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MEDICAL DIAGNOSIS.

by

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The Editor of the "Caduceus," having kindly invited me to contribute a paper on any subject which would interest medical students, I have chosen Medical Diagnosis. The subject is of importance to the student and also to the graduate of medicine; if the diagnosis is wrong then the prognosis may be wrong and the treatment will be disappointing to patient and doctor. Sometimes it is difficult to diagnose a case, but failure is often due to some fault in the methods of examination or lack of concentration of mind. As an author writing on the diagnosis of acute intussusception puts it, "This (the diagnosis) usually presents no difficulty provided the physician has the condition in mind." The medical student is being prepared for clinical work when Anatomy and Physiology are being studied; a knowledge of the normal structure and functions of the human body must precede the study of the abnormal conditions met with in disease. Pathology demonstrates the causes, course and results of disease and is a valuable aid in diagnosis. The principles of Medicine and Surgery provide the facts necessary for differential diagnosis. In the wards and outpatient department the patient is examined and history obtained; from a careful consideration of all the facts bearing on the case a decision is arrived at or in professional language a diagnosis is made.

The Clinical Examination and History.

Case-taking in the wards may at times be wearisome to the student and no doubt some cases seem too simple to warrant so much time being spent in writing out details; but if it is realised that careful case-taking is an important training in method which will be valuable in medical practice later, the work will have a greater interest. It is true that few doctors write out their cases but most apply the methods of taking the history and carrying out the clinical examination which they learnt as students.

In forming a diagnosis the thoroughness with which the clinical examination is made is of the first importance. The history of the disease has also some value but considerable experience is required to bring out the facts of special significance in each case. As the history is a statement by the patient, it may be misleading in important details; defective memory or lack of intelligence may lead to facts being omitted or the patient may knowingly give a wrong statement. Hence the wisdom of relying chiefly on the facts obtained by clinical examination. A boy was admitted to hospital suffering from pain in the ear and examination showed acute inflammation of the mucous membrane of the external auditory meatus. Next day when the swelling had become less acute, examination showed a large pea firmly fixed in the mucous membrane. No history of a foreign body could be obtained when patient was admitted to hospital. A patient had acute conjunctivitis in one eye and as the sight of the other eye was defective owing to an injury some years previously, he was anxious lest he should become blind. On turning up the eyelid a tiny piece of straw was seen and removal resulted in cure of the conjunctivitis. He afterwards remembered that the eye became painful soon after a visit to his stables. In another patient, a plug of wool, which had been left in the external auditory meatus and its presence forgotten, was found to be the cause of chronic discharge from the ear. While the medical student cannot exhaustively study the diseases of the Eye, Ear, Nose and Throat, every opportunity should be taken to acquire the methods of examination. Acute glaucoma diagnosed early warrants a favourable prognosis as early operation will preserve the vision. A woman was operated on for this condition in one eye and good vision was obtained; the other eye became affected when in Singapore and unfortunately she delayed seeking treatment until she returned to Hongkong when it was too late for operation and the sight was lost.

In women when the examination of abdominal tumours arising from the pelvis is being made, auscultation should never be omitted. The passage of a catheter has sometimes led to the mysterious disappearance of an abdominal tumour. The history given indicated fibroid of the uterus and that diagnosis had been suggested but auscultation gave distinct foetal heart sounds and the tumour disappeared later. In hydramnios with large excess of liquor amnii and in hydatid mole, auscultation of the tumour will probably not help and other signs must be sought for; so also in pregnancy with death of the foetus.

Even doctors of large experience may fail at times not because of the difficulty of the case but through over-confidence. A distinguished physician was consulted and after giving instructions as to diet, etc., he said, "Remember, one cigar a day." The patient on his return visit reported that he had considerably improved but was rather uncomfortable after smoking the cigar as he was a non-smoker. A surgeon of world-wide reputation diagnosed glands of the neck to be of tuberculous character and recommended operation, but a doctor in general practice was consulted and found that the glands were chronically inflamed owing to an eczema of the scalp; treatment applied to the scalp rendered operation unnecessary.

In sport and war many defeats can be traced to underestimating the strength of the opposing forces and so also in diagnosing a case. It is often assumed that a case presents no difficulty when further investigation would have shown that the significance of the symptoms had not been appreciated. "Distrust the obvious" has been given as a warning in working out the diagnosis of a case.

Pain during defaecation and haemorrhages have led to cases being diagnosed as suffering from haemorrhoids but examination of lower part of rectum proved that stricture of the rectum was the correct diagnosis.

Abdominal diseases are admittedly not easy to diagnose accurately and special attention should be directed to acute abdominal conditions which require early operation. Mr. Cope in his book, "Diagnosis of the Acute Abdomen" states, "The general rule can be laid down that the majority of severe abdominal pains which ensue in patients who have been previously fairly well and which last as long as six hours are caused by conditions needing surgical intervention." It would be of interest to test this rule when cases of this type come before us. One case of acute appendicitis was attended within seven hours of onset of symptoms, (pain in region of umbilicus, nausea, no fever, pulse normal); no pain nor tenderness in region of appendix. On a second examination a few hours later, the general condition was worse and there was definite localised pain over appendicular site. Operation four hours later showed an appendix on the point of rupturing and full of dark brown loetid smelling fluid. There was no sign of any adhesions which would have prevented the toxic fluid setting up a general peritonitis. Another case seen soon after onset of pain had symptoms of intestinal colic but no indication of the appendix being the source of the trouble; visited a few hours later pain and tenderness were localised in right iliac fossa and early operation demonstrated that appendix had perforated. The practical application of the above is that all cases of severe abdominal pain lasting more than six hours should be kept under close observation so that a definite diagnosis may be made at the earliest moment, if the case cannot be diagnosed on the first examination. While appendicitis does not occur as frequently in Chinese as in Europeans, the condition is by no means rare. In the Alice Memorial and Affiliated Hospitals eight cases were operated upon in 1921 and six in 1922; they were cases of the severest type and no doubt many other cases occur which do not come under Western treatment. It need hardly be emphasised that examination per rectum will often yield valuable information in regard to an appendicular abscess which abdominal examination alone has failed to detect.

Acute salpingitis has been confused with appendicitis, but careful vaginal examination clears up the diagnosis. As the cases were sent to hospital early they were placed under favourable conditions for further observation, and appropriate treatment resulted in the symptoms subsiding. Ectopic gestation, (if on the right side) may closely resemble appendicitis. It should be remembered that the condition is common and also that many cases do not present the symptoms of severe internal haemorrhage. It has been possible to recognise and

operate on cases before serious hæmorrhage has taken place which is the most favourable time for operation. Some cases have been advised to undergo operation but as the symptoms did not seem to the patients urgent enough to demand operative measures, they refused; one or two returned later for operation. Acute intestinal obstruction, acute intussusception, rupture of gastric or duodenal ulcer have their special signs and symptoms and should be borne in mind when urgent abdominal pain is present; the common sites of hernia should be examined. A small femoral hernia may exist without patient giving any history to call attention to the fact. A patient is suddenly seized with severe abdominal pain and enquiry brings out the information that some unripe fruits or other indigestible food have been eaten a few hours previously; the symptoms seem to point to intestinal colic and satisfied with this diagnosis a purgative or opium is given. Some relief results and urgent symptoms are allayed for a time, but if they are due to an acute surgical condition valuable hours have been lost. From a surgical standpoint it is difficult to find a satisfactory explanation of failure to recognise that a serious abdominal catastrophe has occurred; opium is the worst possible treatment.

Difficulty in diagnosis is sometimes due to the fact that more than one condition is present in the same patient. A recent case was one of severe injury at ankle joints with continued high temperature, though the local condition was improving; the patient was found to be suffering also from Typhoid Fever. A patient had Appendicitis complicated with miscarriage. Another difficulty results from the treatment by native methods which mask the symptoms of the disease.

The regular medical attendant is usually the first to be consulted whatever the condition may be and his advice has great influence with the patient. The advice regarding nearly all tumours should be that operation should be done without delay. The recent advances in Pathology teach that the distinction between malignant and non-malignant tumours is not as sharply defined as was formerly supposed.

The object of this short paper is to suggest lines of thought which it is hoped will lead to the practical result that accurate diagnosis of every case will be the goal towards which all students and graduates alike will strive. Distrust the obvious.

A STUDY OF THIRTY CASES OF CIRRHOSIS OF LIVER

BY

G. E. AUBREY, M.D. (LONDON.)

Late Visiting Physician, Government Civil Hospital

Case	Sex	Age	Size of Liver	Ascites	Spleen	History of Gonorrhoea	History of Syphilis	History of Malaria	History of Dysentery	History of Alcohol	Clonorchis	Blood	Urin	Wassermann	Summary of Causes
1	F	40	Large	+	+	0	0	Prob-able	0	Very little	0	Normal	Normal	+	(1) Syphilis
2	M	38	Small	+	N	0	0	0	0	0	+	Normal	Normal	-	(1) Clonorchis
3	M	43	Small	+	N	0	0	0	Yes	0	0	Normal	Normal	-	(1) Dysentery
4	M	48	Small	+	N	0	0	Yes	0	0	0	Normal	Normal	+	(1) Syphilis (2) Malaria
5	M	39	Small	+	+	0	0	Yes	0	oz. xxx a day	0	Normal	Normal	+	(1) Alcohol (2) Syphilis (3) Malaria
6	F	40	Large	+	++	0	Yes	Yes	Yes	0	0	Normal	Normal	+	(1) Syphilis (2) Malaria (3) Dysentery
7	F	40	Large	+	N	0	0	Yes	Yes	0	0	Normal	Alb. trace	+	(1) Syphilis (2) Malaria (3) Dysentery
8	M	50	Large	+	+	0	0	Yes	0	oz. x a day	0	Normal	Pus	-	(1) Alcohol (2) Malaria
9	M	38	Large	+	+	0	0	0	0	oz. xx a day	+	Eosinophils 20% L. Mono 4%	Casts	-	(1) Alcohol (2) Malaria

A STUDY OF THIRTY CASES OF CIRRHOSIS OF LIVER—Continued

Case	Sex	Age	Size of Liver	Ascites	Spleen	History of Gonorrhoea	History of Syphilis	History of Malaria	History of Dysentery	History of Alcohol	Clonorchis	Blood	Urine	Wassermann	Summary of Causes
10	M	35	Large	+	++	0	0	Yes	0	Pints 4-6 a day	0	L. Mono 6%	Normal	—	(1) Alcohol (2) Malaria
11	M	46	Small	+	+	0	Yes	Yes	0	0	0	Normal	Alb.	+	(1) Syphilis (2) Malaria
12	F	41	Large	+	N	Yes	Leuco. derm. edge of Scalp	0	0	oz ii a week	0	Normal	Normal	—	(1) Alcohol (2) ? Syphilis
13	M	31	Small	+	N	Yes	0	0	0	oz xii a day	0	Normal	Normal	—	(1) Alcohol
14	M	30	Large	+	N	Yes	Yes	Yes	Yes	0	+	Poikilocytosis	Normal	++	(1) Syphilis (3) Malaria (2) Dysentery (4) Clonorchis
15	M	30	Small	+	++	0	0	Yes	0	0	0	Normal	Normal	—	(1) Malaria
16	M	30	Small	+	+	0	0	Yes	0	0	+	L. Mono 6%	Normal	—	(1) Malaria (2) Clonorchis
17	M	46	Small	+	+	0	0	0	0	oz xii a day	++	Normal	Normal	—	(1) Alcohol (2) Malaria (3) Clonorchis
18	F	46	Small	+	++	0	0	Yes	0	0	0	Normal	Normal	—	(1) Malaria
19	M	26	Normal	+	++	0	0	Yes	Yes	0	0	Normal	Normal	—	(1) Malaria (2) Dysentery
20	M	19	Normal	+	+	0	0	Yes	Yes	0	0	Normal	Normal	—	(1) Malaria (2) Dysentery

