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Vol. 5 May, 1926 No. 1

All medical papers and other scientific contributions intended for the Journal, and all books for review and magazines in exchange, should be addressed to the Editor, "Caduceus," Hongkong University, Hongkong.

Changes of address of members of the Society and all business communications should be sent to the Business Manager, "Caduceus," Hongkong University; Hongkong.

Presidential Address.

R. E. TOTTENHAM, B.A., M.D., F.R.C.P.I., D.P.H.

Firstly I want to thank the Committee and Members for the great honour they have done me in asking me to deliver the Presidential Address.

It is always a very great pleasure to be associated in any way with an organization of this kind, particularly to those of us whose principal interest is centred in the scientific side of our profession.

From the point of view of medical education it is as important to develop scientific interest as it is to learn to be an efficient practitioner.

Let me emphasise that medicine is a profession, not a business career, and that if the sole object of a man be to make money he had better leave medicine alone.

The aims of a Doctor should be to cultivate sympathy in his dealing with the public, he should always endeavour to put himself as far as possible in their place, and to only advocate that form of treatment which he sincerely believes to be the best for the patient, not what will be most remunerative to himself. When there is a question of an operation under consideration, he must not say to himself, "Now if the patient is operated on I will make $400, and if not only about $30, therefore operation is obviously the treatment of choice." He must absolutely put his own interests to one side, and if he does so it will pay him in the long run, patients will come to him, for they value an honest man, and a man whom they can trust.

From the patient's point of view an operation is a very serious matter, there is the initial risk to life, and some weeks of pain, and discomfort. No patient ever forgets having had an operation, and as has often been remarked he or she will date subsequent events from that time, just as we all do from any big event in our lives. If you really believe that an operation is best for your patient, then do not hesitate to advocate it, but in summing up the case always consider the patient's social condition, whether they have to perform physical work, and so forth, no man or woman who has much physical work to perform can afford to be a chronic invalid, and it is your duty to make your patient as physically fit as possible. Well-to-do patients may sometimes prefer to lie up for long periods rather than face an operation, if so give them the option, when the case allows of a choice, but make the matter quite clear to them lest they blame you later.

Another point which we all have to keep before us is, that it is our duty to advance the scientific side of our profession as much as lies in our power. Therefore if you have an opportunity of doing any research work, do it, and publish your results; further if you have anything of interest to say about your cases, it is worth publishing it, therefore write an article and submit it to one of the Medical Journals.

I advise everyone to cultivate the habit of writing on medical subjects, but always remember that you must seek to cultivate the reputation of only writing when you have something worth while to say: there is a great tendency at the present time to write in order to get ones name into print. Get into print by all means, but be sure your articles do you credit. Many candidates for higher posts are solely judged on the character of their published work. Recently in the States one of the Doctors told me that every man on the staff of his hospital has to write or leave, I am afraid that the remark did not create in me the impression he desired, for I at once thought "what is the use of a man writing if he has nothing worth saying, and if he be compelled to write he will just put down sufficient padding to fill the pages."

I have not as yet had the pleasure of being present at any of the meetings of this society, but I hope in the near future that I shall, for I think such a society as yours may well be the forerunner of a Hongkong University Academy of Medicine, which most of you when graduates, could organise for the advancement of medicine in the Colony.

Let me say briefly what I mean by an Academy of Medicine. It would be essentially a medical society, meeting at regular intervals, one meeting being devoted to surgery, another to

pathology, another to medicine, one to obstetrics, one to anatomy and so forth.

Each of the different branches of medical science would have its own committee of say a President, Secretary, and two ordinary members. The duty of the committee would be to keep in touch with all those in the Colony who are interested in that particular section, and request papers from each of them once a year. I believe each section could meet at least three times in the year, twice before Chinese New Year, and once after it. In the case of some of the sections such as surgery where many papers might be forthcoming, no doubt meetings could be arranged even more often.

The proceedings of each meeting would be published in the Caduceus with the remarks of the speakers, the latter could be furnished in writing (by the speaker) to the Secretary at the close of the meeting.

I want to make it quite clear that I am in no way advocating the founding of a medical society which would be a rival to those already in existence in the Colony. What I have in mind would be practically entirely a University institution which any Doctor in the Colony could join as an associate, but membership would be limited to University Medical Graduates and members of the Staff of the University.

Some Academies confer an Honorary Fellowship on distinguished Doctors, it is entirely a medical distinction, and not a degree in the ordinary sense of the word; naturally the fewer of these Fellowships conferred the more highly appreciated they would be. Had an Academy of Medicine been in existence, we might even have had the pleasure of admitting our recent distinguished visitor to the Honorary Fellowship.

I want to emphasise the fact that the admission to the Fellowship would not be a University function, but would be carried out at a meeting of the Academy in much the same way in which their President would be inaugurated.

I am anxious that if an Academy be formed that it should be a University institution, and the meetings be held here, for I am sure students would enjoy being present, and would learn a good deal that would help them in later life.

Before I close I feel I should say a few words about the future of Midwifery in this Colony.

For teaching purposes I am a very strong supporter of the policy of having a Midwifery Hospital separate from the General

Hospital, there is no doubt in my mind that midwifery under such conditions would be more efficient; as it is an entirely different subject to either medicine or surgery. For instance there is all the difference in the world between doing a private case in a nursing home which only takes maternity cases, and doing a case in a home that caters for all types of patients. Unfortunately we have no hope of getting a midwifery hospital attached to the University for teaching purposes, but in the future it would be very nice to see the different midwifery hospitals of the Colony staffed by our men, each hospital providing accommodation for say three ward clerks who would live there until their cases had been taken out; the work superintended by whoever was in the Chair of Obstetrics, then each hospital would have the interest of preparing its own annual report, and of entering into competition with the others.

Lastly since I have been associated with the Tsang Yuk I have had an opportunity of seeing the work of Chinese nurses, let me say that I am greatly impressed, and I believe that nurses trained there will prove of very considerable benefit to the community, and I think that Dr. Hickling cannot receive too much praise for the valuable work she is doing, there, and elsewhere in the Colony.

Again Gentlemen let me thank you for the very great pleasure you have given me in allowing me to come down here and address you this evening.

The Mosquitoes of Hongkong.

A. G. MILLOTT SEVERN, B.A., M.D., D.P.H.

Everyone in Hongkong is familiar with the activities of mosquitoes, where they are a perennial nuisance. Malaria and other mosquito-borne diseases are prevalent, but apparently little has been done towards a scientific study of this important group of insects in this Colony.

The first attempt at a systematic examination and classification of the mosquitoes of Hongkong seems to have been made in the years 1900 and 1901 by Dr. John C. Thomson, a Government medical officer. His report was published in the appendix of the Report of the Principal Civil Medical Officer for the year 1901.

He was able to examine more than thirty-one thousand mosquitoes, collected as adult insects, during a period of twelve months, from thirty-six Police Stations throughout the Colony, including the New Territories, Cheung Chau, Lamma, and Stonecutters' Island.

He states that 3.7% of the mosquitoes examined were Anopheles, these being of three species only, viz.:—

Anopheles sinensis.
„ maculatus.
„ minimus. (In order of frequency.)

The last two were described as new species, not previously recorded elsewhere.

Dr. Thomson differentiated twelve species of Culex, which comprised 96.3% of the total number of mosquitoes collected. These included:—

Culex fatigans.
Stegomyia scutellaris.
Armigeres obturans.

Also three other varieties of Culex which were considered to be new species, and others which were noted as "probably new species."

Tables were published showing the distribution of the mosquitoes both as to time of year, and place where obtained.

It is noteworthy that no specimens of the Stegomyia fasciata were found at that time, and also no Anopheles were recorded from Stonecutters' Island.

Dr. Thomson was assisted in the work of classification by Mr. Theobald, the eminent entomologist.

This is an interesting survey made at a period when comparatively little was known about the mosquitoes of the East.

The next extensive collection of local mosquitoes was obtained by the late Dr. H. Macfarlane, a former Government Bacteriologist, during the years 1912-14. Some twenty thousand specimens were sent to England and named by Mr. F. W. Edwards, of the British Museum of Natural History; a list of the species found was published in the Bulletin of Entomological Research.

Most of the mosquitoes were bred from larvae collected by Dr. Macfarlane and various Sanitary Inspectors.

The annual Report of the Hongkong Medical Departmen 1922 reproduces a list of the mosquitoes which have been f in the Colony of Hongkong, as follows:—

Anopheles indiensis, Theo.
„ jeyporiensis, Theo.
„ kawari, James.
„ maculatus, Theo.
„ minimus, Theo.
„ rossi, Theo., Var. indefinitus, Ludlow.
„ sinensis, Wied.
„ tessellatus, Theo.

Stegomyia fasciata, F.
„ fusca.
„ scutellaris, Walk.
„ w-alba, Theo.

Armigeres obturans, Walk.
Ochlerotatus macfarlanei, Edw.
„ togoi, Theo.

Culiciomyia pallidothorax, Theo.

Culex bitaeniorhynchus, Giles.
„ concolor, R.D.
„ fatigans, Wied.
„ fusocephalus, Theo.
„ m meticus, Noe.
„ sinensis, Wied.
„ sitiens, Theo.
„ tritaeniorhynchus, Giles.
„ virgatipes, Edw.
„ vishnui, Theo.

Ficalbia minima, Theo.

Lophoceratomyia minutissima, Theo.
„ rubithoracis, Leic.
Mansonioides uniformis, Theo.
Micraedes malayi, Leic.
Uranotaenia macfarlanei, Edw.

It will be seen that Dr. Macfarlane added considerably to our knowledge of the varieties of mosquitoes found in this Colony. Three new species, the Culex virgatipes, Edw., Ochlerotatus (Aedes) macfarlanei, Edw., and Uranotaenia macfarlanei, Edw., were discovered as the result of his efforts, the last two being named after him.

Last year I commenced to collect mosquitoes, mostly bred from the larvae found by the staff of the Sanitary Department in the course of their duties. These were sent to Mr. F. W. Edwards, the well-known authority, of the British Museum of Natural History, who very kindly offered to identify them for me. A few also were identified at Liverpool University. Altogether more than six thousand specimens have been sent home by me up to the present date.

The following is a list of those species found:—

Anopheles maculatus, Theo.
„ maculipalpis, Giles.
„ minimus, Theo.
„ (sinensis) hyrcanus, Pall.
Stegomyia fasciata, F.
„ scutellaris, Walk.
Aedes (ochlerotatus) macfarlanei, Edw.
„ „ togoi, Theo.
„ japonicus, Theo.
Armigeres obturans, Walk.
Megharinus splendens.
Lutzia vorax, Edw.
Culex bitaeniorhynchus, Giles.
„ fatigans, Wied.
„ mimeticus, Noe.
„ orientalis, Edw.
„ pallidothoracis, Theo.
„ tritaeniorhynchus, Giles.
„ virgatipes, Edw.
„ vishnui, Theo.
„ vishnui, Theo., var.
„ sitiens, Wied.

Also:—
Culex duttoni, Theo.
„ castrensis.
Lutzia halifaxi.

These last three were not identified with absolute certainty, I am awaiting further examples to confirm the identification.

It should be noted that a few of the above species have not previously been found in Hongkong.

The species most commonly found in the Colony is Culex fatigans, this ubiquitous insect is met with everywhere, and at all seasons of the year The Stegomyia scutellaris, the common black and white mosquito, is the next most numerous. It is frequent in hot summer weather, and is a persistent daylight biter.

The commonest of the Anopheles in my collection was A. maculatus.

The Anopheles most frequently found here are A. maculatus, A. sinensis and A. minimus; all other Anopheles, in my experience, may be considered as rarities in this Colony.

It is to be regretted that both the A. maculatus and A. minimus are in other countries well known to be vectors of sub-tertian or "malignant" malaria. The A. sinensis has in Formosa been proved a carrier of benign-tertian and quartan malaria, and in other parts of the East, particularly in the Dutch East Indies, it is suspected to transmit sub-tertian malaria.

It is a matter of interest that these three Anopheles are the ones most commonly found in Formosa, where malaria is a serious problem.

Anopheles are very rarely found in the city of Victoria, and that part of Kowloon situated south of Gascoigne Road is equally free from these dangerous mosquitoes.

My collection tends to show that Anopheles are relatively common in the winter months; this, I think, may be due to the damming up of streams and nullahs by farmers and others during the dry season. These efforts to conserve water often provide suitable breeding places in water-courses where there is, during the rainy season, too rapid a flow to permit the breeding of Anopheles.

The Anophelene mosquitoes of Hongkong are fairly readily distinguishable from other varieties; the only Culicine species likely to cause confusion are C. mimeticus, which has spotted wings, and possibly C. orientalis; however, both these mosquitoes are of infrequent occurrence.

Hongkong is fortunate in possessing at least two or three indigenous species of small mosquito-eating fish. These are found in ponds and streams, but are less common than formerly;

such valuable fish should be protected. A very hardy and voracious species, with an extraordinary appetite for mosquito larvae and even pupae, is the Macropodus opercularis, Linn., the Chinese Paradise Fish. I am sending other fish, with similar proclivities, to England to be named, as I have been able to find but little data regarding them. Specimens have recently been obtained from the neighbourhood of Kowloon City and Cheung Sha Wan.

The Megharinus splendens is an interesting mosquito; it typically inhabits jungle, it is not a blood-sucker, and its larvae, which exist for many weeks in that stage, readily feed on the larvae of other mosquitoes. Unfortunately they are rare in this Colony. The larvae of the Lutzia vorax also prey on other mosquito larvae.

The rocky pools around our coast, close to the edge of the sea, are not always free from the larvae of mosquitoes; I have found Aëdes togoi breeding in large numbers in such pools near "Big Wave bay," in water more saline, through evaporation, than ordinary sea-water; no doubt they occur in similar situations elsewhere in the Colony.

I am informed that when the Panama Canal was about to be opened, and a large amount of sea traffic with the East was expected by this route, the Indian Government were anxious to obtain information regarding the distribution of the Stegomyia fasciata, the yellow-fever carrier. Careful investigations were made in this Colony, with the result that this mosquito was found both in Kowloon and Hongkong on many occasions, usually in earthenware kongs or other vessels used for the storage of drinking water; however, it is apparently not common here, for I have found it only once in more than a year.

With regard to mosquito-borne diseases other than malaria which occur in the Colony, filariasis is sometimes met with, and the Culex fatigans, our commonest mosquito, is considered usually to be the intermediary host. The Stegomyia fasciata is rightly regarded in many countries as the carrier of dengue fever, but seeing that this mosquito is rare with us, and that dengue is of frequent occurrence, it seems probable that dengue in Hongkong is conveyed by some other species of mosquito, possibly by the Culex fatigans; however, further investigation of this problem is necessary

This paper must be considered only as a preliminary report. I have not much spare time to devote to this subject, yet the results obtained during the past twelve months have been promising, and the work will be continued. A further communication may be made next year if the data warrant.

Biochemistry in Clinical Medicine.

S. Y. WONG, M.Sc., Ph.D.

A moment's comparison of medical textbooks to-day with those several years ago will show at once how much biochemistry has contributed to the progress of scientific medicine in recent years. The fruitful application of the methods and principles of physical chemistry to the study of biological reactions should be particularly noted for the clear insight it has gained for medicine into many pathological changes. Combining the merits of both physics, the science dealing with the transformations of energy, and chemistry, the science dealing with the transformations of matter, physical chemistry in the hand of the biochemist has indeed produced startling results in the elucidation of certain life-phenomena which would otherwise remain covered up by the term "vitalism." There can be little doubt that biochemistry, aided by the implements and knowledge of physical chemistry in its momentous advances in the last decade, has laid a solid foundation on which we must ultimately build our interpretation of the functions of living matter.

