our own in the Sporting and Social sides of the University.

At the Annual General Meeting held on Wednesday, 1st February, 1933, the following gentlemen were returned office-bearers for 1933-34.

President :—Prof. W. I. Gerrard.

Chairman :—Mr. Lim Gim Kheang.

Hon. Treasurer :—Prof. L. T. Ride.

Hon. Secretary :—Mr. Ong Ewe Hin.

6th year Rep. :—Mr. P. H. Chew.

5th do. —Mr. Mahan Singh.

4th do. —Mr. H. N. Lee.

3rd do. —Mr. L. A. Tjon.

2nd do. —Mr. W. Heng.

1st do. —Miss M. T. Tso.

Graduate Rep. :—Dr. T. K. Lien.

Professors W. I. Gerrard and L. T. Ride were re-elected. Their support of the Society has never faltered and their re-election came as no surprise. Professor Gerrard's guidance and supervision over the activities of the Society have proved invaluable.

At the first Committee Meeting the following were elected Hon. Vice-Presidents :

Prof. K. H. Digby.

Prof. R. E. Tottenham.

Prof. J. L. Shellshear.

Prof. L. J. Davis.

Dr. Wu Lien Teh.

Dr. D. J. Valentine.

Dr. M. O. Pfister.

Dr. Li Shu Fan.

Dr. G. H. Thomas.

Dr. D. K. Samy.

Major D. McKelvey.

Dr. Chau Wai Cheung.

Prof. Ride tendered his resignation as Editor of the Caduceus and Treasurer of the Society at the end of April because he was proceeding home on leave.

At the 3rd Committee Meeting Prof. L. J. Davis was elected Editor of the Caduceus. On the recommendation of Professor Ride and approved by the Committee it was decided to have an Editorial Board. Dr. K. D. Ling and Mr. Ong Ewe Hin were appointed Associate Editors.

Dr. K. D. Ling was also appointed Hon. Treasurer of the Society.

Your Committee thought it fit to discharge Mr. E. Haroon as Business Manager and Mr. R. A. Evans was elected to fill the vacancy.

Mr. P. H. Chew was elected to serve on the Union Council vice Mr. E. H. Ong who was appointed Hon. Secretary of the Union.

During the session under review two farewell tea parties were given. The first one was given on Wednesday, 8th February, 1933 in honour of Dr. T. Y. Li who was going up to the Lester Institute. Over 100 members were present to wish Dr. Li a very successful sojourn in Shanghai.

The Second one took place on Monday, 12th March, 1934 when our President Prof. Gerrard proceeded home on leave. Over 150 members and friends were there to wish Mrs. and Prof. Gerrard bon voyage and a very pleasant holiday.

Prof. Ride also went on leave in April. We tried to arrange a farewell tea party for him but somehow or other he refused. We hope to see him back with us soon.

On Friday, 26th January, 1934 the bust of the late Prof. C. Y. Wang was unveiled by our Vice-Chancellor Sir William Hornell in the Medical Library. Thus a campaign started over 3 years ago was materialized. There were over 200 members and friends present including a large number of practitioners who had benefited by the late Professor's teaching; Sir William and our Chairman spoke on the occasion.

The following lectures were delivered during the session under review:—

"Manson—the Father of Tropical Medicine," on Friday, 3rd March, 1933. Professor Gerrard's Presidential Address.

"The Pathology of Acute Hematogenous Osteomyelitis," on Tuesday, 21st March, 1933 by Mr. Chiu Put Po.

"Spirochactosis—illustrated by cinematograph" by Prof. P. Muhlens on Thursday, 23rd March, 1933.

"The Correlations of Function and Structure of the Cerebral Cortex" by Dr. F. Goldby on Wednesday, 12th March, 1933.

"Recent Experimental Work Relating to Sound and Hearing" by Dr. L. Reid on Monday, 10th July, 1933.

"Anti-Material Measures" illustrated by a cinematograph film, by Dr. A. Jackson on Friday, 22nd September, 1933.

"Cholera Prevention In China" by Dr. Wu Lien-teh on Monday, 9th October, 1933.

"Early Man" by Professor J. L. Shellshear on Wednesday, 1st November, 1933.

"The Heart—Recent Studies of its dynamics and energy requirements" on Wednesday, 8th November by Dr. K. MacKenzie.

"Cauterisations of pleural adhesions in cases of incomplete pneumothorax" by Prof. Gerrard on Thursday, 16th November, 1933.

"Interesting Advances in Endocrinology," by Dr. T. Howie on Friday, 19th January, 1934.

"The Methods of Treatment of Otorrhoea" by Dr. Li Shu Pui on Wednesday, 31st January, 1934.

We take this opportunity of thanking the above speakers.

Our Annual Social Function was held on Saturday, 7th January, 1934 in the form of a supper Dance in the Great Hall.

A launch picnic was held on Thursday, 11th May, 1933 to Castle Peak.

We did not fare so well in the field of Sports this session.

We won the Inter-faculty Basketball, and tennis tournaments but lost in Cricket.

To the Editorial Board of the Caduceus we owe a vote of thanks. The running of the journal has been going on very smoothly. A competition was held during April, 1934 on "The Contrast between Ancient Chinese Medicine and Modern Medicine." We congratulate Messrs. Woo Hung Tak and L. A. Tjon, who have been awarded the 1st and 2nd prizes respectively.

The Society was invited to a debate by the Arts Association, the motion being. "In the opinion of this house Co-education is a success in this University." Messrs. O. de Souza and Ng Yew Seng represented the Society and were very unlucky to lose.

The Society contended successfully for the repeal of the bye-law of the Union that "The Hon. Secretary of the Union shall ipso facto be a non-voting member of its affiliated clubs." Messrs. Lim Gim Kheang and Ong Ewe Hin represent the Society at the Extra-ordinary General Meeting.

The financial standing of the Society I am glad to say still remains as sound as ever. There is a balance of \$2,992.41, although we have to pay an extra \$500.00 for Prof. Wang's bust and in addition run the essay competition.

Before I close my report I would like to thank the following gentlemen :—Prof. W. I. Gerrard for his kind guidance and invaluable advice. Prof. L. J. Davis for managing the Caduceus. Dr. K. D. Ling for the care he had taken in the Society's finance, Dr. G. K. Lim for the great help he has rendered me in my duties.

The Committee Members for their kind co-operation.

And to each and every one of you for the interest you have taken in the welfare of the Society.

ONG EWE HIN.