A STUDY OF THIRTY CASES OF CIRRHOSIS OF LIVER—Continued

Case	Sex	Age	Size of Liver	Ascites	Spleen	History of Gonorrhoea	History of Syphilis	History of Malaria	History of Dysentery	History of Alcohol	Clonorchis	Blood	Urine	Wassermann	Summary of Causes
21	F	33	Normal	+	+	0	0	Yes	0	0	0	10% Eosinophils	Normal	-	(1) Malaria
22	M	60	Large	+	0	0	Yes	0	0	oz viii a day	+	Normal	Normal	+	(1) Alcohol (2) Syphilis (3) Clonorchis
23	M	43	Very Large	+	0	0	Yes	0	0	0	+	Normal	Normal	+	(1) Syphilis (2) Clonorchis
24	M	49	Large	+	0	0	0	0	0	0	0	Normal	Normal	+	(1) Syphilis
25	M	49	Small	+	0	0	0	0	0	oz viii a day	+	Normal	Normal	-	(1) Alcohol (2) Clonorchis
26	M	60	Small	+	+	0	0	Yes	0	oz ii a day	+	Normal	Normal	-	(1) Alcohol (2) Malaria (3) Clonorchis
27	F	42	Large	+	+	0	0	Yes	0	0	0	Normal	Normal	+	(1) Syphilis (2) Malaria
28	M	30	Small	+	++	0	0	Yes	0	0	0	Normal	Normal	-	(1) Malaria
29	M	52	Small	+	0	0	0	Yes	0	0	0	Normal	Alb. casts	+	(1) Syphilis (2) Malaria
30	M	26	Small	+	++	0	0	Yes	Yes	oz. ii a day	+	Normal	Normal	+	(1) Syphilis (2) Malaria (3) Alcohol (4) Clonorchis (5) Dysentery

ALCOHOL

List of Chinese Wine.

Not more than 25% of Alcohol by weight.

Liu Pun	Ki Kuk	No Mai
Sheungching	Mow Kan	Sam Pin
Yuk Lan	Fung Shup	Ning Mung
Wai Sang	Tit Ta	Kam Ying
Muk Kwa	Nam Tso	Shun Fung
She Tsau	Wu Tau	Chang Tsau
Shut Lee	Shiu Hing	Sam Kat
Ngan Fa	Lung Shan	Mo Kai
Yan Nin	Wu Kuek	Kam Kwat
Pak Hok	Pow Lee	Kap Kai

Not more than 35% of Alcohol by weight.

Sam Ching	Heung Ip
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Not more than 45% of Alcohol by weight.

Fa Tsau	Sz Ching	Mui Kwai Lo
Sz Kwok Kung	Ng Ka Pei	Ko Leung Kon
Kwai Fa Lo	Yan Chan Lo	Fu Kwat Muk K wa
	Ping Kwo Lo	

50% to 55% of Alcohol by weight.

Ng Ching

Above 55% of Alcohol by weight.

Fan Tsau

The Analysis of Fan Tsau is as follows:—

Alcohol. (Per cent. by Volume) - - 53.60

	<i>Per cent. by weight</i>
Alcohol - - - -	45.890
Vol. Acidity - - - -	0.0791
Esters - - - -	0.0844
Higher Alcohols - - - -	0.0990

Usually expressed as grams per 100 litres of the absolute alcohol contained on the sample thus:—

Vol. Acids - - - -	- 147.6
Esters - - - -	- 157.5
Higher Alcohols - - - -	- 184.7

The Analysis of Liu Pun is as follows:—

Alcohol. (Per cent. by Volume) - - 28.43

	<i>Per cent. by weight</i>
Alcohol - - - -	23.33
Vol. Acidity - - - -	0.0506
Esters - - - -	0.0432
Higher Alcohols - - - -	0.111

Usually expressed as grams per 100 litres of the absolute alcohol contained on the sample thus:—

Vol. Acids - - - -	- 178.0
Esters - - - -	- 151.9
Higher Alcohols - - - -	- 391.3

The Analysis of No Mai is as follows:—

Alcohol (Per cent. by Volume) - - 22.11

	<i>Per cent. by weight</i>
Alcohol - - - -	18.020
Vol. Acidity - - - -	0.0598
Esters - - - -	0.0623
Higher Alcohols - - - -	0.3062

Usually expressed as grams per 100 litres of the absolute alcohol contained on the sample thus:—

Vol. Acids - - - -	0.0598
Esters - - - -	0.0623
Higher Alcohols - - - -	0.3062

The cost of these wines vary from 1.5 C. for the weaker to 4 C. per oz. for the stronger varieties, or from 8d to 1s. 4d. per pint. Among these cases alcohol appears as the only cause of Cirrhosis in one case alone, as the chief cause in 8 cases, and as a subsidiary cause in 2 cases. 11 cases in all, or 36.6%.

It is probable that anything from 2 oz a day upwards plays a considerable part in its production.

The average age of these alcoholic patients is 43 years, and in the case of its occurrence in young persons, alcohol has either been taken in large quantities, or some other efficient cause for its production has been present. In 6 cases the liver was small, in 5 large.

Though Samsu is an efficient means of producing Cirrhosis, it apparently does not often injure the Chinese nervous system. None of these cases had peripheral neuritis. It is difficult to estimate the incidence of alcoholic neuritis, as so many of these people owing to their poor diet, have, or are living on the verge of, peripheral neuritis, and a serious illness often precipitates its occurrence. It should be noted that only one of these cases was a female.

Syphilis.

Syphilis appears in these cases 14 times, or 46.6 per cent.

Twice as the only cause, 9 times as the principle cause, and 3 times as a minor cause.

It would appear that syphilis is as potent a cause of Cirrhosis as alcohol, if not more so.

The average age of these patients is 42.6, practically the same as that of the alcoholic patients.

Five cases were female, and 9 male.

A much larger proportion of female than in the case of alcohol, which is almost confined to men.

In 9 cases the liver was enlarged, and in 5 smaller than normal.

When a syphilitic liver is very large, it frequently contains gummatous masses.

Thirteen out of these 14 cases gave a positive Wassermann reaction. The large incidence of syphilis among these cases must not be taken as an indication that this disease is more liable to injure the Chinese liver than that of European, but as the reflection of the fact that about 40 per cent. of the population have syphilis.

Malaria.

It is probable that the majority of these cases have at some time or another had Malaria.

21 have certainly had it.

Of these 21 cases 17 have enlarged spleens, and the remainder, though not having any palpable enlargement, have a definite history of Malaria.

There were 4 cases in which Malaria stands alone as the cause of Ascites.

3 cases in which it is the principle cause, and 14 cases in which it plays a part.

The average age of the 7 cases in which Malaria plays the only, or chief part, is 30.5 years, considerably lower than that of alcohol and syphilis.

Many of these cases were probably infected in childhood.

In 4 cases the liver was small, in 3 of normal size.

Malaria does not greatly alter the size of the liver, as does alcohol and syphilis.

The spleen in 4 cases was very large, and in 3 fairly large.

Dysentery.

Dysentery probably does not play a great part in producing a Cirrhosis sufficient to give Ascites.

In only one case does it stand alone as the cause, and it appears as an auxiliary cause in 6 more.

In none of the cases has there been evidence of a liver abscess.

In the first mentioned case, there had been a very long history of blood-stained diarrhoea in a man of 43 years. The liver was small.

Clonorchis Sinensis.

Clonorchis eggs were found in 9 cases giving a 30 per cent. infection.

In no case does it stand alone. This percentage is greater than the average infection of this class of patient, which is about 12 per cent. Clinical evidence such as this is not alone sufficient to base any conclusions on.

I would require Post mortem evidence, and the exclusion of all other possible sources, before one could establish *Clonorchis Sinensis* as the cause of Cirrhosis.

Treatment.

The only causes which allow of much hope are syphilis (especially when gummata are present) malaria, and dysentery.

It is well therefore to use Potassium Iodide vigorously, and give a course of Emetine to start with; in any case suspected of either of these diseases.

This should be followed by the prolonged use of Quinine, Iron, and Arsenic.

There is no effective treatment for *Clonorchis Sinensis*.

**THE POWDERING EFFECTS OF PISTOL SHOTS
AT SHORT RANGES.**

by

D. J. VALENTINE, M.R.C.S., L.R.C.P.

In Hongkong, where shooting affrays are of fairly frequent occurrence, the effects of pistol or revolver shots possess more than a passing interest, especially from the medico-legal point of view. The medical man in Court is frequently asked at what range certain shots were fired, so that, the more he has learned about their effects from his own experience or that of others, the more valuable will be his evidence. This far from exhaustive article aims at reaching some conclusions on the relation between range and powdering effect.

Weapons used:—Three very common types, *e.g.*:—

.32" Automatic (Carl Walther)

.38" Automatic (Colt)

.45" Revolver (Webley, with 7" barrel)

Ammunition: The so-called smokeless cartridges for each arm were used; in the two smaller types the bullet is nickel-coated but in the .45" Webley it is of uncovered lead, a small card was separating it from the cordite charge.