In the rapid development of biochemistry, not only physical chemistry plays an important part, but also experimental biology. Co-operating with the last named in close range, biochemistry will no doubt form one of the great mainroads through which the future advancement of scientific medicine is to be achieved. While experimental biology, drawing upon the rich sources of biochemistry, is immensely increasing its exactitude and its certainty; biochemistry, responding to the inspiration drawn from the field of experimental biology, is rapidly widening the horizon of its inquiries and approaching with ever increasing velocity the objective of its studies. Prof. A. V. Hill of London University has said:—

> "Just as anatomy in seeking new methods, is beginning to pursue its studies by experiments on the living, rather than by observation of the dead, so biochemistry is passing beyond the relatively simple organic chemistry of the structure of matter which was once alive, and is studying the events occurred in the living cell while it actually lives. Modern physics is getting inside of the almost invisible structure of the atom, chemistry inside the visible structure of the tissues, and biochemistry inside the visible structure of the cell."

It should be remembered, however, that even in the life of a single cell, there is a multiplicity of parallel reactions so

interrelated, interpendent and interwoven as to form a bewildering complex the resolution of which into comprehensible variables constitutes by no means an easy task.

In the annals of biochemistry as in those of pure chemistry, new compounds with special properties have added to the list from time to time. It has been known for centuries that certain poisonous substances produce effects on the living organism in very minute doses; but it has been fully recognized only in recent years that a number of chemical compounds which may be present only in a mere trace is indispensable to the normal activities of the organism. The discovery and isolation of the various active principles of internal secretions has given the physician a number of valuable drugs and placed organotherapy on a scientific foundation. The pronounced properties of adrenalin, thyroxin, pituitarin, insulin, and others are so familiar to most of you that their description seems to be superfluous. I may mention in passing that a new preparation of the parathyroid hormone is now available for clinical uses.

In view of the different disorders arising frequently from a monotonous diet, the adequacy of a diet containing merely the sufficient quantities of carbohydrate, fat and proteins to make the necessary calorific value had been seriously questioned and as a consequence the vitamins or "accessory food-factors" were discovered. There are at present three vitamins definitely known to us—the fat-soluble A, water-soluble B, and water-soluble C. They are essential for growth and the maintenance of body-weight and general health. Lacking any one of them in the diet always results in the development of diseases such as rickets, beri-beri, and scurvy. A deficiency may also lower the resistance of the body to infection. In this connection, it is significant to note the high mortality of infants in this country that may be due to such a deficiency of vitamins, particularly fat-soluble A. In order to provide a milk of high nutritive value, the mother must have a good reserve of vitamins readily mobilizable during lactation. For this reason, the rich people in this country suffer no less than the poor, for they hire wet nurses who belong to the latter class and whose diet is usually inadequate.

The most important application of biochemistry to the practice of medicine is to be found in the fact that the recent advances of biochemical knowledge and technique have furnished the physician with diagnostic methods of precision, and indications for treatment based upon exact knowledge, where but a few years ago empirism afforded the sole basis of treatment. In this respect, the introduction of new methods for blood analysis is particularly significant. Had the discovery of insulin been

made ten years earlier, its clinical application would have been much more difficult, because we then possessed no simple method for the estimation of glucose in blood. Blood sugar serves not only as a basis for the standardization of the insulin unit, but also as a guide to its therapeutic administration. In a recent article in the China Medical Journal, Dr. Robertson of the Peking Union Medical College, has called attention to the importance of chemical control in the treatment with insulin of diabetic cases.

Since the Glycosuria of diabetes takes its origin from hyperglycemia, it is evident that the hyperglycemia is more fundamental, the glycosuria serving only as a safety factor. In the early stage of the disease, the glycosuria may be taken as a fair index of the hyperglycemia, but when the condition has become chronic and the renal threshold for sugar raised, the glycosuria would be a poor guide to hyperglycemia. Blood sugar determination has not been rapidly adopted in general practice by clinicians as a guide to diabetic treatment simply because many of them were content to employ the older and simpler method of urine examination.

Even a moderate impairment of renal function will have a definite influence on the level of urea and non-protein nitrogen in the blood; their determination should be a valuable measure of kidney efficiency. Their increase in the blood constitutes the principal change in nephritis. The retention of creatinine in the blood is, however, of greater prognostic value than the urea in cases of advanced nephritis, since it takes place only when renal function is greatly impaired. On account of its greater insolubility, uric acid is not so easily eliminated as urea and creatinine; and consequently its retention in the blood occurs earlier than in the case of either of them, although an increase of the uric acid level is a less reliable sign of impaired renal function. The estimation of uric acid in the blood, however, furnish very reliable information in the diagnosis of gout.

Determination of non-protein nitrogen and urea will also furnish the surgeon valuable information in determining the risk of operation, especially in cases of prostatic obstruction. In such cases if no other complications are simultaneously present, the urea nitrogen does not generally exceed 20 mgm. per 100 c.c. of blood for hospital patients.

The plasma proteins have recently received considerable attention, although analytical data collected regarding their variations in health and diseases have not been sufficient for the drawing of definite conclusions. It seems to be reasonably certain, however, that exceptionally high values of the proportion of globulin to albumin in the blood-serum are associated

with infections or else with toxemias. In the case of kala-azar, the extraordinary increase of the globulin fraction is of diagnostic significance. What the origin of the rise of globulin in infections is, we are still in profound ignorance. It may be due to the alterations of permeability of the tissue-cells, as some recent experiments tend to indicate. With the introduction of a new centrifugal method for the separate determination of the plasma proteins by the writer, it is to be hoped that additional data will soon be accumulated for the correct interpretation of the variations of the plasma proteins in health and in diseases.

In recent years, great progress has also been made in the revision of methods for urine analysis. Benedict's method has become well established as the most reliable for the estimation of glucose in urine. Folin's permutid method for the determination of ammonia is not only time-saving but also very accurate. With the introduction of direct methods for the colorimetric estimation of uric acid by Benedict and by Folin, the busy practitioner is enabled to make a chemical diagnosis regarding this substance in less than ten minutes. Esbach's widely used method for the quantitative analysis of albumin in urine has also been superseded by more convenient accurate methods, to the last number of which the writer has made a humble contribution.

In conclusion, the contributions of biochemistry to the advances of scientific medicine in recent years may be briefly summarized as follows:—

1. Physico-chemical explanations have been made possible for many physiological functions.

2. Scientific facts have been furnished to support certain clinical observations.

3. Specific and potent drugs have been discovered and prepared for the treatment of certain diseases particularly those of metabolic origin.

4. Convenient and accurate methods have been introduced for the recognition and estimation of the severity of diseases.

The Surgical Side of General Medical Practice.

LEE SHU-FAN, M.B., Ch.B., F.R.C.S.Ed., D.T.M.&H.

It is immaterial whether we have a predilection for medical or surgical cases in our general medical practice, a large percentage of surgical cases will come to us at the first hand

Whether we undertake the treatment ourselves or refer such to the specialists, it makes no difference, it is incumbent on us as G. P.s to carry out two most important duties. Firstly to establish the diagnosis and secondly to give advice to the patient on the proper line of treatment.

I submit that unless a G. P. possesses a fair knowledge of surgery he will fail in his duties to the community and he will also fail to attain to the height of success in the Profession. Moynihan once declared that he was a physician doomed to the practice of surgery, while Harvey Cushing maintained that no surgeon is great unless he is also a physician. But it is equally true that no physician is great unless he has a knowledge of surgery.

While it is comforting to observe that today our people are accepting more and more of surgery, yet we cannot fail to recall a large number of avoidable deaths in our practice because operation was not accepted or having accepted it, it was too late to be of benefit. Often times the responsibility is ours because the diagnosis was not made or having made it, it was too late for any good result.

The province of surgery is so vast that I propose to discuss briefly only such cases as we G.P.s come across in our daily work. I will take them separately under the following headings:—

Enlarged Tonsils and Adenoids.

As tonsils have a protective function to the organism at least as a first line of defence, we must not sacrifice them indiscriminately. There are two indications for tonsillectomy viz. gross hypertrophy causing mechanical interference with respiration and interference with the development of the child. Secondly the chronic septic tonsil which is the cause of chronic toxaemia. The latter type of tonsils are usually small, lying hidden behind the faucial pillars and may be easily overlooked.

The importance of these infected tonsils lies in the fact that it is often through them. that the tubercle bacillus enters the system by way of the cervical lymph-glands. That is why cervical adenitis often cleared up after removal of the infected tonsils. Hence in operating for enlarged tubercular glands of

the neck it is advisable to operate also for enlarged tonsils but both operations must not be done at the same sitting. I made it a rule to remove any enlarged tonsils first say two or three days before the removal of the glands of the neck, otherwise the patient may not submit to the tonsils operation if the cervical glands are already removed.

Except in the case of a child, operation should be done preferably under local anaesthesia. The operation of tonsillotomy consisting in shaving off a slice of the infected tonsil should be condemned. The ideal operation is enucleation as it eliminates the whole of the infected gland-tissue.

Tubercular Glands of the Neck.

Before arriving at the diagnosis, septic glands should be excluded by a close examination of the areas from which the glands drain.

When a patient presents himself with gross glandular enlargement of the neck, be on the guard for lympho-sarcoma as this is a comparatively common affection in South China. Hodgkin's Disease on the other hand is extremely rare, the cervical enlargement in this case usually associates with enlargements of glands in the axilla or groin. Rapidity of growth associated with pain and fixity of the growth is characteristic of malignancy.

Enlarged glands due to secondary syphilis are usually discrete and move under the skin freely, not unlike the feeling of bullets. Often-times palpation of the epitrochlear glands at the elbow confirms the diagnosis of syphilis.

Never incise or curette caseating glands for fear of mixed infection which might result in persisting sinuses.

Although treatment by Xrays, ultra-violet rays and the different injection method of treatment each has its advocates, I am convinced that the best method is radical excision of the glands en masse. Operation entails a great saving of time and does not exhaust the resources and patience of the client while it gives the best immediate and after results. When properly done it confers one of the best results of surgery. But unless one is thoroughly acquainted with the anatomy of the neck and is an experienced operator, one should not undertake the operation as it is a major one.

In order to prevent recurrence any enlarged tonsils should be removed before hand. Stiles had proved that 14% of the enlarged tonsils associated with enlarged tubercular glands of the neck have distinct evidence of tuberculous infection. After

removing these tonsils my experience has been, that at least 90% of the cases can be cured by one operation, that is to say without recurrence.

Piles and Fistula-in-Ano.

These extremely common affections often co-exist. After a thorough trial of each one of the methods of operation for piles I have found the ligation method to be the best as it ensures a smaller chance of recurrence.

While the operation for piles is comparatively simple, the operation for fistula is not so, for it requires certain fulfillments viz. firstly the whole of the fistula tract with its ramifications must be destroyed, secondly the surgeon must be able to dress the case personally until the wound is closed. It is not a simple operation as many thought and therefore it should not be performed in the office. In order to identify the fistulous tract and to show whether or where it communicates with the rectum I have employed the injection of a solution of methylene blue into the tract with the greatest success.

Treatment of Piles by Injection.

This method of treatment is eminently suitable for private practice as it could be done in the office and at the same time without interfering with the earning capacity of the patient. It is indicated in cases in which operation was contraindicated. There must however be no complications present. The injection is almost painless and haemorrhage is usually stopped by the first injection. It is particularly applicable in mild cases. The injection is usually made with a solution of Carbolic Acid at weekly intervals for 3 to 4 sittings.

Stone in the Bladder.

As most of the cases coming to us are late cases with a long standing infection of the bladder, sounding for stone should be conducted with the greatest gentleness, (Whenever possible take a radiograph picture of the stone). Litholapaxy is not advisable unless in expert hands. It is a tedious undertaking, involving as it does, dangerous manipulation in the dark. For the average stone, supra-pubic cystotomy is the operation of choice.

Early Diagnosis of Malignant Disease.

Lymphosarcoma of the neck is sufficiently common for us to be always on guard. The only hope of a cure is early operation by the method of block-dissection.

Whenever a middle age woman presents herself with a lump in the breast, consider it a case of cancer, until it is clearly proved to be otherwise. The chief points in favour of cancer

are its hardness, retraction of the nipple and adherence to the skin and the underlying pectoral fascia, associated perhaps with glandular involvements. In all doubtful cases give the patient the benefit of the doubt e. g. a radical operation.

When a woman complains of haemorrhage or foul discharge after menopause, be on the guard for malignant growth of the uterus, a thorough investigation is at once demanded.

In all patients over 40 years of age complaining of piles or dysentery such a case should be thoroughly examined and if necessary proctoscoped. It may be cancer of the anus or of the lower bowel.

Gastric cancer unfortunately is late in revealing symptoms and when diagnosed with certainty, it is usually beyond hope of surgical relief. But it is well to bear in mind that in all patients over the age of 40, with a persistent dyspepsia and progressive loss of weight, a most careful investigation should be made, including radiography and chemical analysis of the stomach contents.

The great misfortune to the cancer patient lies in the fact that the disease usually commences insidiously, without pain or alarming symptoms, so much so, that it is sometimes only discovered accidentally. It is therefore easily overlooked by both the patient and the attending physician and when diagnosed it is usually too far advanced for any chance of a surgical cure. The maxim is, be always on the alert for cancer.

Abdominal Emergencies.

In all cases of the acute abdomen endeavour to diagnose within the first few hours whenever possible. Let me sound an oft-repeated note of warning, that one should never give morphia or purgatives until the diagnosis is established because morphia will camoflage symptoms and may lead both the practitioner and patient to a false sense of security.

Moynihan is of opinion that every case of perforated appendix is traceable to the administration of a purgative; in other words when perforation occurs some one is responsible. In the case of a perforated bowel or obstructed bowel, purgation is disastrous.

Appendicitis.

From statistics published it seemed appendicitis is more prevalent in Hongkong than in any other part of China.

In a given case with the usual classical symptoms it is not difficult to diagnose but when the appendix is abnormally

situated such as in the pelvis, beneath the liver or retrocaecally, difficulties and mistakes will arise.

The inflamed retrocaecal appendix may simulate renal colic or acute pyelitis. In these cases blood cells or pus cells should be looked for in the centrifugalised urine.

With appendicitis occurring beneath the liver it should be distinguished from right-sided pleuropneumonia especially in children. Rales over the right lung base should be looked for as well as the reduction of the respiratory-pulse ratio. In the event of a mistaken diagnosis operation under general anaesthesia in the pneumonia case would be a great catastrophe. When the appendix is in this situation, acute cholecystitis should be excluded. Here a mistaken operation is immaterial, because both conditions require laparotomy.

Pelvic appendicitis is particularly puzzling to the diagnostician as the abdomen may be quite flaccid and the symptoms unalarming. Whenever doubt arises, insert a finger into the rectum or vagina in order to elicit pain or tenderness in the appendix region. In women, inflammation of the tubes is apt to be confused with it, in fact sometimes it is impossible to distinguish. Enquiry should be made as to any irregularity of menstruation and the presence of leucorrhoea, which are commonly associated with tubal affections. As it is best to operate on appendicitis as early as possible and the tubes as late as possible a mistaken operation here would not be in the best interest of the patient.

In the severer types of appendicitis, it is well to bear in mind that neither the temperature nor the leucocyte count could always be depended upon. The toxaemia is so overwhelming and sudden that there may be no vital reaction to the invasion.

All cases of appendicitis should be operated upon within 24 hours. Between 24 and 36 hours one should exercise the greatest discretion but after 36 hours of the onset I believe conservative treatment gives the better results, preferably by the Ochsner method of treatment, the appendix may then be tackled when the quiescent period is reached say in 8 to 10 weeks. Recent statistics from the London Hospital give the mortality following operation during the first 24 hours as 1.2% on the second day 3.9% and on the third day 8.7%.

Acute Perforation of Gastric or Duodenal Ulcer.

