

MEDIC-ARTS BARN DANCE

The dance started encouragingly, though quite late as usual, with the romantic song "Love is Blue". Instantly numerous shadows of people "souling" were seen against the lovely dim light of the Medic Canteen. Many girls remarked that it was a marvellous idea to have a real barn dance but before long some of them complained that it was exhausting to sit on the straw and started asking for chairs. One could not help wondering whether the truth was that they found it unwieldy to sit on straw with skirts on. Obviously the boys found it tiring too for they would rather stand than sit. The Loosers (the band) provided good singing and music. Our Social Secretary Mr. Stephen Ng, proved that he had quite if not already reached the professional standard when he graced us with 2 songs, "When the Girl in Your Arm", and "Yesterday".

One particular feature of the evening was that the people tended to huddle to one side of the Canteen. Surely, it was not for warmth, because the evening was misty and cosy. Those who were present could easily figure

out why it was the darker corner!

Most of the Arts girls admitted that on the whole it was a successful function. However, they still had something to say. The medic boys, they observed, upheld their tradition of pride and haughtiness. Most probably it was only an illusion arisen from prejudice and we assured them that our friendliness was unmitigable. They went on to say that it was too crowded in the Medic Canteen (but, mind you, it testifies success!). Some Medic boys were book-worms and their conversation dull consisting of commonplace questions like "Which school did you come from?" and "Are you residing in the Hall?" Moreover they were quite unconscious of the fact that they had extended the same question to the very girl a few minutes ago. Perhaps the boys were, not to blame for the girls also complained that it was too dark and they could not recognise most of the boys. Therefore it might just happen that the same questions came from different boys.

Society Hockey Teams

Men:

Victor Abbas
Ali Mohamed Bin
Chan Yiu Cheung
Chiu Tak Wai
Chow Yat Ngok, York
Gan Tong Eng
Hwang Shu Tak, James
Lai Fook Ming, Lawrence
Lim Thuan Kiang
Man Ching Kwan, Gregory
Man Ching Wan, Godfrey
Harpaul Singh (Captain)
Timothy Teoh
Wong Chun Chung
Wong Chun Kuen
Yeung Chan Yin, William
Yeung Kwok Ping

Ladies:

Eileen Au
Lily Chan
Sylvia Chen
Theresa Chan
Carina
Margaret Cheung
Stella Kwong
Juliet Lau
Lee Man Chi (Captain)
Gloria Leung
Susan Shen
Vivian Taam
Vera Tsai

Results of Interfaculty Hockey Competitions.

Men:

7th Jan. Med vs Arch
Won 4:0
21st Jan. Med vs Eng
Won 6:0
28th Jan. Med vs Arts
Won 6:1

Ladies:

25th Jan. Med vs SS
Won 1:0
28th Jan. Med vs Arts
Won 1:0

As usual, our Society Hockey Team proves to be the strongest among the six Faculty Societies.

We are also very delighted to know that our ladies carried away the championship in hockey, too. In this respect, we must thank the captains of both teams in doing a very good job and especially Miss Lee Man Chi who has been working very enthusiastically.

Situation of Omega Rose Bowl Competitions.

	points
Medicine	37
Engineering	29
Architecture	27
Science	16
Social Science	16
Arts	13

CORRESPONDENCE

Are We Proud?

Dear Sir,

From the official publication of the Social Sciences Society, "The Voice" (Vol. 1 No. 3), I read in the article "A Little Bit Green" the following:

"There was a general feeling that comparing with us, the Medicine students are too proud, . . ." The "us" here refers to Social Sciences students.

My deductions from this sentence are:

1. The Social Sciences students are proud, but
2. The Medicine students are even more proud,
3. Therefore, if the Social Sciences students are as proud as the Medical students the latter would not be accused of being "too proud".

May I tell our Social Sciences friends that they are really "a little bit green" to understand the pride of Medical students.

Medical students are proud of their training. The Medical school in Hong Kong is one of the best in S.E. Asia. The five-year course, which seems a bit long, is merely enough to qualify a person for Medical practice, but the training never ends there. Once you step into the Medical world you will never stop learning till death.

Medical students are proud of their vocation. Hong Kong is urgently in need of well-trained doctors. They know they will play a part to meet the needs of society, to improve the health of our fellow people, and to guide their more junior colleagues. They know that they are learning; they know why they are learning.