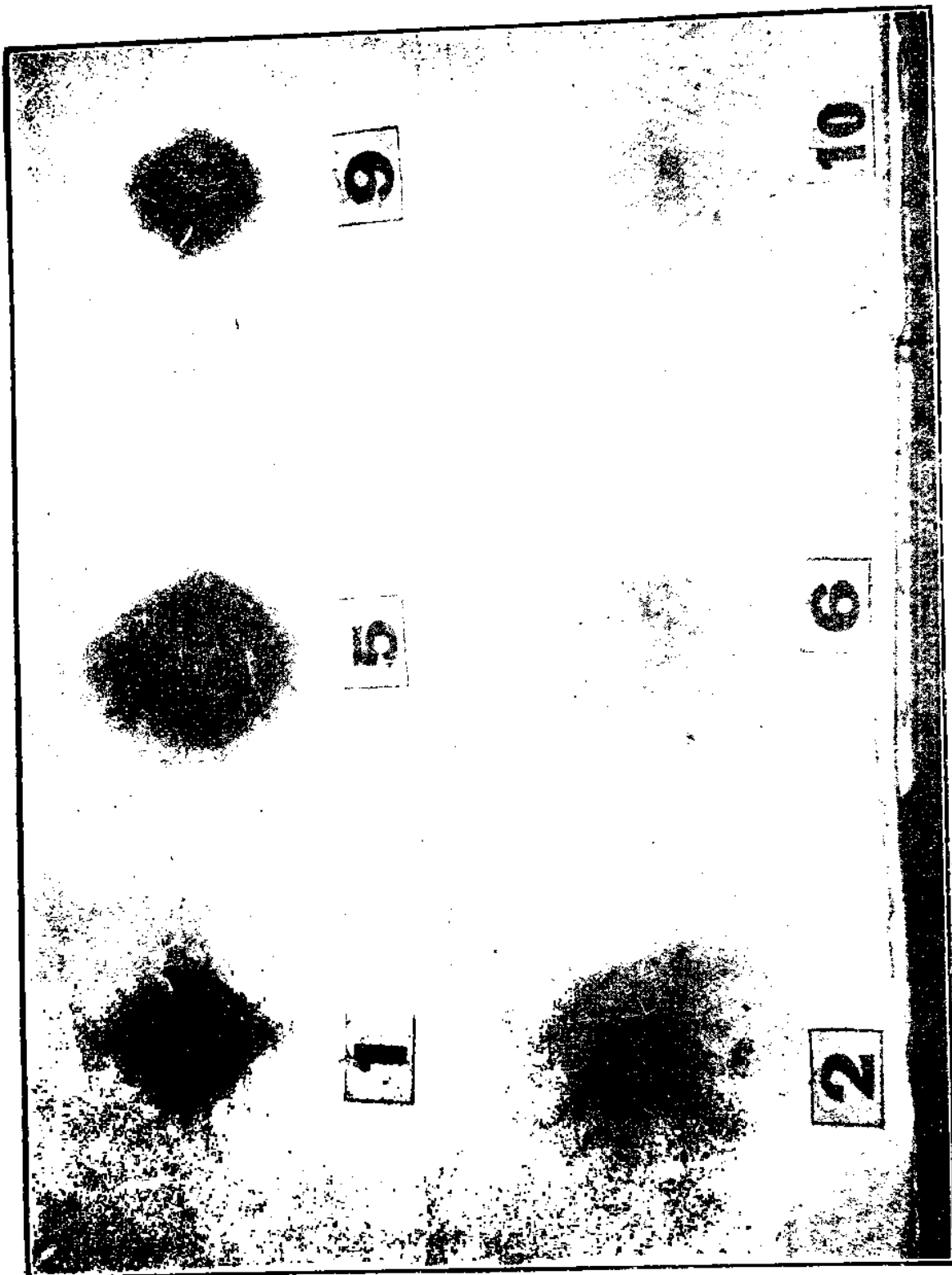
Targets: As most bullets pierce clothing before entering the flesh, white calico was wrapped in four layers on a fairly dense cushion, to imitate actual conditions and to show up the powdering.

Ranges: (a) actual contact; (b) six inches; (c) one foot; (d) two feet.

(a) *Photographs Nos. 1, 5, 9.*

When the muzzles were held lightly pressing against the calico a black central area was formed in each case. These areas fade gradually to the periphery. Immediately after firing a few specks of unburned cordite remain on the calico, but can be easily detached by brushing, unlike the blackening or powdering which cannot be removed, and which, though not actual charring, extends through three layers of calico, but not to the fourth.

The central bullet hole of the .45" (Photo 1) is small and circular, but in the case of the automatics (.38", Photo 5; .32", Photo 9) is large and cruciate, owing to the engagement of the material between the barrel and the moving parts which recoil, with consequent tearing, combined, perhaps with the greater velocity and volume of gas from the automatics, which have no space between chamber and barrel, as has the revolver, to permit of the escape of gas.



9

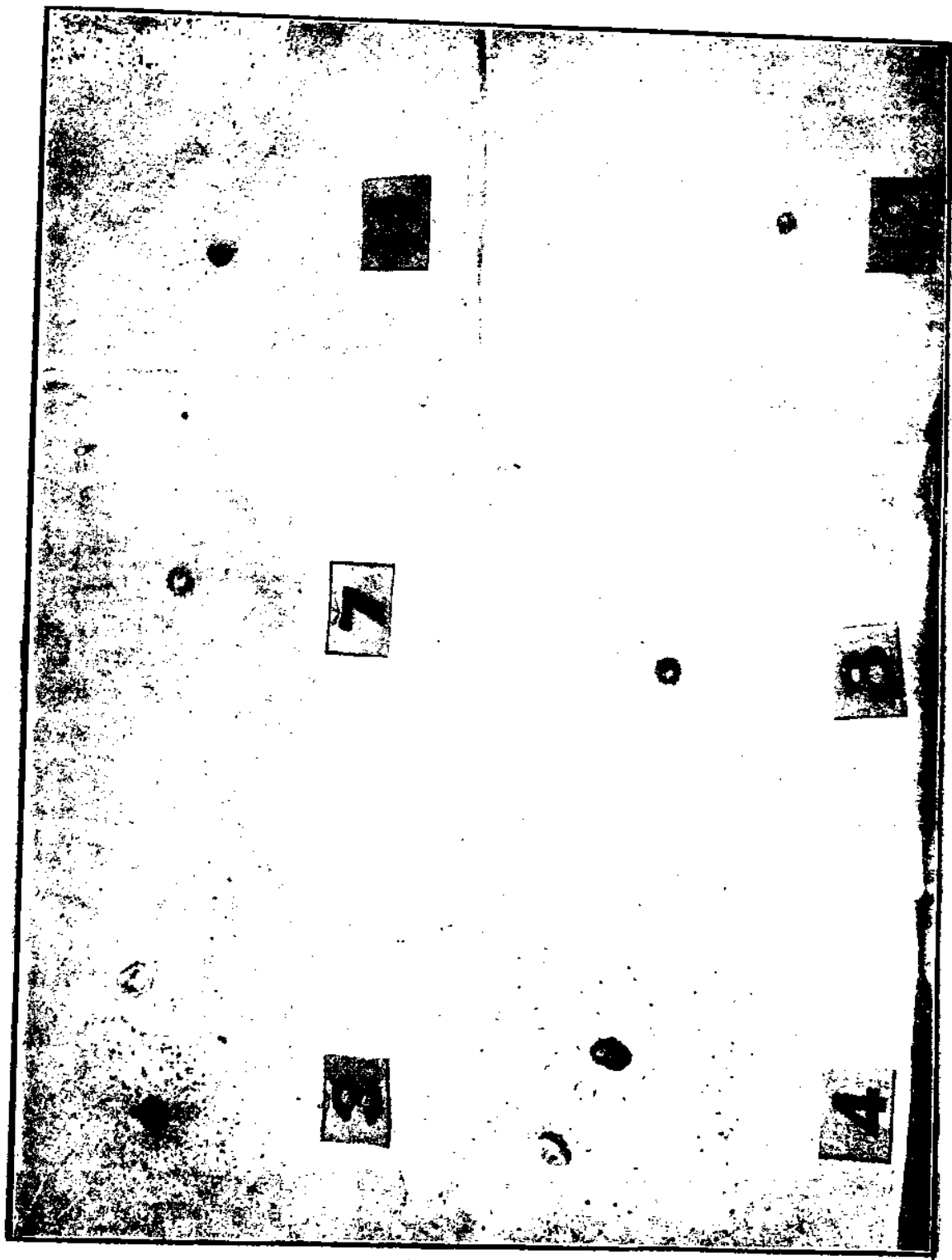
10

10

6

1

2



(b) Photographs Nos. 2, 6, 10.

At six inches range two distinct kinds of effect are superposed; diffuse powdering and speckling. The latter is due to pieces of cordite, not wholly consumed before impact and in addition (with the .45" only) to fragments of lead bullet torn off by the rifling and sprayed on the target. The former, or diffuse powdering, is a general effect of roughly circular shape, covering uniformly about the centre but fading to the edges.

The second layer of cloth is hardly discoloured at all. Each bullet-hole is circular. The wad impression of the .45" is clearly seen below the hole.

(c) Photographs Nos. 3, 7, 11.

At one foot range the diffuse powdering has almost disappeared. The speckling is still seen, though the particles are not nearly so numerous except with the .45", where they are mainly lead spray (*vide* 6). There is no blackening of the second layer, but the holes of the first are black-edged. The wad of the .45" remains.

(d) Photographs Nos. 4, 8, 12.

Here the automatics show no speckling, but only a small round hole with blackened edge, this blackening being very faint in the case of the .32".

The specks from the .45" are still numerous, but not so crowded, extending over a four inch square. The wad mark is distinct, an inch and a half from the heavily margined bullet hole.

.45" REVOLVER ONLY.

The .45" revolver was fired again at ranges of 3, 4 and 5 feet. These are not illustrated. The specks were more scattered as the range increased. At three feet there were some specks three inches from the bullet hole, the pad showing as a definite impression two inches from the hole.

The effects four and five feet are similar. The specks are so few that they can be counted (7 and 6 respectively) all within two inches of the bullet hole, whose margin is still very black. At four feet and over there is no evidence of the pad mark.

Conclusions: It must be borne in mind that these apply only to the above types of pistol and ammunition.

(1) When diffuse powdering is present, apart from the amount of speckling, the range is six inches or less.

(2) When under layers of clothing are discoloured, the range is less than six inches, and probably the pistol was in contact with the target.

(3) With a .32" or .38", speckling indicates a range of less than two feet.

I am indebted to Messrs K. W. Lane and J. Murray for the use of the arms and ammunition and also for useful assistance. I have also to thank Mr. E. R. Dovey for kindly taking photographs of the calico targets.

LEADING ARTICLES

A PATHOLOGIST'S FIRST IMPRESSION OF HONGKONG.

by E. P. Minett, M.D., D.P.H., D.T.M. & H.

Probably the first impression made in a new comer to the medical world of Hongkong, especially if he is an experienced observer, is the small size of the Government Medical Service, in comparison with the population and the wealth of the Colony. Later he learns that the Colony was not always so populous or so wealthy and that the growth of the Colony has outstripped the Medical Service. The "statu quo" or balance between supply and demand is made up by the presence of a fair number of well qualified private medical practitioners, both European and Chinese, holding British qualification together with a gradually increasing number of graduates from the University. The native Chinese medical men are also allowed to practice in the Colony although not holding a modern qualification and recognised at certain public institutions. So that the public is catered for in the medical sense much better than would at first appear possible.

If the new comer is a Pathologist he will at once be struck by the abundance of material to be found in the Public Mortuary daily. The University as a teaching centre is particularly fortunate in this respect, and the student at Hongkong University has a far better opportunity of studying his morbid anatomy and pathology than students of the greater European universities, where the opportunity for post-mortem examinations is often limited to a very few cases, at irregular intervals

The daily average of cases at the Mortuary is about 12, the variations being between 29 cases to never less than 6 or 8 cases. The Mortuary is open to all senior students of the University and to any medical practitioner by asking permission of the Medical Officer in charge

This abundance of material gives the Hongkong students a very great advantage in seeing the effects, on the various organs of the body, of diseases diagnosed during life.