It is difficult for many to believe that a patient with a normal pulse and temperature can be the victim of a perforated ulcer. The history of previous indigestion, the continued board-

like rigidity of the abdomen together with the intense suffering should guide one to the diagnosis.

There is a danger of overlooking this condition when the patient is seen during the stage of reaction as the symptoms temporarily improve.

If operation is done within the first 24 hours 90% of the cases could be saved. After 24 hours the operative mortality is fully 50% our endeavour should be to operate within the first few hours.

Perforation in Typhoid Fever.

One third of the deaths from typhoid is due to perforation. The time of occurrence is usually between the 14th and the 21st. day.

The diagnosis depends on sudden pain followed by tenderness and rigidity of the abdomen. Early operation will save at least 20% of the cases.

Acute Intestinal Obstruction.

Of all the cases of acute intestinal obstruction, about 60% of the cases are due to strangulated hernia, consequently never overlook the hernial orifices in a suspecting case. The great dangers in this condition are meddling treatment and delay. The policy of wait and see is only waiting to see trouble. It is unnecessary to wait in order to demonstrate constipation. Here is a good rule:—in a given case where there is vomiting more than once, with great abdominal pain and the abdomen is flaccid and there is absolute constipation for 24 to 48 hours, assume the case to be intestinal obstruction—operate.

Laparotomy within the first and second day will save 75% of the cases whereas on the third day only about 35%. In fact there are few cases which surgery cannot remedy, if the diagnosis is made and acted upon within the first 12 hours.

The Density of Gall Stones.

KENELM H. DIGBY, M.B., B.S., F.R.C.S.

When I was an undergraduate it used to be said that if an examiner offered you a dried stone and it felt very light and floated in water it was a gall stone.

This is true as far as it goes, but all gall stones do not consist entirely of the specifically light substance cholesterin and after a time lime salts may be deposited and eventually the stone becomes much heavier than water. Even a light gall stone soaked in bile will sink in virtue of the contained bile, and even a gall stone heavier than water will, after it has first been dried, float to begin with in virtue of the contained air.

These stones (with the exception of B which was mislaid) are shown in the illustration, which was taken from an X-ray picture and shows the relative opacity to X-rays. That the depth of the shadow does not more closely correspond with the specific gravity is due largely to the different thicknesses of the stones through which the rays had to pass. In G the stone had broken and the two halves were X-rayed.

Professor Faid kindly determined the specific gravity of these nine gall stones with which I supplied him. Professor Faid writes:—"Apparently some of the specimens are very porous and to a certain extent soluble in distilled water. The results for these are, of course, somewhat uncertain but I took them immediately, i.e. I took weight in water as soon as there was a balance to avoid disintegration of the specimens."

The specific gravities are shown in the table. The wide variation is noteworthy, also the fact that three of the stones are heavier than water.

The specific gravity of human bile in the gall bladder is, to take a round figure, about 1030. The specific gravity of bile in the common bile duct is approximately 1010. We may thus conclude that the majority of gall stones float freely in bile; that is, in the gall bladder, they are displaced by gravity or float away from the cystic duct when the patient is lying down: and in the common bile duct float away from the ampulla when the patient is standing up. Perhaps this is why gall stones in either of these situations often produce no symptoms over considerable periods of time.

Increasing impregnation with calcium salts with the passage of time raises the specific gravity till the stones tend to engage in the narrow parts of the ducts and become impacted.

A

C

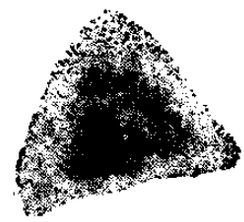
D

E

F

G

H



I

The view that the longer a stone remains in the biliary system the more dense it becomes is supported by a consideration of specimens E & F. These both came from the same patient who had five stones in an immensely dilated common bile duct. E (0.949) was the largest and lowest and F (0.898) was the smallest and highest.

TABLE

Ref.	Specific Gravity.	Remarks.
A.	1.841	Removed from gall bladder of a Chinese male aged 48 years who died from the effects of a crushed foot.
B.	1.498	
C.	1.079	One of 58 small stones removed with the gall bladder of a middle aged English woman, who had had symptoms for 10 years.
D.	0.996	Removed from the common bile duct of a man of 48. There had been a previous attack of pain and jaundice ten months ago.
E.	0.949	The lowest and highest of five gall stones removed from the greatly dilated common bile duct of an English woman aged 49 with symptoms extending over 10 years.
F.	0.898	
G.	0.848	One of four stones removed from the gall bladder of a middle aged English woman who had suffered from biliary colic with occasional transient jaundice for seven years.
H.	0.810	Same as D.
I.	0.693	This solitary stone was found after death in the common bile duct embedded in soft inspissated bile which filled the common bile duct and distended the gall bladder. The patient had pain in the right hypochondrium, jaundice and rigors. Clonorchis sinensis was present in the liver.

The Incidence of Appendicitis in Chinese.

R. M. GIBSON, M.D., C.M., F.R.C S.Ed.

The object of this paper is to introduce a discussion on the Incidence of Appendicitis among Chinese. While it is true, as has sometimes been stated, that Hongkong is not China, still in Hongkong there is a population of Chinese living under conditions similar to those which prevail in the larger cities of China. It therefore seemed that some facts of interest might be ascertained regarding appendicitis by examining the appendices in bodies at the Victoria Public Mortuary and by considering the records of cases of appendicitis treated in the Alice Memorial and Affiliated Hospital during the last thirty-seven years, (1887-1924).

Post Mortem Examinations.

815 bodies were examined and it is convenient to classify the results in two groups: Group A, 5 years of age and over, and Group B, under 5 years.

The average length of the appendix was 3.2 inches in Group A and 2.1 inches in Group B; the shortest was ½ inch and the longest 5 inches. There was a gradual increase in length up to the 30th. year when the average was 3.4 inches; then the average decreased. In infancy and after the 50th. year, the mucosa, submucosa. and muscular coats were thin and poorly developed but thick and well-developed between those periods. Whether the appendix has a function or not is a question which has been much debated; an organ which actually continues to grow and develop can scarcely be called a vestigial relic. Perhaps surgeons have been rather unfair to the appedix because of the evil wrought by the inflamed appendix and have forgotten Stevenson's words "There is something good in the worst of us."

While the evidence of the post-mortem examinations indicates that the appendix has some function, it must be left to the physiologist to decide what the funcion is.

The Caecum was measured in a few bodies and the average was found to be traverse measurement 2.14 inches and the vertical 1.05 inches.

The type of Caecum was noted in 77 of the earlier examinations and classified according to Treves:—

1. Infantile, (persistence of the foetal conical shape with appendix arising at apex of cone). 2.7 per cent.

2. Quadrate, (anterior longitudinal band dividing anterior aspect of caecum into two equal saccules), 13.5 per cent.

3. Third Type, (the lateral saccule has outgrown the the medial and the anterior longitudinal band lies more to the medial side), 83.8 per cent.

The Contents of the Appendix were recorded in 665; concretions were present in 15 per cent. of Group A and 1 per cent. in Group B. It would therefore appear that the conditions which determine the formation of concretions belong to the period of five years and over.

Faecal matter was found in 45.2 per cent. of bodies under five years and in 28.5 per cent. of these five years and over.

When the Caecum and Appendix were cut open it was noticed that in some instances the colour of the faecal matter was not the same in both and the commonest variations were:—

Appendix	*Caecum*
Yellow	Green
Brown	Yellow
Green	Yellow
Yellow	No faecal matter

Time did not permit investigation as to the causation of those differences in colour.

Position of Appendix		*Incidence of Appendicitis*
Splenic	84.0 per cent.	5.0 per cent.
Retrocaecal	12.5 „ „	42.0 „ „
Pelvic	3.2 „ „	11.5 „ „
Anterior } Ectopic }	.3 „ „	

Ectopic;—congenital—(transposition of viscera (1));
acquired—(hernia through foramen of Winslow, (1)).

Careful search failed to find the appendix in two instances of male adults of about forty years of age; in both there were perityphlitic adhesions.

Of 815 bodies examined 81 appendices showed evidence of recent or old inflammation and eight were affected with tubercular disease, secondary to abdominal tuberculosis.

The *incidence of appendicitis*, (exclusive of tuberculous appendicitis), was 17.3 in Group A and 7.4 per cent. in Group B. The following were the pathological conditions found:—

Appendicular Adhesions	46
„ „ with Atrophied Appendix	2
„ „ „ Inflamed Appendix	5
„ „ „ Kink	2
„ „ „ Cystic Appendix (Calculus in and adhesions round gall bladder)	1
„ „ „ Perityphlitis	1
„ „ „ Bulbous distal end	1
„ „ „ Chronic thickening of coats	1
„ „ „ Ulceration of mucosa	1
Appendix with Constricted Lumen	2
„ „ „ „ and Bulbous distal end	1
„ „ Stricture of Lumen	1
„ „ Bulbous distal end	2
„ „ Chronic thickening	1
Gangrenous Appendix with General Peritonitis	1
Perforated „ „ „ „	1
Appendicular Abscess	1
Acute Appendicitis	81
Tuberculous Appendicitis	8

The appendix is often congested in diseases such as beriberi, dysentery, and pneumonia, but those were not included in the above list unless there was other evidence of appendicitis present.

The date of onset of the inflammation which has caused chronic lesions cannot be determined at a post-mortem examination, but there seems to be a marked tendency for adhesions to form during the first year; then later from the twentieth to fortieth years adhesions with other acute or chronic pathological changes are met with.

Before leaving this part of the subject, there are a few points of interest which may be mentioned as they have a bearing on the clinical aspect of appendicitis; some remarks are added on other surgical conditions met with in the post-mortem examinations.

I. Children (Group B).

In the case of an infant 33 days old the appendix was fixed by adhesons to the posterior abdominal wall and a small perforation of the appendix was found.

An infant of 2 months had the distal end of the appendix enlarged and adherent to the small intestine.

An appendicular abscess with the appendix, caecum, and small intestine bound together by adhesions was found in a child of 9 months.

In some instances the mesoappendix was very short or absent; in three the appendix was retroperitoneal; in one child of 2 years the appendix was of 4 in. in length.

If appedicitis occurred, diagnosis would be difficult in the following conditions:—

Tip of appendix in middle line, (2); to left of middle line, (1).

Appendix retrocaecal, tip reaching the inferior surface of liver, (3).

Other conditions of interest were:—

Right kidney; abnormally small, (1); situated very low down, (1).

Spleen; rupture in newborn infant.

Gall-bladder; extensive peritoneal adhesions complicating tabes mesenterica.

Jaundice; round worm found on cutting common bile duct.

Intestinal obstruction; tuberculosis (1), hernia through foramen of Winslow (1).

Transposition of viscera (1).

Congenital absence of left tibia (1).

2. Group A.

Difficulty in finding the appendix was experienced when the appendix was only one inch long, lying embedded in fat in the posterior abdominal wall; in another instance the appendix was ¾ inch, the distal part having sloughed away. In two no appendix could be found.

If it is difficult at a post-mortem to find an appendix, there are occasion when a prolonged search during an operation on an exhausted patient would be inadvisable.

Other conditions.

Spleen: ruptured in a boy 14 years, result of a fall from a height of 14 ft.

Spleen: displaced downwards, enlarged, adherent to bladder, large and small intestines, and pancreas. (In hospital two cases of displaced spleen have been met with).

Liver: deep tear 6 in. long on anterior surface; abdominal cavity full of blood. History of having been struck on abdomen by bag of rice three or four days

Gall-bladder: atrophied (1); greatly thickened wall (1); calculus and adhesions (round gall bladder). wall (I); calculus and adhesions (round gall bladder). and appendicitis also present (1).

Ovary: early cystic, in 3 bodies.

Hospital Records.

There were 93 cases of appendicitis admitted to the Alice Memorial and Affiliated Hospitals from 1887, (when the Alice Memorial Hospital was opened), to 1924. The first case treated was in 1896 and the next in 1904; from 1907 onwards a few cases were treated each year; there were nine cases in 1922 and the same number in 1923.

Sex Distribution.

Of the 93 cases 45 were men and 48 women.

Age Distribution.

Age		(*years*)	*Cases*	*Per Cent.*
6	to	10	10	10.8
10	,,	20	23	
20	,,	30	19	69.8
30	,,	40	23	
40	,,	50	14	19.4
50	,,	69	4	

History.

It is difficult to obtain an accurate history from Chinese patients but a few facts are noted. The relationship of injury to appendicitis has been discussed in medical journals; one patient attributed his illness to a fall on the floor four days before admission; abdominal pain began on the day after the fall; acute appendicitis and general peritonitis developed and proved fatal. Another had been struck on the abdomen by an iron rod two years previously; he had acute appendicitis and recovered. Two of the cases were boatwomen, who were subject to considerable strain of the abdominal muscles when rowing.

Predisposition to appendicitis of a severe type was noted in several members of a Chinese family; all died. The histories also illustrate how indiscretion in diet seems to be a predisposing cause of appendicitis.

1. Chinese gentleman A; age 60 years; general health, good; acute appendicitis developed after eating crabs to excess; refused operation in early stage; operated on too late to save him.

2. Daughter of A; 34 years of age; depressed after the death of her father; died from acute appendicitis after operation.

3. Son of A; age 43; had repeated attacks of acute abdominal pain. He died on second day of the last attack; not operated on.

4. Son of A; 43 years of age, had severe attacks of abdominal pain after eating shrimps and died; not operated on.

5. Grand-daughter of A, age 10 years; after eating peanuts, symptoms of acute appendicitis set in. Operation at first refused, but permission given too late for successful operation. (cases 3 and 4 resided in Canton and notes were sent by a friend).

Duration of Illness.

While the notes do not give a history of previous attacks, the conditions found at operation showed that some had suffered from previous attacks. In 19 cases, the duration of symptoms was stated:—

Duration	*Cases*
2 days	3
3 „	2
4 „	3
5 „	2
6 „	3
7 to 14 „	3
Over 14 „	3

At present among the Chinese, operation is often looked on as the last resort and consequently many cases are brought when the most favourable time for operation has passed.

The Season of the year was noted and cases were most frequent in September and March; May and July came next in frequency. In September, crabs, shrimps, and oysters are possible predisposing causes, while chills are common after the long tiring Summer. Colds and childs are frequent in March.

Classification and Treatment

TYPE	Operation Cases	Recovered	Complications	Died	Complications
Acute Appendicitis ..	28	21	Pyosalpinx (1)	7	Typhoid (1)
			Ectopic Gestation (1)		Suppurative Cystitis (1)
Acute Appendicitis with General Peritonitis	6	—	—	6	Parovarian Cyst (1)
Appendicular Abscess	26	16	—	10	Opium smoker (1)
Appendicular Gangrene	6	4	—	2	—
Appendix eroded or perforated	3	2	—	1	Tetanus Wound of hand before admission
Chronic Appendicitis...	3	3	—	—	—
Chronic Appendicular Abscess	1	—	—	1	Phthisis
	73	46		27	

Summary of Treatment

TYPE	Cases	Recovered	Died	Left Hospital Untreated
Operation	73	46	27	—
Expectant Treatment ...	12	12	—	—
Refused Treatment... ...	7	—	—	7
Moribund on admission...	1	—	1	—
	93	58	28	7

It will be seen from the table of operations that many cases were complicated either by conditions resulting from appendicitis:—general peritonitis, 6; abscess, acute 26, chronic, 1; gangrene, erosion or perforation, 9; or by other diseases—pyosalpinx, suppurative cholecystitis, typhoid, ectopic gestation, phthisis, tetanus.

In the post-mortem examinations, the chronic lesions were more common, indicating that acute attacks had been present but death results from other diseases in most instances. The cases treated by the expectant method were of the subacute type and though operation would be advised, it was not insisted upon; those who left the hospital were probably afraid that operation might be carried out against their wishes.