"Medicine is a guessing game in which one is either rewarded by being wiser or punished for murder". The responsibility of the game is great. The effort paid is tremendous. Care, patience and tolerance are taken for granted. Medical students know they should and shall bear them for life. This they are proud of.

So my dear colleagues, don't be crossed when people say Medical students are "too proud". We know what we are proud of and we have the reason to do so.

Yours faithfully
Propoise

Ed. "Men's thoughts are much according to their Inclination; their discourse and speeches according to their Learning, and infused Opinions." Francis Bacon.

Immunity to measles from a single injection of a safe vaccine

"The analysis was completed of the results of the recent field trials of measles vaccine sponsored by WHO in several countries in order to compare the severity of the reactions and the antibody level produced by various available measles virus vaccine strains.¹ It was found that the Schwarz vaccine caused less reaction than the others tested and gave a satisfactory antibody response. Further studies to measure the duration of immunity provided by different vaccines have been planned. Present evidence indicates that the live measles vaccine will give good protection for years. Despite the pyrexias which they induce, no serious untoward sequelae have been reported from their use on a large scale, and there is good reason for using them for the routine immunisation of children where mortality from measles is high."

Mevilin-L

Mevilin-L is the new single-dose live attenuated measles vaccine. It is manufactured by Glaxo Laboratories Ltd from the Schwarz strain developed by the Pitman-Moore Division of the Dow Chemical Co.

1. See Off. Rec. Wld. Hlth Org. 139,16
2. Official Records of WHO No.147

Presentation

Single-dose vials, in boxes containing one vial of Mevilin-L, one ampoule of Water for Injection, one sterile disposable syringe.

Mevilin-L is a trade mark



Glaxo Laboratories, Ltd., Greenford, Middlesex, England.
Agents: Dodwell & Co., Ltd., Hong Kong. Tel. H237011.

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KIDNEY TRANSPLANT IN HONG KONG

Although the first local kidney transplant was done only recently, it was technically possible to accomplish this as early as 1965. From the surgeon's point of view, one of the delaying factors is the inadequacy of suitable recipients. This is so because chronic uraemic patients encountered in the surgery department are mostly referred cases. Besides, these patients are very ill and unsuitable for operation unless their general condition is improved by dialysis but, unfortunately, such facility is very inadequate in Hong Kong. The source of kidney donor is also a problem as it is the policy of the surgery department not to receive donation from normal and healthy individuals.

The surgeons responsible for this transplant received their training on this field both in Hong Kong and abroad. There was visit to transplant units elsewhere and on returning to Hong Kong, there were lectures held among the staff of surgeons. However, a team was not formally established until roughly six months ago. In the period between 1965 and the first transplant, there was relatively few rehearsal work on animal because any further knowledge can only be obtained by an actual operation. Also, at that time, the department was not enthusiastic about a transplant as it was still regarded as an experimentation.

Since healthy kidney for transplantation has to come from dead persons and there is the traditional Chinese belief of leaving dead body alone, it is very difficult at the present time to have enough kidneys for transplant. But to overcome this, a change in this belief is not enough. There must be cooperation from other doctors and hospitals. This will enable donors dying in places other than Queen Mary Hospital to have their kidneys brought immediately to the waiting recipients.

In Hong Kong, patients suffering from chronic uraemia are far from uncommon. The treatment, apart from a transplant, is dialysis with artificial kidney. But such a therapeutic measure, besides being very expensive, can only be available to a very small number of people in Hong Kong. Patients with this disease are undoubtedly dying of a slow, agonizing and certain death. Therefore it is not surprising to find these individuals are the keenest group who, even without being asked by the doctors, want to have a kidney transplant done.

Comparing the two methods of treatment for chronic uraemia — dialysis and kidney transplant — dialysis undoubtedly has a greater survival rate than transplant. In fact, if dialysis is done by an experienced hand, 90% of patients will survive from the uraemia whereas only 60% can be expected from a transplant with an unmatched-tissue donor. However, an artificial kidney is expensive to operate, requires the care of an expert and the patient is tied to this treatment for the rest of the life. Especially in Hong Kong, such facility can only afford to accommodate for two patients. On the other hand, a transplant is relatively inexpensive, requires less subsequent medical care and allows the patient to lead a normal life until the time of rejection.