Unfortunately the abundance of material is negated by the absence of any history before death, so that in forming his opinions as to the conditions to be noted during life the student is heavily handicapped.

If any sort of a history of illness could be available the opportunities for teaching at Hongkong University would be almost unrivalled. Half the value of a Post-mortem examination is the following up of the diagnosis made by the Physician during life. The proving of its correctness or otherwise constitutes a most important asset in the training of a Physician to the correct interpretation of signs and symptoms noted during life.

A diagnosis made during life and subsequently proved to be correct on post-mortem examination is a great joy to a keen Physician or Surgeon and a diagnosis which turns out to be incorrect is a valuable source of knowledge available for future reference.

The opportunities for original research are practically unlimited, The Government Medical Service are too busy with routine work to follow up this branch to any great extent. Therefore it is to the University that this work must be handed over, and as time goes on I have no doubt that some most interesting results will be attained and published. The greatest authority on Tropical Medicine who ever lived, did most of his original research in Hongkong and there is abundance of material for others to follow in his footsteps.

SOME NATIVE CURES AND SUPERSTITIONS.

by

E. H. LIM, M.B., B.S.

In a short article like this, it is almost impossible to go into details about what I am writing. It has taken me quite a long time to select out those native cures and superstitions of which I know, which have some bearing on modern medical science. I, however, do not recommend my readers to practise what they are about to read.

As a prophylaxis to furunculosis and any dry skin diseases, soup prepared from the frog's, the tiger's or deer's flesh or from the boa-constrictor, taken 20 ounces at a time for three consecutive nights just before bed-time is highly recommended.

It seems almost incredulous that the native woman after parturition who has an offensive lochia would drink the urine from any male child. The first few ounces of urine is passed off and the rest collected and taken by the patient once daily. This is credited to clear off the offensive lochia in a week's time.

Babies suffering from whatever diseases, be it gastritis, enteritis, congenital syphilis, excessive crying at night etc., are cured in a most peculiar manner. The father or any male relative of the child is to go to the garden before dawn and fetch the young cocoanuts which have fallen down from the trees overnight. He is to kick the cocoanuts round in a circle muttering these words "Baby must not cry to-night, baby must get well soon, baby must not cry to-night" He then brings home three of the youngest cocoanuts to the mother of the child, who chews the tenderest part of the husk into a bolus. This is then applied to the anterior fontanelle of the baby just after twilight.

The thorns of pomegranate trees are reputed to have antiseptic powers. The native surgeons use them to open up carbuncles and boils. If the thorns are pounded up and mixed with some native plaster, it serves as a good counter-irritant in cases of flatulent dyspepsia, appendicular colic and vomiting.

Burns and scalds, if treated from the very beginning with Chinese sauce (Soyabean Sauce) heal up very rapidly, besides preventing shock in the beginning.

The dry gall-bladder of the boa-constrictor is given in 1 to 2-grain doses in hot water for cases of measles. The mixture is very bitter. This is supposed to prevent the rising of any complications.

For insect stings dandruff mixed with olive oil has a remarkable effect. The inflammation, after the application, is very mild in character and pain is never greatly complained of.

For cases of acute coryza or bronchitis, cockroaches have been extensively used. In cases of coryza, the head, legs, wings and intestines are taken off and the rest baked until a fine smell exudes. This is then taken hot, 6 or 7 cockroaches are the usual dose. Decoctions of 6 or 7 cockroaches intact are prescribed for bronchitis.

For the diagnosis and treatment of typhoid fever, flour and the white of eggs are used. These two are mixed until it has a doughy consistence. A copper coin soaked in olive oil is used to scrape the abdomen until a slight ecchymosis is produced. The dough is rolled over the ecchymosed areas for 5 to 10 minutes. Substances like "horse's hair" are reputed to be found inside the dough, when broken up. These "horse's hair" are alleged to be the toxins of typhoid. If the test is positive for the first time, the diagnosis is made and a series of similar tests are performed for the complete cure of the patient.

Among the most well-known superstitions is the one known as the "calling back of the soul." Children who have convulsions or have been frightened in any way are supposed to have lost their souls. Old quack ladies are called in to put back the soul into the body. Candles are lighted and an offering is made to the devil. The quack lady repeats some chantings only known to herself which is supposed to bring back the soul. An old mat belonging to the family is used by the quack to strike an old suit of clothing of the child. The clothing is spread on the floor and the sounds made with the mat is intermingled with muffled chantings of the quack lady. The idea is to drive away the evil spirits so that the timid soul of the child may come home.

For a case of prolonged labour, the natives have a peculiar custom of hastening birth. The locks, doors, windows, lockers, drawers and every conceivable closed box are thrown open. This, the natives believe, helps to dilate the passage for the rapid birth of the child.

Barren mothers always look ahead to the birthdate of some fruitful mothers. Squatting over the placenta is believed to bring about conception at the next period.

A superstition in connection with plague epidemics is highly interesting. The natives believe that during an epidemic a certain god tours round the district in an invisible boat. The souls of those who died of plague are supposed to go on board the boat whose ultimate destination is some place in Hades. The following ridiculous custom is therefore observed by the natives during an epidemic.

When the death rate in a village of about 400 souls reaches the figure of 10 daily, the elders give instructions to build a paper boat of considerable size. This boat is secured on a flat board. It is then carried to the front courtyard of the village temple, where the hired monks make offerings to the god with the usual prayers and chantings. The ceremony is only attended by the bravest in the village and is very solemn throughout. The terror of death is on everybody's face. At the end of the offering, drums and gongs are beaten furiously and a few dare-devil lads of the village shoulder the boat. They make away in a breakneck speed with other people beating the drums and gongs and shouting closely at their heels. The boat is carried thus to the nearest river or streamlet. As soon as it is set on fire, it is gently lowered into the water and pushed away. The drums and gongs are beaten afresh; other people yell till they are hoarse; and the boat burns till the board is only seen floating on the river. Thus the natives make peace with the plague god and hope that the epidemic would cease, with a most logical conviction that if the god has such a hearty send-off, he is not likely to revisit the land.

MEMORANDA.

MEDICAL UNITS IN AMERICA.

by

PROFESSOR J. ANDERSON, M.A., B.Sc., M.D., CH.B., D.T.M. & H.

Twenty years ago, Professor Schäfer of Edinburgh University in an address to the medical students of Leeds made the following significant statement:—

“It is certainly not a little remarkable that the American Universities when placed in the possession of adequate endowments, make no attempt to increase the number of their graduates by a lowering of standards, but aim entirely at attracting students both by the thoroughness and efficiency of their teaching and by the facilities for post-graduate study and research which they offer in all departments of science and medicine. The natural result of this must be that these universities will not only obtain the pick of the American students, but will, as years go on, attract students from other countries, so that eventually the centre of gravity of medical science will become shifted westward.”

In the closing years of the Great War, this prediction came so palpably near to fulfilment that the Medical Schools of Great Britain suddenly woke up to the necessity for a thorough revision of their teaching methods. England, relying on the traditions of two centuries, still turned out an occasional brilliant scientist or surgeon; America, adopting the system of separate clinics developed in Germany, had raised the general level of efficiency of all her graduates. England was still inclined to regard the distinguished practitioner as the most competent teacher; America had realised that medical education was an educational rather than a medical problem.

The British Medical Schools turned their attention to the educational system which had met with so much success on the other side of the Atlantic and their interest became fixed on the organisations known as teaching units.

On a recent journey from London to Hongkong, I had the privilege of visiting various teaching centres in America and Canada and of studying at close quarters the unit systems operating in the principal medical schools. The itinerary occupied about ten weeks, and included the Johns Hopkins Medical School at Baltimore, the National Research Institute at Washington, the Pennsylvania University at Philadelphia, the Rockefeller Institute, and the Presbyterian Hospital at New York, Harvard Medical School at Boston, Yale Medical School at New Haven, the University of Toronto, the Rush Medical College at Chicago, and the Mayo Clinic at Rochester.

The systems of teaching in the various schools are modelled on similar lines, and it will be sufficient to give the details of one of the most highly developed institutions such as the John Hopkins Hospital and Medical School.

Prior to entering the Medical School, the student is required to attend a university course which includes Physics, Chemistry, and Biology. This course lasts for four years and leads to the degree of A.B.

In the Medical School, the course again occupies four years and leads to the degree of M.D. The first two years of this course are devoted to the fundamental medical sciences such as Anatomy, Physiology, Pharmacology, and Pathology. The third and fourth years are devoted to practical instruction in medicine, surgery, and obstetrics.

The clinical instruction of the two final years is conducted in the various units, and each student must spend a certain number of hours in (a) The Medical Unit, (b) The Surgical Unit, (c) The Obstetrics Unit, (d) The Pediatrics Unit, (e) The Psychiatry Unit, (f) several smaller elective units.

The Medical Unit is probably the strongest and has a staff of nearly fifty full-time teachers and investigators.

The Director holds the title of Professor of Medicine and it is interesting to recall that the first occupant of this chair was Sir William Osler. The present incumbent is Professor W. T. Longcope to whom I owe a deep debt of gratitude for his kindly hospitality and his constant desire to make my stay in Baltimore instructive as well as interesting.

The duties of the Director included the arrangement of all the classes in Systematic and Clinical Medicine and the correlation of the work done in the special departments. Each special department is in charge of an Associate-Professor, who gives clinical instruction on his particular branch of medicine.

Thus there is an associate-professor in charge of the department of Clinical Pathology, an associate professor in charge of Cardiology, another in charge of Bio-chemistry and Metabolism, a fourth in charge of Tuberculosis, a fifth in charge of the Luetic department, and a sixth in charge of Neurology. Each special department is accommodated in a separate suite of laboratories, and under each associate-professor there are several instructors and assistants.

The clinical material available for the service of the unit consists of 60 beds in the hospital, and a very large out-patient department.

The number of students who apply for entrance to Johns Hopkins Hospital runs into several hundreds, but the classes are strictly limited to 75 for each year. When this number is divided up amongst the various teachers of the unit, the clinical classes seldom exceed about 15 students and the instruction becomes practically tutorial.

To a visitor from Europe, perhaps the most striking feature of this institution—as of all similar institutions in the United States—is the wealth of equipment in their laboratories. In this respect the generosity of private benefactors has placed America in an enviable position.

Rivalries abound amongst the colleges of every country, and in America there is a famous and healthy rivalry between the medical schools of Baltimore and Boston. The Harvard Medical School situated in the most attractive part of Boston, is a magnificent building in grey marble, with spacious laboratories planned on modern lines and thoroughly well equipped. Here the student spends two years over his intermediate medical sciences.

His two final years are spent in one of the great hospitals of the city, the best known of which is the Massachusetts General Hospital. In the three principal hospitals there are medical, surgical, obstetrical, and other units organised on lines similar to the Johns Hopkins Hospital.