Two cases of appendicitis not included in the above list are of interest and are referred to with Professor Digby's permission. They occurred in the Surgical Clinic of the Hongkong University when Dr. Gibson was acting in 1923. One was acute appendicitis complicating large retroperitonal lipoma and the other was miscarriage at third month of pregnancy with acute appendicitis; both were successfully operated on.

Diagnosis.

It would be out of place to discuss fully the diagnosis of appendicitis but reference may be made to experience gained in hospitals where Chinese are treated.

Acute Salpingitis. If the right fallopian tube is chiefly affected acute salpingitis closely resembles appendicitis and cases have been sent in with diagnosis of appendicitis, which after careful examination proved to be acute salpingitis. The differential diagnosis is important as it is seldom necessary to operate in the acute stage of salpingitis; vaginal douching, hot compresses to abdomen and salicylate of soda have proved useful.

Ectopic Gestation. If the history is unsatisfactory regarding the possibility of pregnancy, diagnosis may be difficult when the gestation is on the right side. One such case occurred. When the appendix is situated in the splenic or retrocaecal position, the signs of appendicitis are distinct from those of salpingiis but appendix in the pelvic position will be nearer to the tube and if inflamed accurate diagnosis may be uncertain.

Uterine Pregnancy at third month complicated with appendicitis. The symptoms of appendicitis in this case were definite and the uterus enlarged; the cervix was slightly dilated and there had been a small haemorrhage before admission but no history of any ovum having been passed; the pain was most marked towards the left side. The appendix was removed,

adhesions being found, but the uterus was not explored so that pregnancy might not be disturbed. The patient's condition improved but pain to left of middle line continued, and appeared to be connected with the uterus. It was found that miscarriage had taken place before admission and part of the membranes had been left. The pain cleared up and recovery followed the removal of retained membranes.

Retrocaecal appendix. The signs are slightly different from those caused by inflamed appendix in splenic position; tenderness and pain being more lateral and at a higher point.

Cholecystitis with gallstones associated with appendicitis. One case was met with in a male age 20 years and one instance was seen at the mortuary. An interesting paper by Braithwaite (Brit. Jour. of Surg. July 1923) describes experiments on flow of lymph from the ileocaecal angle to the region of the pylorus and the common bile duct with regard to causation of duodenal and gastric ulcers. The writer remarks that B. coli infection of gall bladder may possibly be caused by infected lymph from a diseased appendix.

Ileocaecal Tuberculosis is comparatively common and gives symptoms like chronic appendicitis.

Dysentery, Typhoid and Colitis may suggest appendicitis or appendicitis may occur as a complication of those diseases.

Opium is often given in China for abdominal pain and makes the diagnosis more difficult and causes serious delay; after taking opium the patient feels better and seeks to avoid operation. The physical signs found are the most reliable guides to diagnosis.

It is not often that a doctor has the opportunity of personally noting the early symptoms of appendicitis which are described in text books and the cases of two Europeans may be mentioned.

(1) The gentleman was apparently well on the evenng preceding the attack. Severe abdominal pain began in the early morning. He was seen at 10 a.m. when there was acute pain above the umbilicus but no tenderness in right iliac region nor other signs indicating that the appendix was implicated. Arrangements were made for his own doctor to visit him with a view to removal to hospital. Patient was kept at rest and no opium was given. At 2 p.m. another examination was made when definite tenderness was found in right iliac region, pain was very acute there, and the pulse rate was 60. Immediate removal to hospital was arranged for and operation was performed at

5.30 p.m. The appendix was full of faecal matter, acutely inflamed and at one point was near perforation. No adhesions were present and patient made a good recovery.

(2) Another similar case was seen at very early stage and operation within 24 hours saved the patient.

Prognosis.

Reference to duration of illness and the stage at which the disease had reached before Chinese patients sought treatment, (Abscess 27, Gangrene 6, Gen. Peritonitis 6, and the complications mentioned) shows that the prognosis cannot at present be favourable, but as the number of doctors practising Western medicine in China increases, cases of appendicitis will be diagnosed at an early stage and the prognosis will improve.

Acute appendicitis must be included in the case of urgent surgical conditions for which operation gives the chance, and should be advised in every case.

Operative Treatment:—

There are special difficulties which face the surgeons in China. Cases are seen much later than in the Home hospitals, they are often under the influence of Chinese medicines which render diagnosis difficult, the general health is poor through lack of proper nourishment, and toxaemia has often begun. Experience teaches that operation done in the shortest possible time compatible with the condition present is the best treatment.

In dealing with acute surgical abdominal diseases, it is advisable after an examination has shown that operation is necessary, to allow the patient a few hours' rest after the fatigue of travelling. A further examination should be made immediately before operation as a full history is not always given at first and it may be possible to make an exact diagnosis which will shorten the duration of the operation. (Cases of Ectopic Gestation often require immediate operation). In abscess of the appendix when the general condition is bad, opening and draining the abscess may tide the patient over the critical period and if necessary a second operation may be done later. A prolonged search for the appendix is not wise if tōxaemia is present.

Ether by the open method is the best anaesthetic and in the climate of Hongkong, bronchial troubles rarely follow. But severe shock may occur even under ether and should be anticipated by injection of pituitrin. Subcutaneous saline is often of use and may be given by the nurse while operation is being carried on.

While ether is being administered, the heart is stimulated and if the anaesthetist judges by the pulse alone he may be deceived as to the general condition of the patient. The patient should be carefully watched during the first few hours after operation as there is a marked tendency in serious cases for shock to supervene when the stimulating effects of ether have passed off. If this fact is kept in mind, means will be taken to prevent the shock which will be more efficacious than waiting to treat shock when it has developed.

The abdominal incision used will vary according to the condition present. Drainage is often necessary; in retrocaecal appendix drainage by tube in loin is satisfactory.

After-treatment is similar to that for other abdominal operations; when toxaemia is present aspirin may be used instead of morphia for relief of pain; an injection of pituitrin relieves discomfort caused by flatus. Vomiting is sometimes due to worms.

In the light of the facts obtained at post-mortem examinations and from hospital records can any deduction be made regarding the incidence of appendicitis in Chinese?

Only a comparatively few cases of appendicitis are treated in the various hospitals in Hongkong and these are the severer types, but in the mortuary 17 per cent., (of 5 years and over), showed signs of appendicitis, mostly of subacute or chronic types. It must be remembered that only a comparatively small proportion of the total population comes to the hospital for advice and not all of them are willing to enter hospital for operation.

If a deduction may be drawn, it might be stated that appendicitis is not a rare disease among Chinese in South China, but that relatively few go on to suppuration or gangrene and the following reasons are suggested: —

1. There is a heavy infantile mortality and only strong children survive the common diseases, (tuberculosis, pneumonia, malaria, gastro-enteritis, etc.); the fittest survive and resistance to infective diseases is greater.

2. The great care bestowed on the teeth is probably a factor in preventing severe intestinal bacterial infection. Gastric catarrh is common but gastric ulcer is comparatively rare. In the post-morten room no instance was seen in the examinations made, but a few cases have been met with in hospital.

3. The diet is chiefly vegetarian; the poor cannot afford beef and others are vegetarians on religious grounds. A vegetarian diet is more conducive to a healthy alimentary canal than a diet rich in proteids. But over indulgence in shrimps, crabs. etc., seems to be a predisposing cause which in Chinese produces the worst type of appendicitis.

Conclusions:—

1. The milder types of appendicitis are common amongst Chinese but the majority of these do not come to hospital for treatment.

2. Relatively few cases of the suppurative or gangrenous types occur but in the large cities most of these are brought to hospital.

My best thanks are due to Professor Digby for consent and help in the preparation of this paper; to Dr. Minett and Dr. Pope for their great kindness in giving every facility for the examination of bodies at the Victoria Mortuary and to Dr. Mitchell for permission to use the records of the Alice Memorial and Affiliated Hospitals.

Caesarean Section Under Local Anaesthetic.

D. K. PILLAI, M.B., B.S., L.M.

It gives me great pleasure to be back again at the University after my recent post graduate work in London, Dublin, Vienna and Switzerland. My original intention was to read a paper on my work abroad, especially in relation to Obstetrics and Gynaecology, but the Secretary of the Medical Society, then Mr. Bau, asked me if possible to read a scientific paper; and I chose to speak on Caesarean Section under Local Anaesthetic. As Junior Assistant at the Frauen Klinik, Zurich, I had to do all the Local Anaesthetic in both the Gynaecological and Obstetrical Departments and this paper is based on over 150 cases done under local anaesthetic with no mortality.

In modern Obstetrics, the question of the method of Caesarean Section is still under discussion.

Reference to the medical literature gives us conflicting views and varied results, but so far no ideal anaesthetic nor the best method of Caesarean Section has been agreed upon.

The first step in the improvement is the replacement of the motor area incision for the lower uterine segment; further to have the best results possible caesarean section is done under Local Anaesthetic.

Studying in the various clinics of Europe one cannot help noticing the anaesthetic mortality in all types of surgical operations and caesarean section with which we are most concerned to-day.

Reporting on deaths under general anaesthetic for caesarean section; Barsch had 2 deaths—one from post-operative pneumonia, Walthard had 3 deaths in 205 abdominal transperitioneal cervical caesarean section in the Frankfurt and Zurich Kliniks, one case due to aspiration pneumonia and two in general anaesthetic. Labhardt of Basle had 4 deaths in a series of 25 cases of caesarean section for placenta praevia—one death from aspiration pneumonia and lung abscess. Martins from Bonner Klinik had 136 caesarean sections, with 10 deaths, a mortality of 7.3%. Of the 10 deaths, one died under the anaesthetic during the operation and another from aspiration pneumonia. His statistics shows a mortality of 20% of the total cause of death due to general anaesthetic. Heinmann had 5 cases with one death from post-operative pneumonia; the section being done as a prophylaxis to terminate pregnancy for a cervical myoma.

When one meets an obstetric case in labour with contraction and disproportion between the head and the pelvis, the question comes up whether pelvic enlargement or caesarean section would be the best treatment. For any contraction below 6 cm., caesarean section is an absolute indication. The new treatment of caesarean section under local anaesthetic will probably help one to decide the above query.

While at the Coombe Hospital, Dublin, I saw a case of pelvic enlargement for slight degree of pelvic contraction, the urethra was damaged, the patient developed incontinence and died later of urinary trouble.

Studying the above statistics from the different clinics in Europe the mother mortality due to general anaesthetic accounts for a fair proportion of the deaths from caesarean section. General anaesthesia is also not too safe for the Caesarean Child, so Labhardt mentions; he had a caesarean section child die of asphyxia from general anaesthetic. Heinz Kustner experimentally found on animals that the delivery of the young by section without general anaesthetic was always a success, the young being born quite fresh and respiration quite normal; on the other hand operating under general anaesthetic, the newly born was always inactive and of a blue colour and poor cutaneous reaction. This experiemental work is fully in accordance with our observation on human subjects, the child is nearly always extracted fresh.

In classical caesarean section (i.e. incision on the fundus) which only takes a short time to extract the child, asphyxia or apnoea is not so marked on the caesarean child.

The fundal section is quite simple to one who has handled the knife but the results of such operations have not been very satisfactory as shown by cases on the Continent.

The cervical caesaran section is a painstaking, more difficult operation than the fundal classical section. With the ideal Local Anaesthetic of ½% novocain one is able to take time over the operation. The operation itself requires many new instruments; an obstetric forceps for the extraction of the head, special caesarean clamps and bayonet retractors held by strong assistants, hook retractors, etc.

The first assistant should thoroughly understand the surgeon and be a first rate mopper, the bleeding though not excessive, floods the incision area and there is danger of incising the face of the child.

Incision.

1.—Skin is incised transversely 2" above symphysis pubes and 4½" long.

2.—Anterior rectus sheath is incised transversely, the muscles retracted and the peritoneum incised longitudinally.

3.—The movable peritoneum over the lower uterine segment is incised transversely and held down by retractors.

4.—The lower uterine segment is incised longitudinally 4", a bayonet speculum holding the bladder well back and the head is extracted with forceps. As soon as the child is taken out 2 c.c. of Ernutin and 1 c.c. of Pituitrin is injected intramuscularly. The placenta is allowed to separate by itself. The bleeding is not severe as the lower uterine segment is not so vascular as the motor area. The area of muscle to be sewn is not so thick. The whole area of the operation is covered over with peritoneum; as many as three caesarean sections have been done on the same patient without adhesions resulting from previous operations.

During the ten months of my assistantship at the Frauen Klinik, I helped in forty caesarean sections with no anaesthetic mortality. At this point it would be interesting to mention the indications for caesarean sections adopted in this Klinik:

1.—Various degrees of contracted pelvis.
2.—Blood in urine (drawn with soft rubber catheter) when os not dilated with oedema of cervix.
3.—Oedema of cervix.
4.—Prolapse of cord.
5.—Placenta Praevia.
6.—Disproportion between head and pelvis after a trial labour.
7.—Accidental haemorrhage.
8.—Eclampsia.
9.—Transverse lie of child due to previous ventrofixation of uterus in elderly primipara.
10.—Pernicious vomitting.
11.—Mitral stenosis and aortic regurgitation.

Lumbar Anaesthesia for Caesarean Section.

In the Tubinger Klinik most of the caesarean sections are done under lumbar anaesthesia. Vogt had seven failures in his

series of 139 cases under lumbar anaesthesia; 3 cases failed completely to relieve pain. In 4 cases the reason for the failure of the anaesthesia was due to curvature of the spine. He had in 139 cases, 1 death due to the reactionary combination between the local anaesthetic and morphia scopolomine. Baum noticed in 40 caesarean sections with lumbar anaesthesia the sinking of 8 foetal heart rates and 2 foetal deaths; he ascribed the cause of death to lumbar anaesthesia. Taking into account all the cases of caesarean sections done under lumbar anaesthesia, one is led to conclude that it is by no means an ideal anaesthetic to replace general anaesthetic.

Local Anaesthetic.

With local infiltration of ½% novocain, Herroberarzt E. B. Fry made the first experiment of caesarean section under local anaesthetic. Traugott writes of 12 cases of caesarean section under local anaesthetic and had only three cases of complete anaesthesia. In 7 of his cases ethyl chloride had to be supplemented and in 2 cases general anaesthesia had to be given during the second half of the operation. Giesecke of Kiel reported 11 cases and in one of the cases the anaesthesia was so complete that the operation could not have been better done even under general anaesthetic.

In the Zurich Frauen Klinik the method of local anaesthesia has been further improved and since 1920 all cases of caesarean section under local anaesthetic has been completely successful; (except for eclampsia where a general anaesthetic is always given.)

For the first time a big series of caesarean section has been carried out under local anaesthetic with exceedingly good results.

The Technique of Local Infiltration Anaesthesia with ½% Novocain.

The processes for preparation of abdomen for local infiltration are as follows:

The abdominal wall is washed with soap and water, alcohol-ether and solution of Bin iodide in spirit 1/500.