Kidney transplant has passed the stage of experimentation and gained the status of a conclusive treatment. The limited availability and high expense of dialysis

IF I GIVE MY KIDNEY TO YOU

by
Lee Ping-chung

If I give my kidney to you,
Will you handle it with care?
Will you always treat it tenderly,
And in every way be fair?
If I give my kidney to you,
It will serve you all your life,
It will swear that I'll be true to you,
By the supernal that lies above to.
Will you live with it when you're alive,
And go with it when you're dead,
And always be, as you are with it, true,
And too?
Think it over and be sure.
Please don't answer till you do,
And when you promise all these things
to me,
Then I'll give my kidney to you.

do not justify the burden this small community of Hong Kong has to make while other means of treatment is available.

THE LIVING SKIN

Basal cell cycle

The replacement time for the epidermis as a whole thus depends on its thickness and the cell cycle, that is, the period between successive divisions of the basal cell, which is the only epidermal cell to divide under normal conditions. The cycle can be conveniently divided into four phases, which take place in the sequence:

- G1 first (long) rest period
- S synthesis of DNA begins, in order to double the cell chromosomes
- G2 second (short) rest period
- M mitosis phase.

It is likely that the synthesis (S) phase is of the order of 10 to 12 hours, whereas mitosis (M) lasts only one to two hours. Thus, when a tissue section is viewed at any one moment, there will be considerably more cells in the S period than in the mitotic one. In general, the G2 rest period (between DNA synthesis and mitotic division) is short, though there is evidence that a small proportion of the cells in skin may remain for some days at this stage. There is, however, no doubt that the long cycle of the basal cells is due mainly to the prolonged G1 rest period.

Response to injury

When a cut is made in the skin, for example with a razor blade, the epidermis is repaired first by the sliding or migration of cells to cover the gap and then by the multiplication of undamaged neighbouring cells to restore the original epidermis.

From the magnitude of the response, it can be deduced that proliferation is not confined to cells of the basal layer; indeed DNA synthesis and cell division can be observed in the prickle cell layer. The cells of this layer have thus not lost their capacity to divide if required and they can be diverted from their normal pathway of keratin production.

Little is known of the mechanism of this injury response, except that it does not occur unless the epidermis itself is damaged. The infliction of a hypodermal wound results in no increase in cell division in the overlying epidermis. One hypothesis is that damage to the epidermal cell releases a stimulating 'wound hormone'; another is that the epidermal cells are ever ready to divide at this high rate, but they are normally held in check by an inhibitor.

Psoriasis

Psoriasis is one of the oldest recognized skin diseases, but it was confused with leprosy until Willan (1757-1812) dif-

ferentiated it fully. However, he used the term 'lepra', but considered psoriasis a synonym. 'Lepra' is indeed the more appropriate name (from the Greek lepra — a scale); 'psora' is in fact an itch, and psoriasis is not characteristically itchy.

Even today, despite its clear-cut clinical and pathological features, psoriasis has so far resisted the efforts of research workers to elucidate its genesis. It affects about 2 per cent of the population of Britain, and there is overwhelming evidence that the tendency to psoriasis is inborn and hereditary. A voluminous body of biochemical information based on comparisons between normal and psoriatic skin has been accumulated in the search for a biochemical lesion, yet almost all the differences that have been detected could be explained in terms of the essential pathology of psoriasis — an increased rate of epidermal cell production.

A useful view of psoriasis is that it is an abnormal skin reaction pattern rather than a disease in the ordinary sense, that is, there is present some stimulus without which the skin would behave normally. Some evidence of this can be obtained from the Köbner phenomenon. Some ten to fifteen days after the skin has been traumatized, patches of psoriasis appear along the line of the injury. The reaction cannot be elicited invariably, but usually can when the psoriasis is active and progressing. In the light of this concept of a reaction pattern, it may be useful to compare the logistics of epidermal cell proliferation in psoriasis with what normally occurs after injury.

In psoriasis the epidermis is thickened, but this thickening is mainly due to increased cell volume and the failure of cells to flatten and develop a granular layer as in the normal course of keratinization. The real number of cells between the basement membrane and the surface remains about the same. Thus, when measurements of the replacement time show that it is reduced from thirty to three or four days, it is clear that this has to be accounted for by a nine or tenfold increase in the number of cell divisions. However, one of the striking features of psoriasis is the great elongation of the basement membrane, so that each unit of surface area can now be replenished by approximately three times as many cells of the basal or germinative layer. It seems undoubtedly true that cells in this special position have the ability to divide continuously, but in psoriasis, as in the healing epidermis, this attribute is not confined to the basal layer; divisions also take place in what would normally be the first three layers of viable cells.

more worthy to him than a longer but crippling life.