At the Boston City Hospital, an interesting innovation in clinical education has just been launched. A compact specially-planned building has been erected in the centre of the hospital grounds and two of the floors have been set apart as wards for a limited number of patients. The rest of the building has been divided up into special laboratories and furnished with the most modern equipment applicable to clinical medicine. The Director is one of the Harvard Professors of Medicine and under him there is a staff of specialists in charge of the various departments, such as clinical pathology, neurology, and cardiology. The small group of cases admitted to the wards can be selected from the large general hospital surrounding the unit building, and in this way the Director can have his beds filled entirely with the type of disease which he proposes to demonstrate or on which he wishes to concentrate all his resources of investigation. As soon as the demonstration or investigation is completed, the cases can be transferred to the general hospital and a fresh series admitted to the unit service.

In New York, the Rockefeller Institute conducts a hospital department on somewhat similar lines, but it is not a teaching institution, and the whole effort of the staff is concentrated on research. As a rule only one medical problem is taken up at a time, and a limited number of patients, selected as illustrative of the problem, are drafted into the Hospital. The highly organised staff, each member of which is a recognised specialist in his own line, is then in a position to make an intensive study of the problem and carry out the various lines of investigation. The large volume of original contributions emanating annually from this source, is evidence of the activity and the scientific importance of the department.

The medical units attached to the Presbyterian and the Bellevue Hospitals in New York, to the University College Hospital in Philadelphia, and the Yale Medical School in New Haven are staffed by full-time professors and associates and each centre has a particular flair towards some special branch of clinical medicine. In New York one becomes most interested in Basal Metabolism; in Philadelphia the keynote of medical progress seems to be Clinical Pathology; in New Haven, the visitor becomes stimulated with its atmosphere of Psycho-physiology.

In Toronto and in Chicago, the teaching of clinical medicine is largely in the hands of visiting physicians, but in each place there are facilities for research and investigators of a calibre sufficient to give life and inspiration to the whole medical school. I spent a week in Toronto with the team which was associated with Dr. Banting in his work on Insulin, and in Chicago I realised, under the guidance of Dr. Sippy, the full importance of the subject of Dietetics.

The Mayo Clinic at Rochester is an organisation *sui generis*. The rise of the brothers, William and Charles Mayo, from the position of country practitioners to that of world-famed surgeons will remain one of the romances of medical history. Founded on a commercial basis, the Clinic takes no part in undergraduate teaching, but a definite proportion of the annual income is put aside for medical endowments and research fellowships, and the facilities at Rochester are almost unlimited. As time goes on, the Clinic is likely to become a considerable factor in the medical education of America.

From Rochester I travelled across the Canadian border and over the Rocky Mountains to Vancouver.

In connection with this tour, I wish to acknowledge my great indebtedness to the Rockefeller Foundation. Dr. R. M. Pearce, the Director of Medical Education, kindly drew up the schedule of visits, and provided me with all necessary letters of introduction. Dr. Vincent, the President, and the other officers of the Foundation gave of their expert knowledge and the resources of their departments with unflinching courtesy.

I am also under a debt of gratitude to the distinguished medical men with whom I came into contact in the various teaching centres. I shall always remember and admire the friendly spirit and genuine hospitality of the medical profession in America and Canada.

**THE FIFTH CONGRESS OF THE FAR EASTERN
ASSOCIATION OF TROPICAL MEDICINE HELD AT
SINGAPORE FROM 3rd TO 17th SEPTEMBER 1923.**

This meeting was the fifth since the inauguration of the Association in Manila in 1908.

The object of the association is to promote the science and art of tropical medicine in the Far East.

The advance of medical knowledge can only be promoted by the frequent intercourse of those who are working out the problems of medicine. The greatest hindrance to scientific advancement in the tropics is scientific loneliness; men working singly get their minds set in grooves, which require to be corrected at frequent intervals. The meeting of the association in Singapore has fulfilled its function of promoting the science and art of medicine in the Far East. This result has been achieved by the meeting together, both socially and scientifically, of men of different minds and races, in order to discuss the subject of medicine without regard to national boundaries.

There were brought together men of different governments, different associations and different viewpoints; their results were pooled in a common melting pot, discussed at open session and afterwards in private between individuals. One tends to value the results of a meeting by its papers and discussions; but the most important results are intangible; for they arise from the private conversations between individuals.

The paramount importance of this aspect of the question was fully realised by the officers in charge of the meeting; and one must express admiration for the great hospitality shown by the people of Singapore.

Individual success in life is in great measure due to the dignity and prestige of the individual, and this cannot be asked by the individual, but is meted out to him by his fellow men. It is difficult to be successful in an undignified setting.

From the commencement the meeting was bound to be successful, in that the medical profession, and in particular the congress, was put on a high and dignified setting when the Governor of the Straits Settlements, Sir Laurence Guillemard, opened the Congress. By this act he gave expression to the importance of the meeting and throughout the whole congress, with the dinners and the garden parties at Government House, there was no possibility of those, whom he represented and governed, failing to appreciate the national importance of medicine.

The principal subjects discussed were Malaria, Beri beri, and Hookworm disease. The discussions on malaria were of great interest and showed the necessity of men meeting together to discuss their points of view. Many questions were brought forward which require further investigation. Of these the more arresting were that the

Anopheles Maculatus is a virulent carrier in Johore, whereas in Sumatra close by it is generally regarded as relatively unimportant, and at Gemas the clearing away of the scrub and undergrowth seems to have favoured the development of the *Maculatus* and to have caused serious outbreaks of Malaria. Dr. Wellington has been working for some years at Gemas and his paper was of peculiar interest. Briefly the story is that the main railway was built through the tropical jungle and, as the ground became cleared, malaria became rife; at Gemas itself an important railway junction was built necessitating a considerable amount of earth work and cutting of spurs. Whenever new ground was turned up and scrub removed the incidence of malaria increased; and the greatest difficulty was experienced in getting the work done. At this period the help of the medical profession was called in and improvement took place. Whenever the engineers went on ahead without medical consultation the malaria increased. At the present time the hospital which was built to house the patients is empty and the disease most unusual. From the economic side the work has been worth while.

Dr. Wellington has found that scrub clearing, which in some places is so effective, is in this region absolutely contra-indicated. He regards the virgin jungle as being comparatively harmless and finds that on its being disturbed malaria breaks out.

In attempting to analyse the cause of this he has come to the conclusion that the harmful mosquito is the *maculatus*, that this mosquito is rarely found in the virgin jungle and is not found in shaded pools. He regards the clearing of the scrub as acting by permitting direct sunlight to reach the water in stagnant pools, and this as favouring the breeding of the *maculatus*.

He likewise regards the turning over of the soil as in some way being a factor in the incidence of malaria.

It is frequently said that new works, and particularly those involving large earth works, are followed by outbreaks of malaria. The work at Gemas therefore should be very carefully analysed in order to get to the basis of the affair, and certain definite lines of research should be instituted.

1. Why should the turning over of earth predispose to malaria? Are there plasmodia in the soil? Or more probably is it that new earth works tend to stagnant pools and disturbed drainage?

2. If *maculatus* is uncommon in virgin soil or jungle from whence does it arise? What is its natural abode so that we may there attack it?

3. What has *maculatus* got to say about the matter? It perhaps arrives at the same conclusion; that when new earth is turned over or scrub cleared it becomes infected; it must surely also realise that where great works are carried out the number of men increase. Coolies are brought from different places and no doubt cause considerable increase of the disease. I am not in a position to be

positive; but it does appear to be that while the discussions go on as to which mosquitoes carry malaria, the most important carrier is frequently forgotten and uncontrolled, man himself. This, however, does not explain the increased prevalence of a particular variety of mosquito.

Turning from Gemas to Port Swettenham, the work of Malcolm Watson next attracts attention where the conditions are entirely different: there we have the mangrove swamps close to the sea. He says "In every part of the tropical world instances of the deadly power of malaria in coastal regions could be given. In the Malay Peninsula and Archipelago for example, the Governor, Sir Frank Swettenham, in 1901 ordered the new port called after himself to be closed, so overpowering was the malaria. "-----" Carey Island is situated on the coastal belt of such land. "-----" In 1906 the late Mr. E. V. Carey took up a concession of 30,000 acres on the island and began the planting of rubber and coconuts. The land was bunded and drained. Tide gates were necessary. "-----" To-day some 14,000 acres are under cultivation. No European—of a population of from 20 to 30—has contracted malaria on the island since 1912."

The problems near the coast have been different from those inland, and one lesson of the conference is that each locality must be dealt with without too many preconceived notions of the results obtained at other places. Another lesson is that Malaria control is worth while economically and no government can afford to neglect the question.

The discussions on Beri beri were mainly concerned with measures for the control of the supply of rice and further discussion was delayed until the next congress to be held in Japan in 1927.

Many other papers and discussions of scientific interest were read and discussed.

Dr. W. A. Sawyer of the International Health Board read a very good paper on the advantages of nation-wide and international organisation for disease control. Such a paper as he gave replies to a question so often asked after a scientific meeting: Well was there anything new? No new discovery is brought forward but rather a clear indication that it is of no use finding out things unless the knowledge is applied. The Hookworm problem in Queensland was recognised 25 years before extensive preventative work was undertaken. He describes how a complete survey of Australia was taken in hand to determine the extent of the disease. The value of such work is very great; it impresses upon public services the great economic advantage to a community in eradicating disease in childhood; it educates a whole population to the necessity of public health services, and thereby prevents the conception of curtailing, necessarily first, those services which are not directly producing a cash balance sheet; and finally it draws the attention of the general practitioner to a possible cause of obscure disease, or makes him mindful of the fact that to say a child is delicate is not always a sufficient explanation.

The Honourable Dr. A. L. Hoops in his presidential address gave an excellent summary of the aims of medicine and the extreme importance of sound health measures to a community: His paper should be read by all students in the East.

Naturally the Congress was concerned with matters of public health rather than with definitely clinical subjects and yet we had a very instructive paper of encephalitis lethargica from Dr. O'Driscoll of Sarawak; and on dysentery Professor Houghwout has added to our knowledge. Professor Houghwout read a most interesting paper on whether or no parasitology has a place in the medical curriculum; This whole question of what shall be taught to the student is becoming more and more difficult with the increase of medical knowledge so rapidly preceeding, and it is indeed a difficult matter to appreciate just what a student shall be told. Naturally the anatomist feels that two years is none too much for anatomy.

When at Kuala Lumpur we were taken to see the research laboratory of which Dr. Stanton is the director. After having seen it, and the work which has been done on Beri beri, malaria and tropical diseases generally, one is not surprised at the high opinion which the profession has of Dr. Stanton.

At the congress the members were invited to the laying of the Foundation stone of the new college of medicine at Singapore. It should be a matter of satisfaction to us to see the serious commencement of another British school of medicine in the Far East, for without the education of the people of the countries of the Far East in western medicine, discussions on preventative medicine are of little value. We offer them the heartiest good wishes and look to a new era in preventative medicine. Students have an idea that universities are built for them and I am afraid even in supposed enlightened communities the general public hold the same view. Such is however not the case, the function of a university is general, and may I say international, education.

In all the principal towns in the Peninsula I found well equipped museums, at which one could get a very good idea of the fauna and flora of the country as well as much information on anthropological and ethnological matters. We look forward to the time when our finances will permit of the founding of a good museum in the university itself.