With a 20 c.c. syringe filled with ½ c.c. novocain adrenalin solution and a 6" long flexible needle infiltrate the incision area. The first prick infiltrates just the cutis and produces a blotch; and going deeper into the subcutis you inject as you push the point of your needle deeper. Storacker states that he has given 14 cases of local anaesthetic in this manner of infiltrating the skin without causing any pain. Having infiltrated the skin you carry on and infiltrate the subcutaneous tissues. Then follow

the infiltrations of the sub-fascial tissues, e.g. the rectus muscle, the preperitoneal fat and the peritoneum systematically. For women with fat and lax abdominal wall, it will be easier to inject if the patient holds her head up or raised on a pillow. In this way one will be able to appreciate if the point of the needle is over or under the rectus sheath. It is necessary to infiltrate under the rectus sheath which is really the chief point in the success of a good anaesthetic. There is no danger whatsoever in injecting any part of the solution into the peritoneal cavity. When one does the local anaesthetic for the first time he is rather afraid to go deep enough with the result that a poor effect is obtaned. On the other hand one should not be too vigorous with the point of the needle as one is liable to injure the bladder, femoral artery and vein, (and I have punctured the inferior epigastric artery once, but except for a haematoma nothing special resulted.) Vackes and Weinverg state that they have not seen any injury done to the intestine and that this accident is still more unlikely when the pregnant uterus fills the abdominal cavity. To prevent this accident one should raise the pelvis a little and get the intestine up to the diaphragm. In a few cases, while giving local anaesthesia, the uterine wall has been punctured and infiltrated and in these cases I found no opening the abdomen a few drops of blood in the vesico-uterine pouch. An injury to the bladder I have not seen and there is absolutely no danger if one catheterises the patient just before the local infiltration. The absorption of the local anaesthetic from the peritoneal cavity is likewise without danger to the patient as reported by Baruch in his 21 cases. The local anaesthesia is a direct local infiltration of the tissues and nerves and is not nerve blocking as advocated by Braun. Our method of infiltration is much more commendable than nerve blocking, and the anaesthesia is complete for two or two and a half hours without the patient feeling the least bit of pain, the novocaine adrenalin concentration being the same throughout the anaesthesia. According to Braun the patient feels the pain when manipulating with the parietal peritoneum. When one does the local anaesthesia described above i.e. retro and intra peritoneal infiltration one is able to succeed with certainty of complete anaesthesia of the abdominal wall and peritoneum.

The serosa of the bladder wall, the peritoneum, the surface peritoneum of the uterus, the ovaries and the tubes are not sensitive to the thermocautery, and we have not observed in any case sensitiveness to the knife or scissors. Braun states the sensitiveness of the serosa as very variable. According to our experience on the whole we find the entire visceral serosa absolutely painless against touching and injury with sharp instruments, so long as you do not damage and lacerate the tissues. During the extraction of the child the patient seldom

complains of any pain, and in suturing the uterus, the patient seldom complains of the operation or is able to localise any painful spot. One patient compared the pain to the cramp during menses. As regards the anaesthesia we add to the ½% novocain solution, 2 to 4 minims of 1/1000 adrenalin hydrochloride to every 100 c.c. of the solution and it usually requires 300 to 500 c.c. for a good anaesthesia. As much as 800 c.c. have been injected without any bad effects following. As regards the danger of novocain Braun mentions 3 deaths in 144 cases due to local anaesthesia. Looking up the reports one cannot help noticing that no post mortem examinations were done and to report that the cause of death as due to local anaesthetic is unjustifiable—it might have been an error in technique or intercurrent condition. No operative disadvantage is attributed to by Brütt in 17 of his cases under local anaesthesia. Brütt reports one death in his series, 1 case in particular being stromectomy on an imbecile. He injected 140 c.c. of ½% novocain and at the end of the local anaesthesia the patient suddenly collapsed and died. Brütt attributes the accident to a direct infection into the vein by the novocain anaesthetic. It is possible that a wrong solution might have been used. The post mortem examination gave no direct explanation of the cause of death. Brütts is of opinion that the cause was a functional undetected condition of the heart, that the novocain made worse the condition of the heart and death of the patient. This view of Brütt I am inclined to agree and wish to enlarge from observation made by the Ober Arzt at the Frauen Klinik.

The following is a short history of a case I wish to describe. Frl. 27, pregnant 3rd to the 4th month. Diagnosed by the Professsor of Medicine, Zurich, as light compensated Mitral Stenosis, and suggested termination of pregnancy. Patient stated that she had dyspnoea for a year.

At the beginning of the local anaesthetic patient began coughing and restless; when a total of 400 c.c. of ½% novocain had been injected the patient was not able to lie flat, and developed a fit of coughing, dyspnoea, cyanosis of the lips, forced respiration acceleration of the heart beat and the pulse scarcely felt at the wrist. Her state grew worse and a severe oedema of the lungs and tracheal râles developed. The Professor of Medicine who was called into consultation agreed to our diagnosis of acute heart insufficiency with lung oedema and insisted on our postponing the operation. After stimulation with Digitalin, Camphor and Caffeine and a venesection the patient improved by degrees, and in two hours the patient could be placed flat on the bed without dyspnoea or tachycardia. In this exceptional case we do not attribute the cause to novocain, because in the preparation of the patient we gave morphia 0.01 gram one hour before

and 0.01 gram half hour before operation. This assumption is probable, the patient had heart affection and shortly after the morphia injection, affected the heart, causing irregularity of the heart beat, made worse by the novocain.

It is interesting for us to find out whether morphia or novocain or the combination that has caused the above symptoms and this being the first case in our experience we are not in a position to give a definite explanation. Professor Cloetta of Zurich was asked in discussion regarding the case and he stated that he made the same combination, morphia and novocain at the Sauerbruchschen Klinik and had observed two cases of severe collapse. Cloetta stated that morphia and novocain react unfavourably in the body and produce toxins and to give morphia as an analgesic before novocain anaesthesia for preparation is not only unsuitable but dangerous. After 10 days of observation and stimulation with digitalis and camphor and prepared before operation with a preliminary somnifane injection, 300 c.c. of ½% novocain was injected and the operation of uterotomy and tubal sterlisation was carried out successfully. Blood pressure during the operation was 115 and after the operation 116; pulse 80 to 85; respiration 16 to 18 before and after operation. This proved clearly that the accident that happened was in no way due to novocain, but the incompatibility between novocain and morphia was the cause of the unpleasant incident.

It showed therefore that the case of Brütts was not due to heart insufficiency and novocain, but due to the reactionary combination between morphia scopolamine and novocain, and based on this finding a human experiment was done. A great quantity of novocain was injected into a patient with heart lesion and no bad effect resulted. From then on, all cases in the Klinik with heart affection, had only novocain without any preliminary preparation with morphia. Braun in his 112 cases did not inject more than 250 c.c. of ½% novocain and noted that any increase produces an intoxication, but we have reason to state that in our experience as much as 500 c.c. to 800 c.c. ½% novocain can be injected without any dangerous effects so long as morphia is not used in the preparation of the patient.

When you combine novocain ½% with adrenalin in the proportion of 2 to 4 minims to 100 c.c. of solution, you have a perfect anaesthesia lasting 2 to 2½ hours. Knowing the duration of the anaesthesia you have a safe anaesthetic with which you can carry out your operation step by step without hurrying; and the closing of the abdominal parietal wall can be carried out without the patient straining. It is also possible with local anaesthetic to do the operation without tearing or damaging the tissues. Further it is possible after the extraction

of the child to wait for the spontaneous separation of the placenta and the stitching of the lower uterine segment can be carried out without much bleeding. General anaesthetic in very special cases of abdominal caesarean section is safe for the mother and child and yet we must refuse to accept any anaesthetic mortality. In spite of our having at our disposal an ideal local anaesthetic, and want a general anaesthetic.

In concluson the chief points are as follows:—

1.—Lumbar Anaesthesia is not successful in all cases.

2.—Nerve blocking has variable results.

3.—All cases with heart affections should not have a preliminary injection of morphia.

4.—In caesarean section, the lower uterine segment not the motor area, is incised, and a pair of obstetric foreceps is necessary for the delivery of the head.

5.—300 to 350 c.c. of ½% solution of novocain (with 2 to 4 minims of adrenalin hydrochloride 1/1600 in 100 c.c. solution) is an ideal local anaesthetic, lasting 2½ hours with no anaesthetic mortality. I am indebted to Herroberarzt Eugene B. Fry of the Frauen Klinik, Zurich, for statistics mentioned in my papers.

Editorial.

The Caduceus has again passed through another year of its existence and during that time there is much to rejoice over, but there is also much to fill our hearts with regrets.

The Caduceus.

In the issue for 1924, the then Editor concluded his article with these words:—

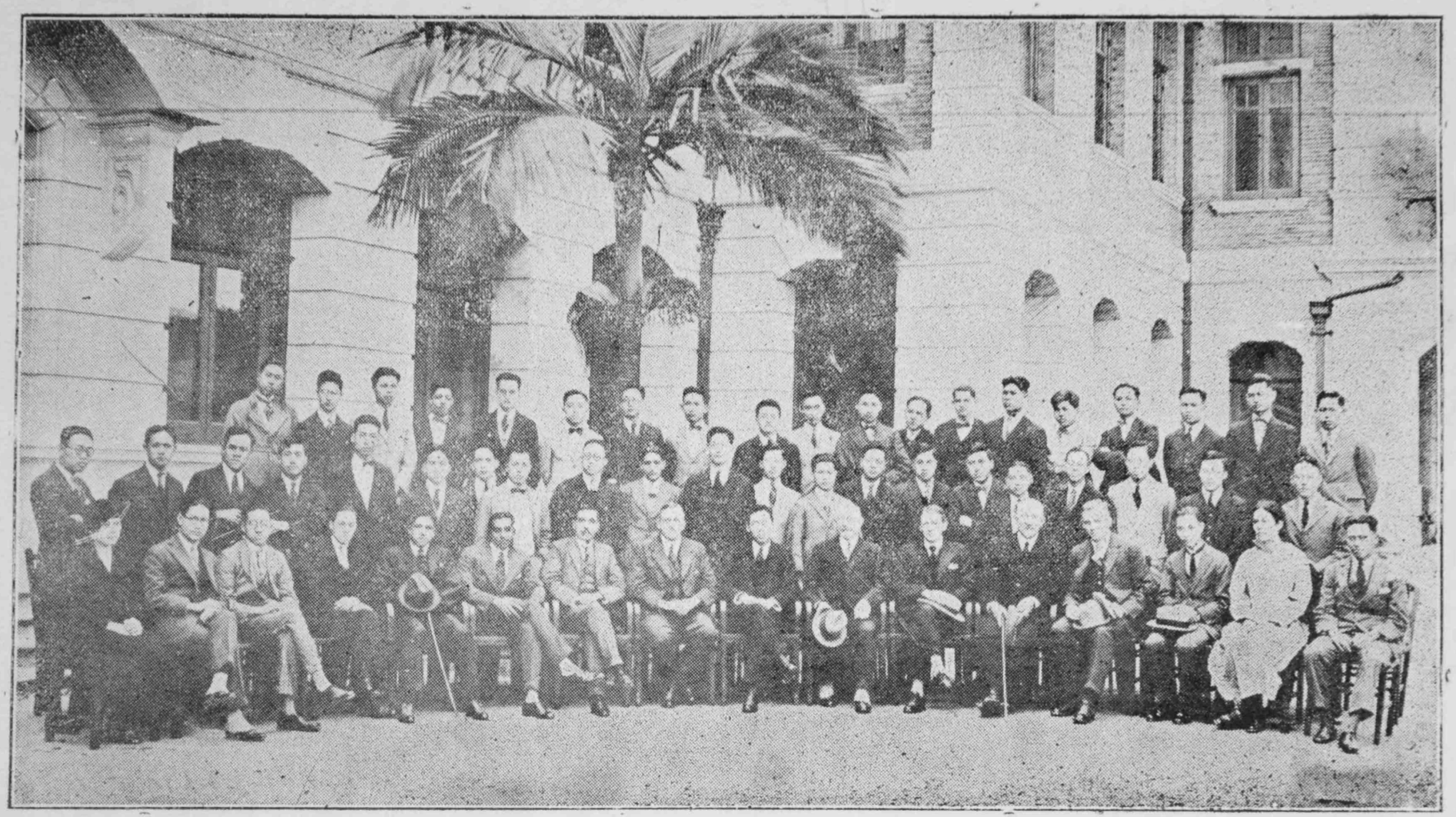
> "The future of the Caduceus is not as simple as one would like it to be. A time may soon come when we may be asked to hand our cherished work to some other organisation—what then?"

To-day we are no nearer to the solution. Some people would like to see our Journal handed over to the management of some other associations; others again would like to see it alter its present form and either rise to the dignity of a purely scientific journal or degenerate into a mere students' Rag Magazine. All these views have their supporters, but it seems to us no other than the existing form of the Caduceus can ever meet with our needs.

The Journal furnishes a medium for the publication of work carried on by the various departments of the University; it encourages our graduates and other members to the habit of careful thought and recording of their observations; it tells the sister universities of the world that we live and labour and daily aspire to the great things of life that count; it gives information regarding the mode of life, habit of thought and news of the University.

But what in our opinion is more than all these, is the fact that it forms a bond of union linking together our graduates in all parts of the world. It is inconceivable that men and women who have worked together within the sacred precincts of the University, who have met each other in lecture rooms or in the open fields for five long years or more, can ever be entirely devoid of that gentler sentiment called affection for their alma mater or for their companions of past years. If such persons there be, in whom the thought of the University or of their former companions can awaken no softer feelings, then they must really be in the language of Shakespeare, fit creatures for "treasons, stratagems and spoils," and their "affections must be dark as Erebus."

Only four years have passed since the Caduceus first saw the light of day and though we have reason to be proud of our



THE VISIT OF SIR ARTHUR W. MAYO ROBSON, K.B.E., C.B., C.V.O., D.SC., F.R.C.S. TO THE UNIVERSITY.
THIS PHOTOGRAPH WAS TAKEN AFTER SIR ARTHUR'S ADDRESS TO THE MEDICAL SOCIETY.
FEBRUARY, 1926.

achievements so far, yet we cannot help feeling alarmed at hearing the ominous murmurs of those who would like to see it change. It is characteristic of the restless spirit of this age to long for alterations and destruction. We confess to the charge of being conservative and even old fashioned in being slow to changes, but it seems to us in no other age as the present is it so important to appreciate the truth of Rousseau's remarks—not necessarily for the present discussion, but also on our outlook on life in general—that "Pigmies may pull down but it requires great men to build up."

This Journal was built up by the unceasing efforts of many committees; it embodies the labour of love of its founders and many past Hon. Secretaries and Chairmen; it is the product of the sweat of many an editorial brow. We feel the sacredness of the trust thus committed to our keeping and come what may, we shall defend the journal with the last drop of our editorial ink.

The Hongkong University Medical Society.

Through the untiring zeal of Professor Digby and Dr. G. H. Thomas, the University Medical Society was founded twelve years ago. The membership then was not large but what was lacking in numbers was amply made up for in zeal. There were fortnightly meetings which were held in the Anatomy School. For ten years the Society existed without an organ for its articulation, and then in 1922, the Caduceus was born. From that humble beginning the Society has grown to its present size, with a widely circulating journal and a membership in many parts of the world.

Encouraging though the results have been yet we feel they could be bettered, if the aims of the Society are more clearly and widely understood by members and their friends.

The Society knows neither race nor creed; we recognise no party interests nor politics, our principal aims being social, scientific and educational.

As a social factor in university life, it is intended to be the common ground where undergraduates, graduates and their friends can meet for a quiet chat over a cup of tea. The advantage of thus bringing the Past and the Present together is immense and we need not dilate on it here.

In this connection, we would like to remind our members and friends of the Annual Reunion Dinner held under the auspices of the Society, which will be announced later; we trust every one will make an effort to attend this great function of the Society.

Following on the practice of the Society in the past, we hold fortnightly meetings at which a member or a friend presents a paper on any scientific subject of medical interest. By thus fostering the student's interests on things scientific, and encouraging them to think on and discuss these things, the society is adopting the right method in moulding their thoughts and directing them into the proper channels. One cannot overestimate the importance of such meetings where experiences are shared and views exchanged. Personally, we have always felt that the memories of such meetings have made our love for the University richer and fuller.

But we are often disappointed with the poor attendance and our lady-undergraduates are often conspicuous by their absence. And yet it is the mass of undergraduates who will benefit mostly by the Society.