When compared with transplant of other vital organs, kidney transplant has a more promising future because it is not an irreversible venture. When a transplanted heart or liver fails it is usually synonymous with death. But with the failure of a transplanted kidney, there is always a second chance as the patient can again rely on dialysis until, perhaps, the next transplant.

It has been argued that this increase in the population of actively dividing cells is sufficient to account for the increased epidermal turnover rate and that it is not necessary to postulate a shortening of the cell-cycle or intermitotic period. A reduction in the cell-cycle time may well be the major operative factor. This is more in keeping with the view that keratinization is suppressed by the rapid rate of division than with the view that failure to keratinize is the primary lesion. If the available cellular energy must be shared between division and synthesis, then the synthetic mechanisms will never have enough time to develop their products fully before successive divisions bring the cell to the surface.

Another characteristic of psoriasis is dilatation of the capillary vessels in the dermal papilla. Again, views differ about whether this is a primary or a secondary reaction. It may, however, be said that clinical remission can be obtained without changes in this capillary dilatation.

Drug action

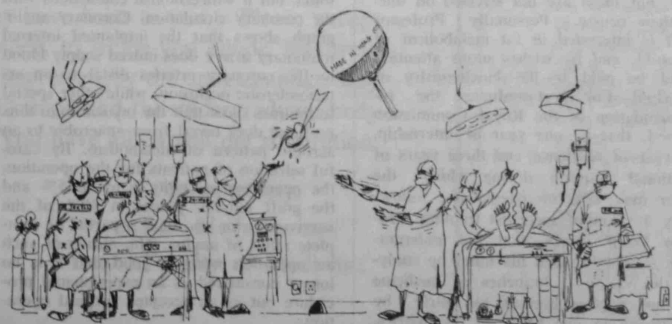
It is of interest that the psoriatic process can be arrested by drugs with a great variety of actions. Within a few days of applying steroids such as beta-methasone 17-valerate or fluocinolone acetonide, particularly under occlusive polythene dressings, clinical remission can be obtained. This is associated with a return to normal of the ridges of the cell network and the development of a granular layer. The capillary dilatation and irregularity frequently persist long after the lesions have cleared.

On the other hand, there seems no doubt that the clinical efficacy in psoriasis of the various steroids is related to their ability to cause vasoconstriction in normal skin, which is the basis of a method for assessing potency of topical steroids. Their action is certainly not related to any interference with the normal cell cycle, for they do not act as antimetabolites in either normal or wounded skin. In general they act as stabilizers of the membranes of cells and intracellular organelles, such as lysosomes.

Probably the 'biological clock' controlling cell division is dependent upon the build up of a stimulator or anti-inhibitor within an intracellular organelle, which, having reached a maximum, spills over to initiate the chain of events leading inexorably to division. If in psoriasis the clock is upset by reason of instability of this hypothetical organelle, then its stabilization by steroids might sufficiently prolong the intermitotic period to let the synthetic processes proceed to the point at which they inhibit mitosis.

The psoriatic process can be stopped in a much cruder fashion by the use of cytotoxic agents. For example, the folic acid antagonists, aminopterin and methotrexate, administered orally can control psoriasis. Synthesis of DNA requires the reduction of folic acid to a tetrahydrofolic acid derivative, which acts as a means of methyl transfer. Interference with DNA synthesis makes it impossible for the cell to duplicate its chromosomes, and thus cell division is stopped. Although the psoriatic lesions are resolved, the capillary dilatation is not affected, and it may even remain clinically visible for long periods.

All of these observations imply that as yet no treatment deals with the basic cause of the abnormal cell multiplication in psoriasis, but a study of the processes in the light of these new concepts of cellular interaction may well bear fruit. (From Glaxo Volume 30 — with the kind permission of Glaxo Lab. Ltd.)



MODERN TRENDS IN PAEDIATRICS

(AN INTERVIEW WITH PROFESSOR OTTO WOLFF)

An interview with Professor Wolff was arranged on January 13th, 1969 by Professor Wolff, the Director of the Institute of Child Health of London and External Examiner of Paediatrics.