No description of the congress is complete without mention of the amount of work in organisation and entertainment which was done by Drs. Hoop, Scharff, and Rattray.

J. L. S.

ANNOTATIONS.

Clinical Notes on Cases of Ectopic Gestation.

The following notes have reference to six cases of Ectopic Gestation which were operated upon in Alice Memorial and Affiliated Hospitals in one year. In the same year two cases were recorded

in the Public Mortuary, Hongkong. Jeffres and Maxwell in their book, "Diseases of China" state, "Tubal pregnancy is relatively uncommon, but from time to time cases are reported." It is probable that Ectopic Gestation is of more frequent occurrence than hospital statistics show, as not all cases seek western treatment.

My thanks are due to Dr. E. L. Perkins and Dr. I. E. Mitchell for their valuable assistance in obtaining notes of the cases and assisting at operations.

Notes of Cases.

Case 1, age 25 years, was admitted to Hospital with diagnosis of "Acute Appendicitis," probably requiring operation.

History. Patient had been married 8 years, her only child was born 4 years ago: no history of miscarriages nor of previous illnesses.

History of present illness. Patient is thin and anaemic but no sign of collapse present: periods had been normal until 3 months ago; during the last three months the amount lost had been less than usual.

Pain began 10 days before admission and was most marked in the Hypogastric region; the initial pain gradually passed off but pain returned with greater severity 5 days later when it spread over the abdomen and a swelling was observed in the right iliac fossa. *Constipation* was marked during the 10 days before admission.

Examination on admission. On palpation tenderness was complained of in the right iliac fossa: an abdominal swelling was present in the same region, its upper limit being one inch below McBurney's point: Temperature 100° Fhr., pulse 104. On the following day patient felt better but at noon the Temp. was 101° Fhr. and pulse 100: the swelling in the right iliac fossa had increased in size. Rigidity of the abdomen was not well marked.

Diagnosis.

Enquiry was made as to the possibility of Ectopic Gestation but the history was so indefinite that no conclusion as to its existence was arrived at.

Operation.

The abdomen was opened through an incision near outer border of Right Rectus muscle; free serous fluid was found and a mass of thickened omentum. The Omentum having been ligated and removed, a dark thin walled sac about 1½ in. diameter was found and removed after ligature of vessels on each side of sac. On incising the sac after removal the presence of a small embryo was disclosed. In the pelvic cavity was a large mass of clotted blood. The right ovary was enlarged and cystic and was also removed. The abdomen was closed without drainage and patient progressed favourably till the 12th day when a pelvic abscess required drainage. The wound then healed.

Comment.

- (1) Ectopic Gestation on right side may closely resemble Appendicitis. The history and signs of pregnancy, if present, should help. The position of the swelling was at a lower level than usually found in Appendicitis but, appendicitis presents such varied signs that on this feature alone not much reliance can be placed.
- (2) No definite history of amenorrhoea nor passage of decidua could be obtained.
- (3) Experience in subsequent cases showed that when peritonitis and a large blood clot were found at operation, a gauze drain passed down to the pelvis and brought out at the lower angle of the abdominal incision is advisable.

Case 2, age 21; married 3 years; two children; last child born 11 months ago; no miscarriages or other serious illnesses.

Present illness:—

1. Amenorrhoea for two months.
2. Attacks of severe abdominal pain and uterine haemorrhage for 10 days before admission to Hospital.

Examination.

Abdominal tumour was found evidently bulging down into pouch of Douglas and extending up nearly to Umbilicus; swelling rather to *left* of middle line; per vaginum cervix left close behind symphysis pubis and uterus lying anterior to the swelling. Temperature on admission was 98° Fhr. and pulse 98; patient though suffering severe abdominal pain was *not collapsed*.

Operation.

Operation was advised and carried out on the morning following admission to Hospital. On opening abdomen in middle line a large mass of blood clot was found shut in by Omentum. The left Fallopian Tube was distended with blood and rupture had taken place into the peritoneal cavity. The left Tube and Ovary were removed. A gauze drain was introduced through lower angle of Abdominal incision and removed next day. Patient made a good recovery.

Comment:—

- (1) Age of patient, 21 years is younger than average of English cases (25—35 years) but earlier marriages in China should be borne in mind.
- (2) *No long period* of sterility: only 11 months since last child was born.
- (3) History of two months Amenorrhoea, was helpful and swelling more to *left* side of abdomen practically excluding appendicitis.

- (4) Temperature being slightly subnormal pointed to possibility of internal haemorrhage.
- (5) Patient weak but *not collapsed*.
- (6) Gauze drain made post-operative treatment more satisfactory than in Case 1.

Case 3, age 38 years: has had three normal pregnancies, the last 11 years ago:

History of present illness:—

- (1) Amenorrhoea for *two* months: then vaginal haemorrhage, slight in amount continuing for 20 days, followed by a severe haemorrhage: again slight loss of blood for 10 days.
- (2) Pain in lower part of abdomen on both sides for two weeks before admission: pain was not of severe nature but patient had to give up her occupation of sewing bales.

Examination on admission: Temp. 99.8° Fhr., Pulse 112. An indefinite swelling was found stretching across the abdomen midway between symphysis pubis and umbilicus: per vaginam the cervix was pushed close behind symphysis pubis. The case was considered to be probable ruptured Ectopic Gestation and operation was recommended.

Operation.

Operation was performed on the day following admission.

Abdomen was opened in the middle line below the umbilicus. There was no free blood in the peritoneal cavity. On examination of *Right Fallopian Tube* and *Right Broad Ligament* a cyst was found connected with the *Right Broad Ligament* which ruptured on examination and dark fluid escaped into the peritoneal cavity. The *Right Fallopian Tube* was found to have ruptured on its posterior aspect. It would seem that an early Ectopic Gestation had existed in right Fallopian tube, haemorrhage had taken place and the tube had ruptured into the broad Ligament. The broad Ligament was sutured and part of tube removed but ovary left.

Examination of Left Tube.

The left tube was found distended: it was freed from adhesions and removed intact. Subsequent examination showed the tube to contain a small 6-7 weeks embryo surrounded by an unruptured amniotic cavity, the whole being surrounded by a mass of blood clot. Both ovaries were left. A gauze drain was passed down to pelvis through lower angle of abdominal wound and removed 24 hours later.

Patient convalesced satisfactorily.

Comment.

- (1) History of sterility for 11 years and age of patient 38 years resemble type of case described in English Text books.

(2) Evidently a case of Ectopic pregnancies in both tubes, the only case noted in our Hospital records.

(3) Patient was not collapsed.

Case 4, age 31 years, has had four children, the last child having been born eight years ago.

History.

(1) Amenorrhoea for two months, then vaginal haemorrhage began and two yellowish coloured membranes were passed.

(2) Slight abdominal pain at that time which continued.

(3) Then second period of Amenorrhoea for six weeks followed by a slight show.

Examination on admission:—

Abdominal swelling was found extending to within two inches of umbilicus. Milk in Mammæ; uterine souffle heard to right of middle line midway between umbilicus and symphysis Pubis. Pulse 98, Temp 101° Fhr.

Progress.

The diagnosis of the existence of a pregnancy probably Extra-uterine was made. It was decided as there were no urgent symptoms to keep the patient under observation. By the sixth day, temperature became normal and pulse had not increased but had slightly decreased in frequency. During a fortnight in hospital pulse varied between 70 and 80. Twenty-three days after admission, while the pulse was 84 and Temperature normal patient was seized with severe abdominal pain and immediate operation was advised: a delay of twelve hours occurred as permission of friends had to be obtained.

Operation.

Immediately on opening the abdomen a foetus was found lying free in the peritoneal cavity covered by the omentum, the umbilical cord passed down towards a large sac in the pelvic cavity. The wall of the sac was very thin, and it was impossible to remove the sac without opening into it on account of adhesions. Profuse haemorrhage took place which was controlled with great difficulty. The sac was removed and no further haemorrhage took place. Patient died from shock as result of haemorrhage a few hours after operation.

Foetus.

Umbilical Cord was pulseless and foetus dead though death seemed to have been recent. Foetus about five months.

Comment.

(1) The pregnancy was probably secondary abdominal, foetus had been expelled into peritoneal cavity when severe pain had set in.

(2) Haemorrhage at operation. In operating on a large sac it is wise to apply clamps to each side of sac *before* touching the sac even though no active haemorrhage is apparent.

- (3) Operation at an earlier period before rupture of the sac or even at the onset of the severe abdominal pain would probably have saved the patient, but the Chinese custom of having a consultation with relatives before granting permission to operate caused a serious delay of twelve hours.

Case 5, age 34 years, married 11 years, has had four children.

History. No menstruation for 13 months; for 9 months had no pain, but in 10th month had sudden acute pain in lower part of abdomen. Patient knew she was pregnant and movements of child ceased after the severe abdominal pain. Pain continued for one month then stopped for one month, and again became severe a few days before admission.

Examination. Patient was examined and a large abdominal swelling was noted arising from the pelvis and extending upwards on left side; Diagnosis of Ruptured Extra-uterine pregnancy was made and operation performed same day.

Operation. Abdomen opened in middle line, a sac was found with firm thickened wall extending upwards above the umbilicus closely resembling a pregnant uterus; the head and shoulders of foetus projected from a rupture at upper part of sac. The child was removed and cord which was pulseless, cut and tied. The sac was removed, the anterior part of its wall being closely adherent to the fundus of the urinary bladder—otherwise the sac had very few adhesions. Wound was closed and drained as in other cases and patient made a good recovery.

Comment.

- (1) Foetus evidently about eight months, well formed and well preserved tending to become a lithopoedian.
- (2) Sac at first sight seemed to be the uterus which had ruptured, and was almost in the middle line. Subsequent examination showed it to be a sac formed in connection with the right Fallopian Tube. The uterus was small and pushed to the left side of the abdomen.
- (3) The size of the sac and its thickness made removal easy: the placenta being no longer physiologically active gave no trouble.

If a case of Ectopic Gestation has advanced towards the later months of pregnancy various methods of treatment have been suggested:—

- (a) If foetus is still alive the pregnancy should be allowed to continue until term in the hope that a living child may be obtained, operation being performed at term while the child is still alive.
- (b) That operation should be immediately performed, as the foetus will in all probability be deformed, and the risk of endangering the life of the mother by allowing gestation to continue is very great.

- (c) That operation be delayed until 6 weeks after the foetus is believed to have died, the aim being to avoid interference while the placenta is still physiologically active, as haemorrhage from the large placental site may readily be fatal.

In this case the foetus was already dead when patient was admitted and illustrates the safety with which an advanced case can be operated upon when the foetus has been dead for some time but early operation in every case seems most rational treatment.

Case 6. 27 years.

The history was that pregnancy existed and that symptoms resembling miscarriage at 2½ months had taken place three weeks before admission to Hospital.

Examination. Abdominal pain was present midway between symphysis pubis and umbilicus, tenderness on pressure over site of pain. On bimanual examination a swelling was found behind the uterus in pouch of Douglas probably in the right Fallopian Tube.