With the increasing and more exacting demands of the medical curriculum, students do not have much opportunity for reading anything outside their work. And yet there are a great many subjects related to Medicine that a medical man is expected to know which is not included in the curriculum. What then can be more profitable than to sit leisurely on an afternoon listening to a paper carefully prepared by the lecturer for that day?

Again, while papers are occasionally solicited from graduates and their friends, yet preference is always given to undergraduates for it is one object of the Society to encourage them to read papers. The experience thus gained is invaluable. We do not expect a high standard of originality from students, whose time and facilities are necessarily limited, but there is nothing to prevent them from reading more or less extensively on a subject, collecting their facts, and then advancing their own views either for or against the prevailing views. In this way the attributes of fearless enquiry, courage of one's own conviction, and independence of thought are early engrained into the students character, thus preparing these youthful minds for the Great Adventure, whose god is truth, whose confines are vast humanity, and whose aim is the relief of suffering.

The labour spent in preparing a paper is not labour lost, and the confidence obtained by getting accustomed to face an audience is an advantage not to be despised. Whatever qualifications a man may have as a scientist, as a clinician, as a researcher, or even as a general practitioner, yet if he lacks the art of conveying ideas clearly and convincingly even though on paper he labours under great disadvantage. We cannot too much or too frequently impress on our undergraduates and friends the fact that education does not necessarily mean booklore or even

practical work alone. We hold that he is rightly educated, who most permits the various factors and agencies to bring out and develop the fullest capacities in him, and the Society seeks to help to develop the best and the noblest in every student.

But there is also another advantage. In the preceding paragraph, we made reference to the art of writing, but the art of speaking is equally if not more important. To speak clearly, interestingly, and impromptu, is an art not easily acquired, and only practice will improve if not make perfect. The surprising thing is that few students will seize this opportunity of educating themselves, and the result is that at each meeting the discussion that follows is but weakly participated in by the undergraduate body.

A lecturer once told the present writer that it is most disconcerting to address an audience of young critical minds whom he knows is calmly weighing all that he says, and yet when he sits down he cannot help feeling extraordinarily uncomfortable at not knowing what they think of him or of his lectures. Shyness of course and not mental stagnation, is mainly responsible for this non-committal attitude, but one would have thought that shyness as an attribute thrives only in a girls' school. Each student expects the other to begin speaking, and the result is an awkward silence broken only by an occasional shuffling, as each attempts to kick his neighbour on to his feet to begin the ordeal. The truth of the matter is that we all make mistakes in public speaking at one time or another in our lives, and it is far better to make them now than when in our maturer years.

In this connection, it is interesting to note in the Nineteenth Century Review for November 1925, that a certain Mr. Keeton in a lengthy article speaks of the Chinese students' "interminable orations which are inevitable even at the committee meetings of the most insignificant recreation club in a Chinese university." For our part we have very seldom heard "orations," and "interminable orations" as descriptive of profound silence is certainly a unique way of expression. Mr. Keeton's article may be a correct description of his own class or university, but to generalise loosely, as he has done, betrays an ignorance which for a lecturer can only be described as phenomenal. All that he has said is not true of many students and certainly not true of our medical students, whose good name it is our duty to protect. To interpret the mind of the people of another race, to describe their characteristics, their customs, their history, their habits of thought, and their failings, are at all times and in all places a most difficult subject, but Mr. Keeton rushes in on grounds where older and wiser men fear to tread. We ourselves do not

know him, but judging from the article, we suppose it is written by a very young man. For youth is the age of omniscience, and gaily to undertake a task of such magnitude does require a very youthful person indeed! Still we would recommend our students to read the article even though for no other purpose than to see in what strange form courage may take.

The re-organisation of the Caduceus.

With the rapidly increasing circulation of the Caduceus, the committee feels that it is desirable to re-organise the managing staff of the Jaurnal.

Accordingly, Article V of the constitution was altered at a general meeting to read—"The Caduceus shall be managed by the said Committee, who shall appoint an Editor and a Business Manager."

Improvements of the Journal.

The Editor has much pleasure in drawing the attention of members and their friends to the improved features of the "Caduceus" which he hopes will enhance the popularity of the Journal.

In subsequent issues, it is proposed to publish each time at least one article of medical interest that has special reference to China. This being a Chinese University, it is hoped that such articles will appeal to our European and American subscribers.

We propose also to publish short articles on Minor Maladies which we hope will not be without practical interest.

For the benefit of freshmen and junior students, we intend to publish at least one general article in each issue.

We often receive enquiries from members requesting information concerning the whereabouts of other members. The editor therefore appeals to all members and friends to send in to him a short note containing their names, their addresses, their present position and any other information which may be of interest to their friends. With such information he hopes later to compile a drectory of all members.

We also intend to inaugurate a special news page in which news of members will be published free. Information for such publication concerning the marriage, change of address, birth of a child, death of a member, etc., will be gladly accepted. Enquiries from all our subscribers will be promptly attended to. We solicit articles from all our members and we shall be pleased at all times to hear from them concerning their work and their experiences. We desire our members to know that the Journal is theirs and the Committee's Motto is *"We serve."*

Our Honorary Graduates.

While our University is yet too young to carve for herself a name in the niche of fame, it is gratifying to see that in our association with well-known men who have honoured us by becoming Honorary Graduates, we have at least a slender claim to recognition. For in the list of our Honorary Graduates for the Degree of LL.D (Honoris Causa) we notice with pride such names as those of H.R.H. The Prince of Wales, Sir Patrick Manson (the Father of Tropical Medicine), Sir Frederick Lugard (Administrator and First Chancellor of this University), Professor Finot of the University of Paris, Sir Charles Addis (the Financier), Dr. Ernest Muir of Calcutta (the well-known authority on leprosy), Dr. Henry Houghton (Director of the Peking Union Medical College), Sir Charles Eliot (British Ambassador and one time Vice Chancellor of this University), and a host of others. By reflection, as it were, we share the glory of their personalities and achievements, and in the list of prince of royal blood, statesmen, financiers, scholars of repute and keen scientists, we have excellent models to copy, and in following their footsteps we cannot but be great ourselves.

The Traditions of a University.

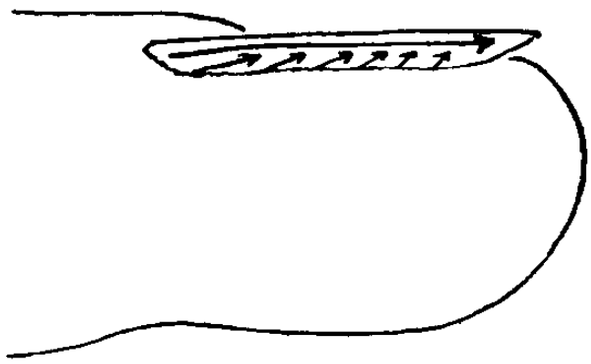
As one moves among the nobler buildings of an ancient English or American University, one cannot help feeling a certain amount of dignity and pride. To be a member of such a university is to be the heir of a great academic history. From the dim long past, great minds have moved along these same shaded walks and cloistered halls, and each in his time contributing his little won renown for the university. Such are a great many British and American Universities. Though the very names of many of these men belong now to the pages of history, yet their very presence seems still to hover around the scene of their past labours, and like the "invisible crowd of witnesses" that St. Paul speaks of, they inspire the younger generation to greater and greater things.

No such tradition is ours, no glorious past can we boast of in our short period of fourteen years. But we are encouraged with the thoughts that delightful though it is to be the heir of an ancient institution with all her intellectual splendour and glorious past, it is much more stirring to have a hand in the creation of the tradition of one's university. Theirs is the glory of the past; theirs the accumulated splendour of many ages—ours the glorious uncertainty of the future, the tantalising possibilities of what may yet be. And in the fields of research lie our avenue to greatness.

Opportunities for Research.

If it is true that the mind of man is so constituted that there is greater joy in the striving than in actual obtaining of an object, then the joy and excitement are ours. For looking over the vast unexplored fields in China, rich with many possibilities, we feel right at our doors are potential factors that can make us great. In this country, centuries ago, major operations were performed, vaccination practised, and even to-day, amidst the heaps of chaff of superstition and charlatanism, there is much that will add to the store of scientific knowledge for combating disease. Time was when everything that came from the West was regarded as scientific, and everything that came from non-European origin, was treated with suspicion. But the pendulum is lowly swinging in the opposite direction.

It is a Chinese belief that where a poisonous snake has its abode, there, close by, must be some herbal antidote against its venom, and arguing by analogy one feels that in some cases at least where there is a disease there must be medicine which can cure it. That such a view is not without a substratum of truth, is forced on us when we remember that long before the western world of science had ever heard of quinine the natives of Peru in their malarial swamped country had discovered how efficacious the cinchona bark was for the purpose of treatment. And quinine to-day ranks high as a weapon in fighting malaria. If such be possible in Peru, it is more than probable that there are a great many herbs in China still unknown to western science that may yet proved of incalculable value in the combat of disease. One's mind is stirred with the possibilities but time, men and money are needed. We feel that a department of experimental pharmacology and therapeutics is urgently needed in this University. Only then, can we make full use of the opportunities that lie so close at our door. To our mind no glory is greater than that of having contributed to the sum-total of human knowledge for the relief of sufferings. We desire no stately edifices or gilded domes to immortalise us; if it be our good fortune to be able to add something of permanent value to the stock of human knowledge then we have somethng grander than bricks and mortars by which we shall be remembered. Then it shall be said that as an institution we have not lived in vain—and that freely of the world's knowledge we have received, freely we give.



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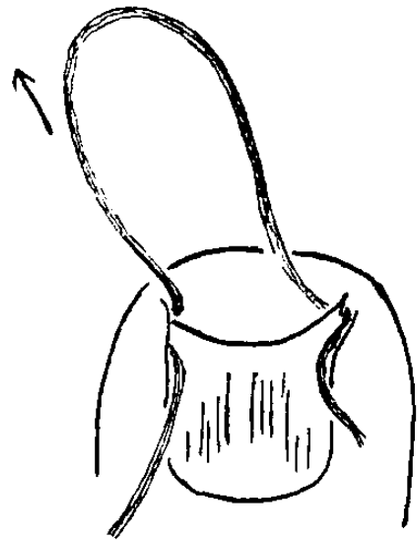

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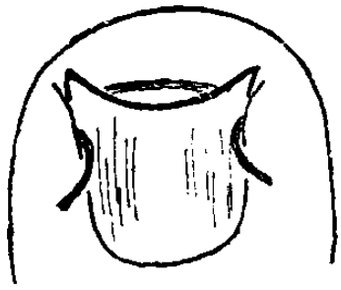

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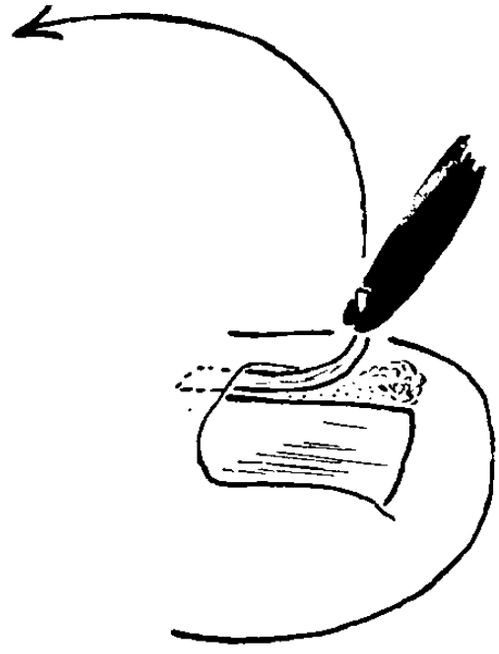

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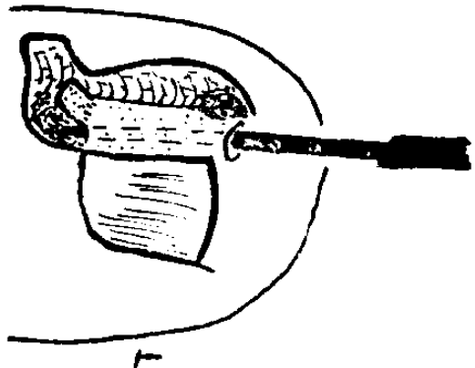

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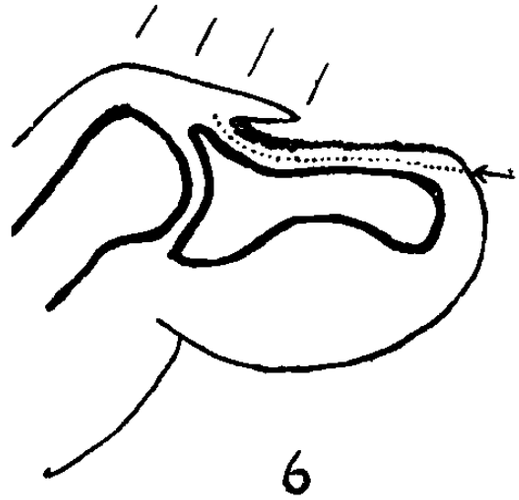

6

Minor Maladies

Ingrowing Toe Nail.

KENELM H. DIGBY, M.B., B.S., F.R.C.S.

Like many of the other ills which affect mankind *Ingrowing Toe Nail* is the result of artificial conditions. It is not as its name might suggest due to inherent perversity of the nail. It is predisposed to by the wearing of shoes or boots which press upon the medial side of the great toe and crowd the toes together, and of course the condition is commoner in a hot damp atmosphere such as that of a Hongkong summer, for the heat causes the feet to swell and this means that the foot wear becomes relatively tight. But the main exciting cause is *cutting the toe nails too short.* This is not always realised; and medical men in the past have received fixed salaries to cut shorter and still shorter the ingrowing toenails of the European members of the staffs of business firms in the Tropics.

The side of the toe nail is rounded and the soft parts can be pressed upon it without causing any difficulties there. But the angle between the blunt side and the scissor-cut margin is sharp, and if this angle does not project beyond the soft tissues the latter may come to be pressed upon it and are liable to be chafed and tender. If the nail be now trimmed still lower temporary relief is obtained at the risk of more trouble as further soft parts are pressed upon a fresh sharp angle still more deeply buried. The irritated soft tissues swell and as the nail grows distalwards from its base the sharp angle is driven by the urge of growth into the swollen tissues forced on to it by shoe pressure. The skin is eventually worn through and deep septic infection by the border of the nail supervenes.

A nail grows in thickness from the whole of its nail bed but in length from the root, that proximal portion of the nail bed which is covered by skin. (Fig. 1). When the nail is torn off the bed bleeds slightly but in 4 or 5 days heals and fresh nail substance is formed so that the nail bed hardens. But the new full thick nail grows slowly from the base and takes four months before its free edge projects well clear of the soft parts.

The treatment here advocated for ingrowing toe nail is as follows:—

1. Prophylactic. The toe nails should not be cut short but left so long that the corners are well clear of the flesh. This is especially desirable in hot climates. As the great toe is the one usually affected it is with the nail of the great toe that particular care should be taken to avoid its being cut too short.

2. When the nail has been mistakenly cut too short and tenderness is complained of, but no sepsis has occurred, the aim should be to grow the corner of the nail free of soft tissues as soon as possible. The middle of the free edge of the nail should be cut deeply concave but the angles not cut at all. These angles should be slightly raised by inserting a strand of soft silk or waxed thread. (Lister's dental floss is sterile and waxed and serves well) beneath them (Figs. 2 and 3). They should be changed every few days. As a rule they give quick relief. Loose shoes should be worn and exercise on the feet reduced to a minimum till the nails are long enough.