Professor Wolff first pointed out that the role of prevention in modern medicine was becoming more important. Many adult diseases are preventable if treatment is given early in childhood. For instance, mitral stenosis due to rheumatic heart disease will no longer appear if haemolytic streptococcal infection is treated early in child. Also, antenatal care is gaining greater significance. Diseases such as German measles which may cause congenital deformities in the developing foetus may be preventable. Chromosomal abnormalities like Down's syndrome may be diagnosable early during the pregnancy, and therapeutic abortion may then be advised.

At present the paediatrician is looking at the adolescent with more attention than before. In the past, there has been a gap between the work of the paediatrician and the adult physician, when neither took the responsibility for the adolescent. However, nowadays many paediatricians are more concerned. The emotional development of the adolescent is of particular importance. Emotional problems are common at this age and often involve difficulties in the adjustment between the older and younger generations. Fortunately such difficulties appear to be less common in Chinese families.

In many fields, knowledge is now available which permits the prevention of conditions which interfere with good health of children and adolescents but too often the means of applying existing knowledge to the community are inadequate or non-existent. There is therefore an urgent need for research into the provision of medical services, preventive and curative, for children.

Professor Wolff was asked about the relationship between emotional and mental development. He said that the two are closely related. A child must have a normal emotional development if his mental development is to be normal. One may be brought up in an unfavourable environment, and grows up as if mentally retarded. There are cases where unfortunately a wrong diagnosis of mental retardation is made. Therefore it is important to realize this intimate relationship, and ensure normal emotional development. The question of what is being done in the United Kingdom about emotional health was then raised to Professor Wolff. He pointed out that there were child guidance clinics everywhere, and that there were child psychiatrists who would look into the problem of emotional health of the child, but too often advice and help were given too late.

What is the role of the paediatrician in relation to child health? Would it be too much work for him to be at the same time a doctor, a home visitor, a medical social worker, a public health worker and an educationalist? It is best to have different people working together to form a team. Team work is more efficient than individual work, and the paediatrician works as a member of the team. The whole team will work towards the same aim: for the care of the child's health. According to the needs of the child, any member of the team may be leading. The paediatrician often assumes an important role. Moreover, the handicapped children, either physically or mentally, require special attention.

What are the relations between the family doctor and the paediatrician? Professor Wolff considers this as one of the most difficult problems. In countries like the United States, people tend to favour specialists, while in Britain the habit of having a family doctor is still retained. The idea of group practice is preferable. As a compromise, a group of perhaps 6 doctors, each one having a special in-

terest in a particular field and yet a general practitioner, who can give medical advice to all members of the family, should work together. Professor Wolff thinks that a paediatrician is a person who comes between parents and child, but he must not identify himself too much with the child; otherwise the parents may be annoyed.

Professor Wolff was asked whether the work of the paediatrician should begin at marriage of the parents or at conception. It is true that some marriages are not suitable in the sense that the children born will be less gifted than normal children. For instance, the marriage between two mentally-retarded is more likely to give rise to mentally-retarded children. Also parents with certain chromosomal abnormalities may give rise to abnormal children. However, it would be out of one's job if one should interfere too much with private business of others. The doctor can persuade the partners concerned and inform them of the hazards, but he can do little more. It raises the difficult problem of whether the community or the individual is more important. We cannot prevent these individuals from getting married; they are entitled to have their own children. It is quite unfair if we should restrict what they want to do, but then the community will get more burden, e.g. malformed or mentally retarded children. After conception, the role of the paediatrician is obvious. He is to work hand in hand with the obstetrician for the care of the coming life.

Is the paediatrician also concerned with birth control? Yes. The paediatrician views the situation from two aspects: the poverty and malnutrition of the world, as well as the high infant mortality rate. As long as there is still a high infant mortality rate, parents are very unwilling to accept birth control, because so long as they have more children, it is more likely that at least one or two will grow up into an adult. So even though more children in a poor family will lead to sufferings of poverty and malnutrition, the parents are still not glad to adopt birth control. Therefore we must reduce the infant mortality rate of the community before we can expect birth control to be accepted. In the more developed communities, people do not have the fear of their children dying at an early age, and will then be more ready to take up birth control. Thus the improvement of society condition and birth control has to go hand in hand. Otherwise it will only be a futile attempt to propaganda birth control.

