

RES MEDICA

Journal of the Royal Medical Society



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FIRST ISSUE

Res Medica



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PRINCIPLES AND PRACTICE — Alan Boyd, Malcolm F. MacNicol

MISCELLANEA — James O. Drife, Michael R. Ferguson, Hamish Maclaren

SYLLABUS FOR THE 242nd SESSION (1978/79)

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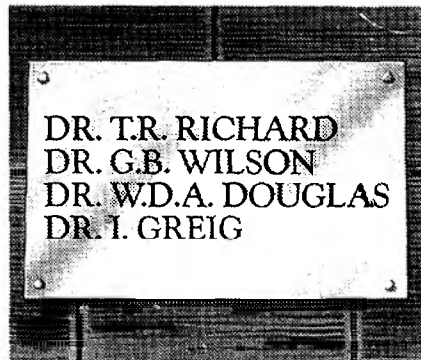
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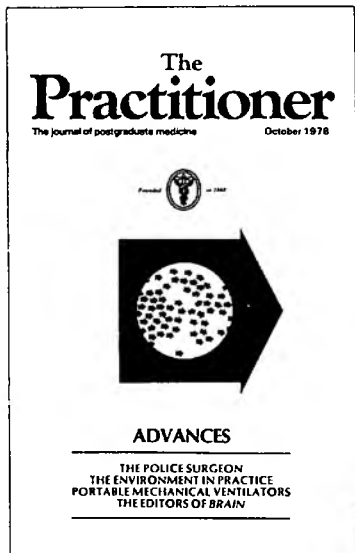
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EDITORIAL

After a hiatus of several years *Res Medica* is back. It will be an occasional publication with perhaps two issues a year. Our aim is to publish a journal with a wide range of articles, from the historical to the philosophical, from the political to the scientific and from the lighthearted to the polemical. In other words it will attempt to appeal to the heterogenous membership of the Royal Medical Society – and to others – to the ingenuous freshman, the cynical final phase student (although perhaps today the adjectives should be transposed), the overworked houseman and the eminent practitioner.

In this issue we have contributions from prominent figures in Edinburgh Medicine and from junior members of the Society. These latter show that the flame of scientific enquiry which made the reputation of the Society burns on still, even if at times it has appeared to gutter.

Firstly, we have a pair of counterbalanced articles by Sir Derrick Dunlop and Professor R.H. Girdwood on the Edinburgh Medical School in 1922 and 1978 respectively. Sir Derrick gives us a pithy insight to the life of a clinical student fifty-five years ago, whilst Professor Girdwood outlines the future of our Medical School.

Secondly, the scientific section contains an account of the management of duodenal ulcer by Alan Boyd, a fourth year student, whilst his colleague Charles Clark has contributed the text of dissertation given to the Society on the dangers of diving. The last of the scientific articles is by Mr. Malcolm MacNicol, Lecturer in Orthopaedics at the P.M.R., on peripheral nerve injuries.

On the lighter side we have one of Jim Drife's entertaining *jeux d'esprit* pricking the balloon of medical jargon, and accounts of students' travel – to New York by Mike Ferguson and to Holland by a group of R.M.S. members – the amanuensis being Hamish Maclaren.

We would like to thank all those who have contributed to this number as well as all those who have helped us and wished us well. We hope that you, the reader, will find something of interest herein – and perhaps even something informative or of use.

Since our last edition the Society has undergone a metamorphosis even more marked than that undergone by the journal. The R.M.S. has moved into new and almost palatial premises in the Students' Centre. The availability of a large comfortable coffee lounge and convenient and warm library facilities has led to a change in the balance of use and membership of the Society. The roll of members is much larger now although most of those are birds of passage using the facilities at lunchtimes but contributing little to the scientific life of the Society. Attendance at Business meetings has been low but supported by a small cadre of diehards. There are however signs of an awakening interest amongst the membership in the educational role of the Society and we hope that the revival of a medium for them to express this will stimulate them to contribute to *Res Medica*.

We hope that you will enjoy reading this number.

The Editor

Comment and Reflections

Teviot Place now:—

THE EDINBURGH MEDICAL SCHOOL IN 1978

by

Ronald H. Girdwood

M.D. Ph.D F R C P Ed. F.R.C.P. Lond., F.R.C. Path., F.R.S.E.