3. When infection has occurred the only course to pursue is avulsion of part of the nail. It is a waste of time to wait in hope of any other relief. One pointed blade of a pair of scissors is thrust beneath the nail longitudinally beyond the affected part and the nail cut. A pressure forceps is clamped upon the nail and turned back in a curve (fig. 4). If pulled too sharply backwards the nail may break and a second pull be required. The pain is sharp and an anaesthetic should be given. The nail bed heals in a few days. A few months later as the nail becomes fully grown there is danger of recurrence. This can nearly always be prevented by avoidance of shoe pressure, strict abstinence from nail cutting and raising of the angles on soft silk.

4. In the rare cases where there is recurrence of pain and suppuration as the avulsed nail grows, the nail bed (that is the growing layer of the nail) should be extirpated. After the lateral or medial strip of nail has been again avulsed the skin over the root and the tissues along the side border of the nails are raised as a flap (Fig. 5). The root (the most important part of all to remove), is carefully dissected off the sloping proximal part of the terminal phalanx. A very narrow pointed knife is then passed between the rest of the nail bed and the periosteum (Fig. 6).

This small operation requires some nicety of judgment, for it is undesirable in the presence of sepsis to either expose the bone or to open the distal interphalangeal joint and on the other hand complete removal of the nail bed is essential. A stitch or two helps to replace the flap of soft tissues.

Annotations

Melanomata.

C. Y. WANG, M.D., B.Sc., F.R.C.P.E., D.P.H., D.T.M. & H.

Melanomata may be defined as a group of tumours in which the specific characters of the tumour cells is the presence of a variable amount of an iron-free pigment, melanin. Much difference of opinion exists regarding the origin and nature of the pigmented cells. According to some authorities, headed by von Recklinghausen, these cells arise from the endothelial lining of the lymph channels, but controverting this view is the observation of Unna which points to their epidermal genesis. An entirely new stand-point was later put forward by Ribbert who claimed that all melanotic tumours had arisen through proliferation of the chromatophores which, as defined by him, are connective tissue cells with the specific function for the production of melanin. Such cells are found between epidermis and papilla, between the choroidal sinuses and along the vessels of the meninges, and have been shown in the cutaneous pigmented growths to migrate from the corium into the basal layers of the epidermis. Yet another view held by Krompecher and Kromayer was advanced that the pigmented or naevus cells are epidermal in origin, but are transformed to spindle shaped connective tissue cells.

Regarding the origin and constitution of the melanin pigment there appears, however, to be more general agreement with the contention that it is an intermediate product of a specific metabolism of the cell obtained by the interaction within the cell of an enzyme (oxydase) formed by the cells as its specific activity and a mother-substance (melanogen or chromogen) of a protein derivative. It is the enzyme, therefore, which is specific to the pigment-producing cell and which in the presence of sufficient melanogen brought to the cell by the blood and lymph converts it into melanin. Where this ferment is absent, as is assumed in albinism, no melanin is formed; but where, on the other hand, there is an over supply of the melanogen, as is also assumed in Addison's disease, due to loss of function of the adrenals, this mother-substance, common to adrenalin and melanin, is not changed, as it normally will be, into adrenalin, but accumulates in the epithelial cells which thus stimulated to the production of the ferment convert the surplus of the substance into melanin. This is taken to account for the increased pigmentation of the skin in Addison's disease.

Bloch has shown that this particular enzyme or oxydase which oxidises in situ the chromogenic substance absorbed by

the cells can be demonstrated by the application of di-hydroxy-phenylalanin — a derivative of pyrocatechol — (contracted to "Dopa"). When this comes in contact with the oxydase (called by Bloch dopa-oxydase) in tissue sections a precipitation of a pigment occurs. By this "dopa" test Bloch has demonstrated that all basal cells of the epidermis, hair bulbs and follicles react positively to the reaction and that mesodermal cells are "dopa" negative. Further by this reaction a distinction can be established between pigment carrying cells (chromatophores) which are "dopa"-negative from pigment producing cells (melanoblasts) which are "dopa"-positive by virtue of the ferment they produce.

Amongst the most notable recent contributions to the study of the morphology and histogenesis of melanomata is the work of Dawson which appears in the October number of the Edinburgh Medical Journal. It is based on the investigation of 102 cases of melanomata extending over a period of many years, and is accompanied by a wealth of excellent illustrations taken from tumours in successive phases of development. The conclusions he has drawn from it appear sound and consistent and can only be very briefly referred to here.

1. The formation of melanin in the skin is a characteristic function of the basal cell layer of the rete Malpighii.
2. Through a series of cell transformations the basal cells form intra-epithelial cell nests, and in these formations they lose their intercellular fibrils, become detached assuming a spindle or star shaped form, and finally migrate and settle in the upper corium. In this way a simple naevus is formed.
3. The malignant form of melanomata arises usually from a benign naevus, either from proliferation of the original naevus cells embedded in the corium or from the cells of the surface epithelium and its inter-papillary processes.
4. The so-called melano-carcinoma, melano-sarcoma, melano-endothelioma, melano-perithelioma and melano-fibro-sarcoma are, in all cases, derived from progressive transformations in the epithelial cells.
5. The ocular melanomata have their origin in the same way in the pigmented basal epithelium in the episcleral tissue, that is, by a series of progressive changes of the basal cells—pigmentation, detachment, polymorphism and final penetration between the sclerotic and cornea.
6. Melanomata arising from other situations, as the central nervous system or the internal organs, are presumed to arise from proliferation of the primitive ectodermal cells which have migrated along the paths of the peripheral nerves.

Virucellular Symbiosis.

KENELM H. DIGBY, M.B., B.S., F.R.C.S.

The recent researches of Gye and Barnard have altered the balance of opinion in favour of the theory of malignant new growths being caused by very minute infective organisms.

Experience in the Surgical Clinic in Hongkong has always led one to be partial to the micro-organism view for one sees chronic ulcers (sometimes with fungus infection), and infective papillomata merging so imperceptably into epitheliomata that it is impossible to say where one begins and the other ends.

The difficulty in accepting the infective theory has always been that it is one type of tissue cell (rather than any micro-organism), which seems to be attacking the body as a whole, which provokes lymphocytic and connective tissue defensive reactions and which eventually forms metastases and over runs the whole body.

This difficulty can be obviated if we can conceive an infective organism which invades a particular cell and grows symbiotically within it enabling it to escape all normal restraints. One ventures to coin a new word or phrase and describe this theory as that of virucellular symbiosis, that is, an offensive alliance or symbiotic union between the virus or infecting micro-organism and the tissue cell.

Reviews of Books.

CHININUM, Scriptiones Collectae, Anno MCMXXV.
Bureau Tot Bevordering Van Het Kinine-Gebruik.
Amsterdam.

The Bureau for increasing the use of Quinine is to be congratulated on its zeal and enterprise in bringing out a second publication of CHINIUM. First edited in 1923, this book hails from Holland and consists of a collection of articles, some short and some long, concerning the therapeutic efficiency of Quinine. The many authors include prominent men from all parts of the world; all of whom write with knowledge and experience.

This handy book of 250 pages is well printed and artistically bound in cloth. It contains several very good plates, the photography of which is first-class.

No roundabout methods are employed to disguise the fact that the true object of the book is in the nature of an advertisement for Quinine and especially Dutch Quinine. This does not in the least detract from a volume full of interesting facts and valuable information. It will be a worthy addition to the Medical Library of the University and should be read by all students of therapeutics. As one might expect the greater portion of the book is devoted to the use of Quinine in the fight against malaria. For some this might be sufficient excuse to put the book aside unread considering more than enough had already been written and nothing new was likely to be learnt. To those who have to deal with the malarial problem this book will appeal; for herein many aspects of the problem are set forth lucidly and compactly by leading authorities.

The account of the proceedings of the Health Commission of the League of Nations and its journey over a considerable portion of Europe is very instructive. This story shows clearly how antimalarial measures necessary in one locality differ from those in another. It also shows that before any measures (worthy of the name) are taken at all an expert survey should be made and local conditions studied; a preliminary which takes time and costs money, but both well spent. Those of us in Hongkong, who read this book, will be bound to reflect on our own malarial problem, especially the one existing in no mean degree in the New Territories. The time is rapidly approaching when a real start will have to be made to rid such a place as Tai-Po of the scourge. The small picture depicted on the title-page within the cover of this book might have been drawn from the New Territories. A buffaloe drags a plough guided by a man, high mountains form the background and the sun shines over all. The superscription

is "Aratro et Quina." This is the solution in a nutshell. Other articles on the prophylaxis, methods of administration and mode of action of Quinine are well worth reading, especially one on the radioactivity of Quinine. The last third of the book contains a number of articles on the use of Quinine in conditions other than malarial, e.g. lobar pneumonia, haemorrhoids, lumbago, varcose veins and ulcers, exophthalmic goitre, cancer, venereal disease, etc., etc. The efficacy of Quinine in some of these diseases is undisputed, in others further trial and experience are required. There are some good aticles on the place Quinine has found in Obstetrics—a place that will be held for long time.

To revert to the main object of the book, viz.—"the increasing use of Quinine," it would be interesting to know whether sufficient Cinchona trees are cultivated in the world to provide for the needs of the world's population. As regards the amount of Quinine available for the Allies during the Great War there was a serious shortage. The following paragraph is taken from a periodical—"Chemist and Druggist" 1919 p. 1065.—"Among all the Allies the call for Quinine was almost desperate—especially in the Italian Forces—in fact the allied cause was in jeopardy. It is scarcely too much to admit that the future destiny of the civilised world rested with the Dutch. The keynote of the situation was the Java Cinchona plantation. The famous War Agreement of September 3rd 1918, saved the situation—the Associated Countries secured practically the whole year's production of Java Quinine on reasonable terms." The British Empire cultivates Cinchona trees in Ceylon. Is this sufficient for its needs? Could they not be cultivated in Hongkong or the New Territories? The Cinchona trees originally grew wild in South America, especially in the eastern highlands of the Andes, in the misty region 3000/10000 feet above sea level. An odd thousand feet should not make much difference—there is plenty of misty region here. At any rate the Superintendent of the Botanical and Forestry Department might have something to say in the matter. If the production were increased the price of Quinine should be less. At present quinine costs 2/1½d. per ounce or a little more than ½d. per dose of ten grains.

The Dutch have led the way as this book testifies, it is up to other Nations to follow suit.

D. J. V.

Bainbridge & Menzies' Essential of Physiology—5th. Edition, edited and revised by C. Lovatt Evans, D.Sc. (Lond.), M.R.C.S., L.R.C.P., F.R.S. Longmans Green & Co., 1925. 14/- net.

Owing to the concise presentation of the fundamental facts and principles of Physiology, Bainbridge and Menzies' textbook has been quite popular among medical students who were preparing for the degree examination on Physiology. A new edition in which everything has been brought up to date without material expansion of the size of the text is welcome. As the editor stated in the preface of this edition, "the alterations have been rather interstitial than reconstructive" and consequently no great departure from the previous edition is noted.

In conjunction with a good laboratory manual of physiology, this textbook serves an important purpose in a brief course on the subject. It is particularly valuable to medical students who want to do a little revision either for examination, or for a better knowledge of physiology.

S. Y. W.

Physical chemistry for students of Medicine:—by Alexander Findlay M. A., D.Sc., F.I.C., Professor of Chemistry, University of Aberdeen, Publishers, Longmans, Green & Co., London.

In view of the fruitful application in recent years of the life phenomena from a dynamic view point, nobody would doubt the usefulness of inserting a short course of the subject in the medical curriculum, however crowded the latter may appear to be. Indeed, to understand the fundamental principles in biochemistry, physiology and the other branches of biological science underlying medical practice, a knowledge of the science of transformation of matter and energy is indispensable. For this reason, this work supplies a great need in medical education. It covers in a clear style and an elementary manner the different phases of the subject so far as they have direct bearings on the study of medicine. It includes, the gas laws, the acqueous milieu of the life processes, diffusion and osmotic pressure, osmotic pressure in the living organism, the behaviour of electrolytes in solution, the law of mass action and chemical equilibrium, law of mass action applied to solutions of electrolytes, hydrogen in concentration. velocity of reaction and catalysis, enzyme action, the colloidal state, absorption, the permeability of the cell membrane. The subject is so simply treated that no extensive knowledge is needed for its understanding. This text is not only admirably adaptable to a course of medical physical chemistry but also forms an excellent reference in connection with the study of biochemistry and physiology. To the medical practitioner, it affords profitable reading in reminding him the laws concerning gaseous exchange in the lungs and tissues, hydrogen concentration of the blood and other tissue fluids, enzymic digestion in the stomach and intestine, etc. Findlay's

"Practical Physical Chemistry" is known to almost every student who has had any work on the subject. There is no doubt that the present volume will enjoy equal popularity among medical students.

S. Y. W.

Insects and Disease of Man: by Carroll Fox, M.D., Surgeon, United States Public Health Service, and Lecturer on Medical Entomology to the Class of Student Officers of the Hygienic Laboratory, Washington, D.C., and one time Assistant Director of Health, Bureau of Health, Philippine Islands, and Associate Professor of Hygiene, Medical School, University of the Philippines. 92 Illustrations, 349 pages, G$4.00. Published by P. Blakiston's Son & Co., Philadelphia.

The author in his preface states that he has attempted to gather together in a concise and practical way, the information necessary for a student taking up the study of medical entomology, or for the health officer working in the field of preventable diseases transmitted by anthropods. The first part deals with the classification, identification, anatomy, life history, general considerations, key to sub-families, etc., together with a chapter on the Arachnda and the Rodents, and Notes on the Technique of collecting, killing, mounting, preservation, and examination of entomological specimens. Part II discusses the diseases carried by Anthropods among human beings. Under each discussion is given the causative agent, source of infection, mode of transmission, period of incubation, communicability, epidemiology, recognition of the diseases, prevention and control, treatment of carriers, prophylaxis, and all practical points including the finer details, such as the articles required, minute instructions in the preparation of material, and the investigations to be made by the field officer. The author has written a book, based on his large experience both as a worker and a teacher, which is practical in all respects. It is a pithy epitome of our present knowledge on the subject. This excellent book can be obtained from Messrs. Edward Evans & Sons, Ltd., Shanghai.

G. H. T.

Reviews of Journals.

Archives of Internal Medicine, Feb. 1926.

An interesting article by Peters and Bulger on "The Relation of Albuminuria to Protein Requirement in Nephritis," brings into prominence the trend of modern opinion regarding the dietetics of Bright's disease. The authors agree with Epstein and Van Slyke, Linder and McLean that in Parenchymatous Nephritis, the diets should contain an adequate amount of protein to cover the nitrogen catabolism together with an additional amount to replace that which is lost as albumin in the urine.

Barach of New York writes fully on the "Methods and Results of Oxygen Treatment in Pneumonia." He considers the ordinary tube and funnel method is useless as a therapeutic agent, while the administration by nasal catheter is little better. A rebreathing apparatus with a special glass nose-piece is the most efficient of the portable instruments. The final results were not very encouraging as oxygen treatment is not exactly curative. In severe dyspnoea with cyanosis, oxygen may prolong life until such time as active immunity is established.

"The Healing of Gastric Ulcers" by Crohn, Weiskopf, and Aschner, brings forward some comforting evidence that in certain types of peptic ulcer, a rapid process of healing takes place under medical treatment. They believe that this rapid improvement of the pathological condition explains the failure in many cases to demonstrate the lesion when the patient has consented to exploratory laparotomy.

I. C. Brill of Portland describes a case of "Acute Febrile Anaemia" which he considers may be a new disease. The outstanding features were moderate pyrexia, tendency to haemorrhages, soft enlarged spleen, leucocytosis, and profound anaemia. The case seemed to occupy a position midway between septicaemia and pernicious anaemia.

The National Medical Journal of China, Feb. 1926.