Along what line should paediatric education develop? In many countries including Hong Kong, a high percentage of the population is quite young. (In Hong Kong 40 per cent of the population are under 15 years of age.) At present, medical undergraduates do not receive sufficient knowledge of the child in their basic medical science courses. For instance, there are many differences in the physiology of the child and the adult, but these are not stressed on during their course. Personally Professor Wolff is interested in fat metabolism of the child, and he wishes more attention would be paid to the biochemistry of the child. For post-graduates, the recommendation of the Royal Commission is good, that is, one year of internship, one year of residence and three years of vocational training during which the doctor may take up paediatrics, followed by 3 years of specialist training. Professor Wolff thinks that the undergraduate should broaden his mind by studying the various branches of medicine and not confine himself too early by specializing in one field, say paediatrics.

Finally Professor Wolff was asked to describe what he considered as the desirable personality one should have if one wished to become a paediatrician. He thinks that at least, the person should be one who likes children and is young in his mind, so that the child may easily approach him. "A Great Man," said Mencius, "is one who has not lost the heart of his childhood." Professor Wolff obviously agrees with Mencius.

We thank Professor Wolff for his interview with us, and also Professor Field for arranging this interview.

(K.H.S. & Stella Kwong)

Medicine Today

LIVER TRANSPLANTATION

Fatal liver diseases are common in the Far East. They include progressive liver cirrhosis and primary cancer of the liver. Liver transplantation is an obvious way of treating these otherwise fatal diseases. This operation, however, presents several difficulties. The first is the inability to make the patient fit enough for major surgery. Unlike patients for kidney transplantation whose pre-operative condition can be improved much by dialysis, the condition of a patient with hepatic failure can be improved but little by exchange transfusion, cross-circulation and perfusion through an animal liver. For this reason, candidates for liver transplant can only be those who are diagnosed to have fatal liver diseases but still in a condition suitable for major surgery. The second problem is the difficulty in the preservation of the donor's liver. The liver must be cooled within 15 min. of the donor's death, or else severe ischaemic liver necrosis will occur. Simple cooling alone may preserve the liver well enough for 2 to 3 hours, while cooling with continuous perfusion can preserve the liver for 8 hours. Still another problem is to find space for the transplanted liver inside the recipient's body. If the recipient suffers from cancer of the liver, of course a hepatectomy is first done, and then the transplant can be inserted in the normal anatomical position. However, if the recipient suffers from a non-malignant liver disease such as progressive cirrhosis of the liver, it is desirable to keep the liver and place the graft somewhere else. Difficulty may arise in finding space to accommodate the graft. A good space to meet such a difficulty is the splenic space after splenectomy. Even so, this is still unsatisfactory because of the many anastomoses which have to be made, and kinking easily occurs if the graft is placed in an abnormal anatomical position. Lastly, as with other organ transplants, there is the problem of immunosuppression.

(Au KW)

Surgical treatment of Angina Pectoris

Many operations have been devised to provide blood flow to ischaemic myocardium. The most successful of these is the most improbable one. It consists of dissecting out an internal mammary artery from the chest wall and implanting it with bleeding side holes into the left ventricular wall. Surprisingly, the vessel will not thrombose or cause an intramural haematoma, but it will establish connexions with the coronary circulation. Coronary angiograph shows that the implanted internal mammary artery does indeed supply blood to the coronary arteries distal to an arteriosclerotic occlusion, while other special techniques show that the myocardium thus perfused does revert from anaerobic to an aerobic pattern of metabolism. By careful selection of patients for the operation, the operation mortality is about 5% and the graft remains patent in 80% of the survivors, who also have a partial or complete relief of angina. The results of such an operation were so good that it is no longer considered as an experimental procedure but as an accepted surgical operation.

啟思

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編者話

「啟思」兩字，原是從本刊英文名直譯過來。但它也含有本身的意義。很多人認為醫學生祇是書蟲，除此以外，便一無所知，一無所思。「啟思」的責任，就是要打破這種見解。我們希望「啟思」能真正發到同學們的思考。而啟發思考的一個辦法，就是寫作。所以我們在此呼籲：當你感到有話要說時，不要遲疑，切勿猶豫，打開思路，馬上執筆，寫下你的意見，寄給我們吧。

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