Progress of case. Two days after admission swelling not so marked, abdominal pain still present but less severe and tenderness on palpation less marked.

Operation. The patient was kept under observation for two weeks. The abdomen was opened in middle line and a ruptured right Ectopic pregnancy found. The tumour was adherent to the pelvic colon and careful separation was necessary to avoid injury to the bowel. The right tube was removed and a gauze drain inserted down to pelvis and removed after forty-eight hours. Convalescence was satisfactory.

The foregoing cases show that it is very difficult to rely upon the histories given and careful inquiry is necessary in early cases to elicit the fact that an early pregnancy probably exists, further they illustrate the fact that early operative treatment is the most rational treatment. The diagnosis of early cases is not always easy; the patient often considers that abortion is the cause of the condition. In early cases the abdominal pain which is more continuous and severe than in abortion, and the continued uterine haemorrhage should make one suspect the probability of Ectopic Gestation. One or two of the cases have been treated as miscarriages before admission to Hospital. Cases which have already suffered from a severe internal haemorrhage are already in a state of profound collapse, and attention is at once directed to abdominal conditions, which in the case of women of child-bearing age lead one to suspect rupture of an Ectopic Gestation, but prognosis is not so favourable as in cases diagnosed before severe internal haemorrhage has occurred.

With regard to conservative treatment, it is of interest to notice that cases have come under observation in which operation was refused by patient or patient's friends, and after treatment, by rest in bed for a week or ten days urgent symptoms have subsided; while

in hospital no further symptoms have developed. As the subsequent histories of these cases are not available it is impossible to say if any recurrence of haemorrhage took place at a later period.

Early operation should be advised in all cases where the diagnosis of Ectopic Gestation is probable and the abdominal route offers the best means of examining the sac and its relations to the abdominal viscera: it is also the only safe method of dealing with adhesions, should such exist.

In conclusion may I quote the practice of Munro Kerr in his obstetric work who always puts to himself the following questions:—

“ Is the woman pregnant? ”

“ Is the pregnancy uterine or extra uterine? ”

“ If abortion, is the abortion threatened, complete or incomplete? ”

He says, “ I make no exception and always decide those three questions.”

R. M. Gibson, M.D., C.M., F.R.C.S. (Edin.)

A CASE OF PELVIC ABSCESS SIMULATING A DISTENDED BLADDER.

Patient, Li Ho, male, age 25, was admitted on August 21st 1923 for inability to pass urine and a symmetrical swelling in the lower part of the abdomen. The following history was given:—

About 12 days ago patient had a severe attack of abdominal pain in the early hours of the morning. The pain was at first generalised but later on was most intense in the right iliac fossa. A swelling gradually developed in the hypogastrium and at the same time he noticed that he passed very little urine and had blood and mucus in his stools.

Condition on Admission:—Patient looked ill. His temperature was 99.5 degrees and his pulse rate 120. Tongue was dirty and coated. The swelling was absolutely symmetrical and reaching up the umbilicus. It was resonant all over, and on rectal examination, the swelling was found to be pressing on it. A sound was passed and a stricture found in the posterior part of the urethra. The tumour was thought to be a distended bladder.

Patient was removed to the operating theatre in the same afternoon and an attempt was made to dilate the stricture. The attempt was successful but only 2 ounces of urine were drawn off. Urethral stones were detected by the sound. Still under the impression that the bladder was at fault, the surgeon proceeded to make an incision below the umbilicus and put in a trocar and cannula. To his surprise, the fluid that escaped was not urine but a large quantity of faecal smelling pus with gas. On elongating the incision and exploring with the fingers, it was found to be a well walled off abscess extending on the left to the pelvic colon and on the right to

the appendix region where the intestines were closely matted together, the bladder being quite contracted. The abscess was drained and no attempt was made to search for the appendix. From August 21st to September 9th, patient had remittent temperature. There was continuous discharge of pus from the wound. For the last two days the temperature rose to 104 and pulse rate to 120. It was feared that a general peritonitis had developed and he was again removed to the operating theatre on 9th September in the hope of draining the abscess more freely. The next day the temperature was 104, pulse rate 160, and respiration rate 44 and the whole abdomen was rigid before his death, pointing to the fatal general peritonitis.

The interesting point in connection with this case is the question of diagnosis. The history alone was very typical of acute appendicitis. Again the resonance of the tumour is not suggestive of a distended bladder, unless of course the intestines are matted in front of it, that condition however is rare. Again the prominence of tumour on rectal examination is more suggestive of a pelvic abscess. The symmetry of the swelling together with the presence of an obvious stricture provides a sufficient ground for the diagnosis of a distended bladder when one remembers that the existence of two separate conditions in the same patient is rare. The treatment of course is not an important factor.

It is a pity that no post-mortem was performed but it is very likely that the abscess was of appendicular origin.

EDITORIAL

THE RELATION BETWEEN MISSION HOSPITALS AND PUBLIC HEALTH WORK IN CHINA.—A SUGGESTION.

It was some time last March when Dr. Grant, Director of the Rockefeller Board of Public Health in Peking, in the course of his address, gave us a general survey of future Public Health work in China. The number of hospitals with their requisite doctors and the amount of money needed for medical education were given in most alarming figures—going up to six numerals in the case of medical doctors alone. The strongest weapon of attack on this gigantic problem, he alleged, is the future education of China's youth in the principles of hygiene. The monumental task seems beyond our realisation. To the pessimist, the undertaking is well-nigh an impossibility in the present state of affairs. To the optimist many nations have achieved it and time alone will put all things right. But time! It may mean many generations. In the meantime, China remains in the melting pot, her people suffering under the curse of epidemics. One might say that it is the penalty of her failure to keep abreast of Western Civilization during the past century in the realm of Science. The other nations made great strides while we lurked behind thinking that our knowledge of science was equal, if not superior, to that of the West. What a conceit! We are learning now, but at such a price. Let us leave sentimentalism aside and face plain facts. What has the Chinese Government done at present in the

matter of Public Health? Putting aside the handful of Government hospitals in isolated parts of China, most of which are either poorly financed or badly run, her efforts have never been earnest in that direction. In fact it may be said without a blush that the authorities are still too "old" to entertain such an idea. The numerous superstitions, for example, the epidemics being attributed to the annual visitations of gods and the difficulties arising out of the question of "Wind and Water" are still rampant in the minds of majority of the Chinese officials—the enlightened few, we may safely concede, care more for their own health than that of the nation. The reader will no doubt see that public health work in China will never progress by leaps and bounds, if her responsible heads place obstacles in the way or even to the extent of showing indifference. One conclusion is now reached, that is, China will not make any headway in public health undertaking, until such time as her political evils are done with. A peaceful and well governed state is necessary to efficient public health work. China's chance of being a peaceful country is still remote, so any hope on our part for an extensive immediate public health improvement "goes bang." Now despite the above rather discouraging views, it is a fact that through generous foreign help, a certain amount of public health work has been carried out in China. The pioneers were the missionary doctors and the Rockefeller foundation is now coming to the fore. Truly in the domain of science, there is no national boundary. This much may be said. The Chinese people will always remember the work of missionary societies. A famous English professor once said "A virtue which the Chinese possess in an eminent degree is the rather rare one of gratitude. A Chinese never forgets a kind act." But we are digressing, the next question is an important one. What is the public opinion in China towards mission hospitals and their doctors? The impression, one can boldly testify, is a very favourable one. The superstitious man at one time or another may look upon the foreign doctors and their work with sceptical eyes. But once within the gates of the hospital where he receives nothing but kindness, his doubts melt away and when he leaves its walls, he is ready to proclaim to the very first man he meets how good the doctors are. The writer knows missionary doctors who built bridges and constructed sea dykes with subscriptions from the people. They have even acted as truce-makers in internecine wars.

The equally important point is this: what is their position in the eyes of the local government? The local authorities have always had great respect for these institutions. The reason is not far to seek. Firstly, the common people place implicit trust in them. Even a most despotic magistrate in China has a fear for public opinion. Secondly, in view of the present state of affairs, the governing body has been militarist and therefore under obligation to these hospitals where their soldiers are being treated. Again the very fact that these institutions are under foreign management commands attention. We are now reaching another conclusion: that is, the hospitals in smaller Chinese towns are held in high esteem by the government and the Masses and they, therefore, have great opportunities for work among the people. Having thus far outlined the position of the mission

hospitals in China, we must turn our thoughts to the following:— It is obvious that in the case of an epidemic in an area where the only medical unit is the mission hospital, it falls on the shoulders of that hospital to undertake preventive measures. Are the mission hospitals fulfilling that function? To take an illustration. In Fukien province, the coast towns, such as Fuknien, Foochow, Fukchin Hinghwa and Amoy where there is at least one mission hospital, are annually visited by epidemics of cholera and plague of greater or lesser severity. In Hinghwa prefecture the writer can testify that annually the death rate due to plague or cholera amounts to several hundreds. The mission hospitals in these towns, as far as he can ascertain, have not organised any extensive anti-epidemic campaigns except the introduction of preventive inoculations. In the case of the cholera epidemic in Foochow, the anti-cholera measures were in the hands of the Y. M. C. A. One is not saying anything against the Y. M. C. A. when one opines that a medical body ought to undertake a work such as that. There are certain obvious difficulties which have crippled the mission doctor's work in the field of preventive medicine. Attention must now be directed towards these difficulties and we must endeavour to see if in any way these obstacles can be removed. Firstly, there is always a fear that the governing body might not show any sympathy towards an organised undertaking. This difficulty is more apparent than real. With a certain amount of tact and "foreign pressure" the magistrate will agree to any suggestion, unless he is very old fashioned. The only thing to do then is to appeal to the authorities of the capital where they are more enlightened as a result of association with foreigners. Secondly, there may be bitter opposition from the people themselves when they see drastic preventive measures such as house to house inspections and the isolation of contacts. Herein lies the key to the solution. Government support must be enlisted. A few policemen by your side will stop any opposition because the Chinese are absurdly timid. To prove my point. In a city where 17 magistrates appointed by militarists were in office at one time or another within a period of 3 months, the field tax of 1926 has been collected besides the numerous war loans. A time will, of course come when the people will realise that preventive measures are for their own good and opposition will naturally disappear.

The last two and most important obstacles must demand our full consideration, that is, the question of finance and workers. It is a well known fact that most mission hospitals are poorly supported and understaffed. It is not fair to expect them to indulge in any big move as they only have enough money to run the hospital and enough men to look after the ordinary patients. The future satisfactory utilisation of mission hospitals as anti-epidemic centres depends on the removal of these obstacles. Our suggestion is as follows:—

That the Rockefeller Public Health Board in China should undertake to form one sub-department in each province, for example, one unit in Foochow for Fukien province. This centre should be established in connection with the mission hospitals in the province which can

then serve as public health organisations in each district concerned. The head department in the capital will be responsible for any arrangements in the event of an epidemic in any given area, for example, the securing of medical supplies, etc. The expenses may be met by public donations and the Rockefeller Foundation will, if necessary, be asked to help.