The opening article, "Notes on the Vitality of Plague Bacilli in Stained Smears," by H. M. Jettmar, contains some striking facts regarding the resistance of these organisms. Fixation of a smear on a cover-slip by passing it through a flame has little effect, and fixation by alcohol after passing through the flame does not kill the organisms with certainty. Smears stained with dilute Carbol-fuchsin still contained living bacilli, but no organisms survived a concentrated alkaline methylene blue stain.

Another article from the Manchurian Plague Prevention Service by J. W. H. Chun states a good case for "Beriberi Control from an Administrative Viewpoint."

"A Statistical Study of 600 Cases of Fractures," by J. T. Tai gives a succinct analysis of the accidents admitted to St. Luke's Hospital, Shanghai, during the two years, 1919-1921. From his data he raises various questions on the broader issue of industrial hygiene.

A paper on "Influenza with special reference to Symptoms, Diagnosis, and Treatment," by H. Lovett Cumming, contains some pertinent observations with regard to the incidence of the disease in China. His experiences in treatment with vaccines, sera, and sero-bacterins are of special interest to practitioners.

Presented at the last conference of the National Medical Association, the paper on "Poisoning Statistics," by B. E. Read of the P.U.M.C. is a valuable work of reference. His handy tables of poisons with Chinese names attached and his suggestive comments should help to clear up many mysteries in China.

"The Duties and Responsibilities of the Present-day Chinese Physician," by Lee Shu-fan of Hongkong is a thoughtful and inspiring article. His advocacy of the scientific spirit is specially opportune.

China Medical Journal, March 1926.

The current issue being a "Special Health Number," the original articles are primarily of interest to sanitarians. Under the comprehensive title of "Broadcasting Health in China," Dr. W. W. Peter gives a lucid description of the activities of the Council on Health Education. As an introduction he tells the story of an anti-cholera campaign in Foochow which reads more like a romance than an article in a scientific journal. In 1919 the cholera season opened with unusual severity and it was estimated that out of a population of half a million, 19,000 died of the disease. In 1920, all available forces were organised, and an educational campaign was conducted on intensive lines during the week preceding the usual annual outbreak of cholera. The result was spectacular, for beyond a few sporadic cases introduced from neighbouring districts, there were no deaths during the Summer; "Foochow was an island of safety in a sea of danger."

Thereafter, Dr. Peter goes on to describe the Methods of the Council for promoting health education. These include the production and distribution of educational material such as books,

leaflets, pictures, and exhibits, medical surveys of schools and communities, special demonstrations, community campaigns, conferences, correspondence, and organisation required. The article is a valuable work of reference for those interested in the public health problems of China.

In his article on "Hookworm in Kwong Tung," Dr. F. Oldt has some valuable suggestions to make for the eradication of the parasite. Among City dwellers the incidence of the disease is negligible, but amongst farming people the infestation varies from 5% to 95%, depending on the kind of crop raised and the locality. The most important crop in the province is mulberry. Nightsoil is extensively used as manure and the methods of cultivation and harvesting give ample opportunity for a heavy infestation of the farmers.

The author proceeds to describe his experiments to destroy the hookworm ova without diminishing the fertilising value of the nightsoil. He tried storage for various periods, and he tried mixing the nightsoil with different proportions of other fertilising agents such as Ammonium Sulphate, Chile nitrate, sulphate of lime, stone lime, and ashes.

The best results were obtained from ammonium sulphate, for all his mixtures showed a marked destruction of hookworm eggs. His conclusion is that "mixing ammonium sulphate with nightsoil to a 12% strength should give a safe fertiliser within one day of mixing."

Dr. F. J. Wampler has a paper on "The Opportunity for Preventive Medicine in China," and Dr. Iva M. Miller emphasises the importance of pre-natal and post-natal cliniques in "Health for China's Children." Both papers were presented at the joint conference in Hongkong a year ago.

Dr. V. B. Appleton places on record a "Further Study of the Growth of Chinese" with measurements taken from a group of 345 students in Fukien, and a group of 242 Chinese boys in Hawaii.

J. A.

The Journal of Pharmacology and Experimental Therapeutics, March 1926.

The Journal of Pharmacology and Experimental Therapeutics for March 1926.

The major portion of the journal is taken up by the results of the experimental work of A. G. Young and others on the

toxic effects of Anilin, Anilin Compounds, and Acetanilid. The manufacture of anilin dyes and pharmaceuticals, and the extensive use of anilin in the rubber industry, gives anilin poisoning an ever increasing importance in industrial hygiene. Amongst individuals not engaged in these industries, the common sources of anilin intoxication are commercial marking inks, certain hair dyes, and black shoe polish.

The symptoms of anilin and acetanilid poisoning are given as follows: Cyanosis, general weakness, mental confusion, dryness of the throat, weak pulse, headache, loss of conciousness, convulsions, coma and death.

It was formerly held that these symptoms were due to the formation of methaemoglobin with resulting blood changes suggestive of pernicious anaemia. A. G. Young and his collaborators now show that Anilin and Acetanilid do not produce Methaemoglobin, and that the cause of death is the direct toxic effect upon the cardiac muscle including the specialised conductive tissue of the heart. In the blood they form para-amino phenol which is excreted in the urine. This may account in part for the cyanosis. Prolonged administration of sublethal doses of acetanilid produces anaemia and emaciation.

A short article by Chapman Reynolds on "Comparative Studies of Propylene, Ethylene, Nitrous Oxide, and Ether," indicates the possibility of Propylene coming into more general use as an anaesthetic. The late toxic action of Prophylene is less than that of Ethylene, and about equal to those of Nitrous Oxide and Ether.

J. A.

The British Journal of Surgery for 1925.

The British Journal of Surgery published quarterly is supreme among surgical publications for the excellence of its paper, printing and above all its illustrations. It is also distinguished by the emphasis laid upon the pathological side of surgery both in the articles and in the excellent atlas of pathological specimens which bring examples from the superb collection of the Hunterian Museum of the Royal College of Surgeons of England vividly before the reader. Experimental work and improvements in technique are less in evidence. Certain articles should be read by all undergraduates preparing for their surgical finals, on account of their general and fundamental interest.

In the January number Sampson Handly elaborates his theory of ileus duplex in patients with general peritonitis (presumably treated by Fowler's position?) One would have imagined that temporary enterostomy (plus caecostomy) would be better treatment than entero-colostomy (plus caecostomy).

In the same number Featherstone exhaustively discusses the causation of post-operative pneumonia and exonerates ether:—"Finally we are forced to the conclusion that relatively pure ether when administered with reasonable care is not an important cause of pneumonia, and that most certainly the routine use of chloroform—a practice still advocated by some surgeons—would not rid us of this grave complication."

In the April number Dibble records the investigations of a committee on gastric ulcer and carcinoma.

"The conclusion of this inquiry is that gastric ulcers, coming to operations as such, prove on removal to be simple in nature almost invariably and that gastric carcinoma as far as can be judged by histological evidence are in a large majority of cases malignant from their inception. This is not a denial of the possibility of malignant change supervening in a chronic gastric ulcer; it is a conservative view of the frequency of this event.....it is not the normal fate of a gastric ulcer to become malignant; neither is it usual for a gastric cancer to originate in a gastric ulcer." This is a re-affirmation of the old English view and is totally at variance with the teachings of the Mayo Clinic and other American authorities. The details of the investigations especially as regards the criteria of malignancy in microscopical sections are well worth reading.

Members of the surgical firm who saw a recent case, in the ward of "woody thyreoid" will be interested in an article entitled Reidel's chronic thyreoiditis describing six new cases and twenty-three cases collected from the literature by Shaw and Smith.

K. H. D.

Acknowledgments.

We have much pleasure in acknowledging the receipt with thanks of the following contemporaries:—

St. Mary's Hospital Gazette, London.

Health Magazine, Shanghai.

Archives of Medical Hydrology, London.

Archivo di Fisiologia, Firenze, Italy.

Archives Internationales de Physiologie, Liege, Belgium.

Boletin de la Universidad Nacional de la Plata, Argentina.

Selected Contributions from the Peking Union Medical College, Peking.

Bibliography of Publications from the Laboratories and Clinics of the Peking Union Medical College and Hospital, Peking.

Contribution from the Department of Obstetrics and Gynaecology, Reprint on "Osteomalicia in China" by Maxwell and Miles, Peking Union Medical College, Peking.

The Japan Medical World, Tokyo.

Taiwan Igakkai Zasshi (Journal of the Medical Association of Formosa).

"Severance," Journal of the Union Medical College, Seoul, Korea.

Mededeelingen Van Den Dienst Der Volksgezondheid in Nederlandsch-Indie. (Reports of the Medical Civil Service in the Netherlands East Indies).

Fourth Annual Report of the Tropical Diseases Library, London.

Medical Report of the C.M.S. Hospital, Pakhoi.

Chinesische Zeitschrift Für Die Gesante Medizin, Moukden.

League of Nations Health Organization Statistical Handbooks Series, Geneva.

Epidemiological Report of the Heath Section of the Secretariat of the League of Nations, Geneva.

Ars Medici, (Journal of Medical Practitioner), Vienna.

Mitteilungen Uber Allgemeine Pathologie and Pathologishe Anatomie, Sendai University, Japan.

Index Universalis, Moukden.

Tohoku Journal of Experimental Medicine, Sendai, Japan.

Bulletin de la Societe Des Sciences Medicales, Montpellier, France.

Gann, (Japanese Journal of Cancer Research), Tokyo.

The Bristol Medico-Chirurgical Journal.

News and Comments.

Professor Wang's Handbook of Pathology.

Published by the well-known firm of Messrs. John Bale and Sons, Danielson and Co., Ltd., Professor C. Y. Wang's little book is a veritable *multum in parvo*. As its name indicates, it lays no claim to be an exhaustive treatise on the subject, but for students going up for their examinations, and for qualified men who want to refresh their knowledge, it is an invaluable book. Neatly bound and clearly illustrated, the whole book may be said to have emanated directly from Professor Wang's department. The book is based on lectures delivered to his classes and those of us who have had the privilege of sitting at his feet to learn that subject, will recall how lucid and inspiring they were. The illustrations are drawn by his pupils and assistants from specimens in his possession, so that we can proudly claim that the book is a product of the Hongkong University. Ever a friend of students, Professor Wang by the publication of his book has endeared himself still more in their affections, for it is a great help to them in their revision, and we note with satisfaction and pride that students in Great Britain and elsewhere are also finding it such a source of usefulness. We congratulate him for it.

Sir Arthur Mayo Robson's Visit.

Sir Arthur and Dr. Turner visited the University last February and then came to the Hospital to see the Clinics. Asked to speak by the students, Sir Arthur said some very pleasant things about us and our clinics which we hope were true. He was invited to address the Medical Society the following day which he consented. There was a large crowd of students in the Common Room to receive him, and after tea, the meeting was held in the Assembly Room of the Union. Dr. Phoon took the chair, and Sir Arthur then recounted his Reminiscences. In an entertaining manner he kept his audience interested throughout his address. The students were much amused when he referred to the state of surgery before the era of asepsis and antisepsis. He told them how when he first succeeeded a retiring surgeon, he was handed a long operating coat which had been worn by his predecessors and which had once been white but now had assumed a nondescript colour, and would certainly have benefitted by washing. The staff of that hospital was shocked when he refused to don that mantle of his seniors and preferred fresh sterilised gowns for his operations. After his address a group photograph was taken outside the Union Building. A great British surgeon with pupils who are now pillars of British Surgery, Sir Arthur is a very pleasant type of Englishman, Courteous and charming in manners, he was not the least bit stiff and bears his greatness with humility.

Our Graduates.

We are always proud of our graduates and that our pride is not without cause is evidenced by their post graduate careers in other universities in Great Britain and America.

Dr. M. K. Yue—After his graduation from this University, took up house appointments and then proceeded to Cambridge for a course in Public Health. After a year's study abroad, we learn that he has obtained his D.P.H. with distinction. He is now back in China and no doubt we shall soon hear of him.

Dr. T. Y. Li—Another of our recent graduates who took up the appointment of House Surgeon and House Physician, was awarded a Rockefeller Travelling Fellowship and left last year to study in the London School of Tropical Medicine and from news to hand we are glad to learn that he passed his examinations with distinction and has obtained his D.T.M.& H. from the Royal Colleges of Surgeons and Physicians, London. He is now studying Pediatrics in Glasgow where no doubt he will uphold the name of this University.

Dr. M. B. Osman—After holding a year's hospital appointment, he was awarded a Rockfeller Travelling Fellowship and left last year for Edinburgh where he is now working under Professor Lorraine Smith. On his return he will be assisting Professor Wang's department.

Dr. K. T. Teo—After holding the appointment of House Obstetrican was awarded the Ho Fook Scholarship. From news to hand we learn that he has been appointed Visiting Medical Officer to the Tan Kah Kee Rubber Estates Hospital in Singapore. He is also enjoying a good private practice.

Dr. H. K. Lung—has commenced general practice in Malacca and is doing quite well.

Peking Union Medical College.

We understand that the Peking Union Medical College is offering intensive studies in Obstetrics and Gynaecology from 28th. August to 18th. September, 1926. The tuition fee is $35. During the first week, besides the special studies in the department, the members of the class will have the privilege of attending meetings of the China Medical Association. Early applications are advised.

Post Graduate Studies in England.

We notice that a large poster has been exhibited on the notice board of the Medical Faculty of the University. The Fellowship of Medicine and Post Graduate Medical Association organizes post-graduate medical work in London and is prepared to offer facilities to any member of the medical profession who wish to pursue further studies in England. Those interested are advised to obtain further information of the Fellowships from the Fellowship of Medicine, 1, Wimpole Street, London.

SCHOLARSHIPS.

Ho Fook (July to December 1925)	Dr. K.T. Teo.
Jordan (January to June, 1926) ..	Dr. F. I. Tseung.
Ng Li Hing (equally divided) ...	Mr. F. T. Hua. / Mr. S. P. Lee.
Chan Kai Ming	Mr. S. P. Lee.

APPOINTMENTS.

January to June, 1926.

POST GRADUATE:—

House Surgeon	Dr. S. A. M. Sepher.
House Physician	Dr. K. C. Yeo.
House Obstetrician	Dr. S. K. Lam.
Clinical Assistant to the Medical Unit	Dr. F. I. Tseung.

UNDER GRADUATE:—

Surgical Ward Clerks.

Hua, F. T.
Hsiu, S. T.
Kwan, P. C.
Lam, H. Y.
Lee, S. P.
Ong, C. K.
Sudan, B. N.
Tu, T. P.
Wu, T. P.

Surgical Dressers.

Chua, B. T.
Hsiu, S. T.
Kao, C. H.
Kwan, P. C.
Kwok, Y. K.
Laing, D.
Lam, H. Y.
Shi, M. W.
Teh, Y. C.
Vephula, C.
Wu, T. P.

Junior Medical Ward Clerks.

Chee, C. H.
Hua, F. T.
Kao, C. H.
Khoo, K. T.
Kwok, Y. K.
Laing, D.
Lee, S. P.
Ong, C. K.
Rumjahn, A. A.
Shi, M. W.
Sudan, B. N.
Tio, S. L.

Senior Medical Ward Clerks.

Chee, C. H.
Chow, T. C.
Khoo, K. T.
Ma, W. M.
Phoon, S. Q.
Rumjahn, A. A.
Tio, S. L.
Tu, T. P.
Vephula, C.
Wong, B. H.

Obstetric Clerks.

Chua, B. T.
Miss E. Ho Tung.
Miss P. C. Lai.
Phoon, S. Q.
Teh, Y. C.
Teoh, B. L.

Pathology Clerks.

Bau, T. Z.
Guzdar, J. S.
Miss E. Ho Tung.
Kwong, S. C.
Miss P. C. Lai.
Li, K. Y.
Tang, Y.Y.

Anaesthetic Clerks.

Bau, T. Z.
Chan, J. C.
Kawn, K. K.
Li, K. Y.
Pang, H. K.
Tang, Y.Y.