When once definite co-operation is maintained between all hospitals and there is a centralisation of management, yearly grants of money can be asked from the government and donations from the people. In the case of an extensive epidemic where there is a shortage of medical workers, the head office could arrange to transfer medical men from other areas to the particular district involved. The reader must not however, be carried away with the idea that the Rockefeller Public Health Bureau in Peking is not alive to this question of Preventive Medicine. In fact it is a problem that has claimed their attention for the last few years—a topic which has been constantly discussed at the various important medical meetings of the Far East. Commissions have been sent to the various provinces to study the problem. One is, however, astonished at the slowness of the progress. There seems to be an atmosphere of indefiniteness about the programmes. We also understand that illustrative public health films are being exhibited in various towns for the education of the public. It is very well to talk about public health education. It will take time. But what we wish to point out is this. Yearly epidemics will continue to devastate the land. What plans are we to adopt in the meanwhile to combat these scourges. There are obstacles to be overcome in a movement such as is proposed but what are they to be compared to the glorious vision of thousands of lives saved from death and thousands of homes saved from ruin. The Rockefeller foundation has already spent huge sums to create a healthier China, here is a chance to lay the foundation for future public health development throughout the country.

THE DEPARTMENT OF OPHTHALMOLOGY.

We learn with much interest that the Peking Union Medical College has arranged a special graduate course in Ophthalmology from September 1923—June 1924. Such an undertaking will undoubtedly give impetus to ophthalmological work in China and we sincerely hope that our graduates will avail themselves of this unique opportunity.

The medical world is beginning to realize that ophthalmology is an important branch of medicine which must not be carelessly put aside. In an August number of the British Medical Journal, it is stated that the Council of British Ophthalmologists in a correspondence with the General Medical Council, urges that no student should be considered to have passed a qualifying examination unless he has shown a sound knowledge of practical ophthalmology in an examination conducted by ophthalmic surgeons. The movement, we are sure, will soon lead to definite regulations being passed by the General Medical Council. The excuse in the past has only been that the medical curriculum is overloaded. That difficulty we also experience

in this university, the ophthalmological department of which is far from satisfactory. However, we should like to mention that it is through the undivided energy of Dr. G. M. Harston that our ophthalmological department is kept alive. Dr. Harston is a busy practitioner and to find time to hold clinical classes shows his great interest in the Medical Faculty. We also note, without any misgiving, that Dr. Howard, Professor of Ophthalmology at P. U. M. C. is an old pupil of Dr. Harston. Now to return to our point, the final year students receive clinical instruction in ophthalmology once a week and for two hours only. We hope that the authorities will see that the training, as offered, is insufficient. A glance at the curriculum shows that the whole of the fourth year is devoted to surgery and medicine. The prevailing custom is to regard ophthalmology as a separate subject to be taught only by a specialist. We venture to think that there ought not to be any distinction between ophthalmology, general surgery and medicine, since the three are closely connected. We wish to suggest therefore that the surgeon or physician should devote a minor part of their time to practical instruction in ophthalmology during the fourth year. The hospitals at our disposal afford ample eye cases for clinical demonstration and we trust that the faculty will soon see their way to such a desirable improvement.

NEWS AND COMMENTS.

Our new Professor of Medicine.

We extend our heartiest welcome to John Anderson, M.A., B.Sc., M.D., Ch.B., (GLAS) D.T.M. and H. (ENG)., our new Rockefeller Professor of Medicine who arrived at this colony in the middle of August. Dr. Anderson commenced his lectures at the beginning of the autumn term, and senior students are beginning to find that the vast sea of medical science when approached and penetrated by the leadership and help of an efficient explorer who has been into its depths, yields its closely guarded secrets more readily and willingly.

As most of us are rather anxious to know more of our new professor, a brief resumé of his past activities will not be out of place. Dr. Anderson had a brilliant career in Glasgow University which he revisited in 1922. He held Resident's posts in Glasgow Western Infirmary, in the Hospital for Skin Diseases, in Gardloch Lunatic Asylum and in Ruchill Fever Hospital. Then for two or three years he had an extensive private practice near Liverpool until the outbreak of the War. In the War he served in Gallipoli, Egypt, Palestine and India, and in these places he had considerable experience in tropical diseases. Returning to London at the end of the War he took up the study of tropical diseases in the London School of Tropical Medicine. At the beginning of 1921 he set out for the West Indies as a member of the Filariasis Commission organised by Sir Patrick Manson and Seamen's Hospital Society. During the year 1922 he was Wandsworth Research Fellow at the London School of Tropical Medicine where he was associated with Professor Leiper in the department of Helminthology.

Though he has been with us for so short a time he has gained the hearts of most of the students through his amiable and genial disposition.

Graduate News.

The name of Dr. Wu Lien Teh, one of China's foremost physicians, crops up every now and then in the world of medical science usually in connection with some newly acquired distinction. We learn that he was elected Vice-president of the North China Branch of the Far Eastern Association of Tropical Medicine during the election of officials at the concluding session of that Association in Singapore. The Medical Society of this University, of which he is an honorary graduate, extends its congratulations to him.

Dr. C. E. Lim, our noted graduate, was appointed Secretary of the North China Branch of the F. E. A. T. M. at the same meeting.

We learn that Dr. W. H. Shih has been appointed a member of the Harbin Plague Prevention Service under Dr. Wu.

Dr. A. K. Oon, one of our recent graduates, has qualified for the degree of D.T.M. and H. (Edin). The Society congratulates him on his success.

Dr. E. H. Lim, our present energetic House Surgeon, has been appointed honorary Clinical Assistant in Ophthalmology, a subject which is now obligatory in the Final M.B., B.S. Examinations. We are glad that the University is showing such great interest towards this important branch of Medicine and Surgery.

We extend our congratulations to Dr. Samy, our second Rockefeller Research Scholar, who sailed at the end of last August for Dublin where he will take up special study in Midwifery and Gynaecology. Dr. Samy was House Surgeon for a year in the Government Civil Hospital before he left.

Extensions of Laboratories.

During the summer vacation our Physics and Chemistry Laboratories were greatly extended. We would have been extremely pleased to hear this good news had it not been that the extension was made at the expense of our Biology Laboratory, which was transferred to the School of Tropical Medicine. This procedure accompanied by the shifting of the Dean's Office to the same School has made the place so congested that there is hardly any sitting place for the students. Would it not be more compatible for the Biology Laboratory to be in the School of Physiology or Anatomy, to either of which Biology has certainly closer relations than to Tropical Medicine?

Personal.

We learn that Professor Wang, our Professor of Pathology, has recently been elected a Fellow of the Royal College of Physicians (Edinburgh). The Medical Society of which he is the President extends its heartiest congratulations to him. Professor Wang is, perhaps, the first Chinese to be honoured with an F. R. C. P.

News came to us of the birth of a daughter to Dr. and Mrs. Digby. Dr. Digby, our Rockefeller and Ho Tung Professor of Surgery, went on leave towards the end of last year and is expected to return shortly. The preponderance of the Medical Department which is reinforced by the arrival of Dr. Anderson, over the Surgical, will not be so great on Dr. Digby's return, the date of which we are anxiously watching for. We hope to be greatly benefitted by the firsthand information he is bringing us of the many Clinics he visited abroad especially in America where he was well received and entertained by the Rockefeller Foundation. Dr. Gibson our capable acting Professor of Surgery has been very kind and cordial to the students who will miss him greatly on the return of Professor of Surgery. As we go to press, we learn that Prof. Digby will be with us in a week or so and by the time this issue comes out, he will have taken up his multifarious duties in the University.

We congratulate Dr. Marriot our former lecturer in Therapeutics and Pharmacology, and Dr. Duncan White our external Examiner in M.D. Examinations, on their recent election as Members of the Royal College of Physicians (Eng.)

We miss greatly our former lecturer of Clinical Medicine, Dr. Aubrey, who has resigned on the arrival of Dr. Anderson. The senior students will doubtless recall many a pleasant afternoon spent by the bedside of patients listening with enlightenment to his interesting and lucid lectures.

Dr. Shellshear, Chairman of the Medical Society, has returned from the conference on Tropical Medicine held at Singapore. He is giving us an account of the conference in the pages of this issue.

Our Last Final.

In the last Final M.B., B.S. Examination held in May a "record" was established in the annals of the M.B., B.S. Examinations of this University. Out of ten candidates only one passed in both parts at the same time. Though it has been the tradition of the Faculty to maintain the standard of all the examinations on the same level as, if not higher than, those of London University, yet a result such as this shows that something must be wrong somewhere. Are our students below the average, or are we having first class examinations with second class lecturers?

Lectures before the Society.

Owing to the long vacation the Society has met only once since its last meeting on May 14th, when Mr. M. K. Yue read his paper on "The Post-Mortem Incidence of Congenital Syphilis in Hongkong." The first meeting since the opening of the autumn term was on 1st October, 1923, when Dr. Anderson gave a paper on "Medical Units in America."

Congregation.

A large congregation took place on 8th June, 1923, when amidst the customary solemnities the following gentlemen received M.B., B.S. degrees:—

Mr. M. K. Yue.

Mr. T. M. Tsoi.

We offer them our hearty congratulations and hope they will continue to be active members of the Society with which they have been associated for so many years.

Scholarship and Appointments.

(a) Ho Fook Scholarship - - - E. H. Lim

(b) Appointments.

1. July-October:

House-Surgeon	-	-	-	E. H. Lim
House-Physician	-	-	-	M. K. Yue
Pathology Clerks	-	-	-	S. C. Cheah S. K. Lam
Anaesthetic Clerks	-	-	-	M. B. Osmau C. C. Cheah
Senior Medical Clerks	-	-	-	S. N. Chau (Extension) T. Y. Li
Junior Medical Clerks	-	-	-	K. C. Yeo C. F. X. da Roza Albert Shem
Surgical Dressser	-	-	-	K. K. Yip
Surgical Ward Clerks	-	-	-	B. C. Lee F. I. Tseung Y. K. Wong

2. October-December:

Clinical Assistant in Ophthalmology	E. H. Lim
Surgical Ward Clerks - - -	da Roza C. F. X. Teo Kah Toh Yeo Kok Cheang
Surgical Dressers - - -	Lee Boon Choe Tseung Fat Im Wong Yan Kwong
Medical Ward Clerks (T. W. H.)	Chow Wei Lung Hsing Kuei Yuen Wm.
Medical Ward Clerks (G. C. H.)	Lam Shiu Kwong Shem Albert Yip Keung Ki
Obstetrics Clerks - - -	Cheah Chong Chee Cheah Swee Cheng Li Tsoo Yiu
Pathology Clerks (Sept. Oct.)	Osman M. B.
(Nov. Dec.)	Sepher S. A. M.
(Nov. Dec.)	Soo Hoy Mun
Anaesthetic Clerks (Sept. Oct.)	Yeoh Cheang Hoe
(Oct. Nov.)	Teh Yoh Chee
(Nov. Dec.)	To Shiu Hung
Prosectors in Biology - - -	Lam Hor Yin Hua Feng Tsai

K. C. Y.