Dean of the Faculty of Medicine

from the

University Department of Therapeutics and Clinical Pharmacology,
The Royal Infirmary of Edinburgh.

In the history of every Medical School there are periods of calm and times of intense activity. Some of the medical teachers in Edinburgh have already experienced three very active phases. First there was 1939 when there occurred the trauma and disruption of World War II. Seven years later came the immediate post-war period, when new members of staff were being recruited, former teachers were returning, and the intake included a large number of 'mature' students. The third peak of activity, which overlapped with the second, was in 1948 when the National Health Service was introduced and the teachers in general found themselves becoming employees either of the University or the N.H.S., not always being allotted to the employer of their own choice. Some would say that a fourth time of unusual activity was in 1963 when a new curriculum was introduced.

At present we are faced with many challenges, which are not necessarily difficulties, except that our administrative staff have to reconcile the many changes that are occurring simultaneously. To this must be added the problems that the administrators have in dealing with each other, because the dust has not yet settled after the reorganization of the National Health Service. The bewildered clinical teacher finds that the University administrative pattern is relatively simple, since he does not require even to know of the existence of many of the central University committees, but he is at a

loss to understand the functions of many of the National Health Service committees even although they may impinge directly upon his work. More importantly he may find it difficult to understand the intended absence of others that formerly existed, but were officially declared unnecessary, and which have now crept back because he and his colleagues find them useful or even essential.

Few things are as dull to discerning medical students as committees. Pre-clinical medicine may excite interest or fury, and clinical medicine is so protean in its interests that it holds the attention. It is to be expected that most students will go ahead with their studies or their relaxation without evincing interest in committee work. At the moment, however, the active discussions that are taking place daily in Edinburgh or London are going to affect the lives of every medical student in a major way and, where possible, student participation is welcome.

It is important that all those negotiating on behalf of the medical student or doctor should remember that the interests of the patient must be paramount. Despite the expression recently of a contrary view, the National Health Service is run for the benefit of the patient, not for the benefit of members of its staff. The University teacher in the Faculty of Medicine, whether pre-clinical or clinical, is equally involved directly or indirectly in discovering what is wrong with patients and assisting in their management.

The New Undergraduate Medical Curriculum

To the undergraduate, who is going to enter his first pre-registration post after 1979, the new curriculum will be the certain change that is of most direct interest to him. Most students will graduate after five years, as was the case before World War II. The ordinary B.Sc. (Med. Sci.) has been swept away, unmourned by most, but the honours degree remains. There is no doubt that the introduction of a new curriculum creates problems for our teachers and administrators, and it is to be hoped that it will not create too many problems for students. Having lived through various curricular changes and having seen hopes failing to be realized each time, one can only pray that this time the most optimistic forecasts will be the correct ones. Time alone will tell, but it is to be hoped that sufficient flexibility has been built in to obviate the necessity for another massive exercise of the same sort in the 1980s. Such academic convulsions are time consuming.

New Professors in the Faculty of Medicine

Never before have so many new Professors taken up post in such a short period of years. Since 1976 there have been filled Chairs of Biochemistry, Surgery, Obstetrics, Community Medicine, Medicine, Oral Medicine and Pathology, Oral Surgery, Preventive Dentistry, Conservative Dentistry and Respiratory Diseases. Personal Chairs have been created in Pharmacology, Psychiatry and Child Life and Health. Chairs of Bacteriology and Radiology await holders, and outside funds have been provided for Chairs of Rheumatic Disorders, Medical Oncology and Cardiology. On the administrative side we are fortunate in having professor Simpson occupying the post of Executive Dean in succession to Professor Duncan. Other retirements or translations elsewhere are in sight, and all this influx of new ideas (and, no doubt, requests for additional Departmental funds) coincides with both the introduction of the new curriculum and a time of financial restraint.

Financial Matters

The busy medical student may not have time to notice much of what is going on in the outside world, but he cannot have failed to discover that he is pursuing his studies at a time of national and international financial difficulties. Economies are necessary both in the National Health Service and

in the Universities. Those who know about the low financial requirements of the University in the 1930s will have a different idea about what constitutes a financial crisis than will those who entered University life in the time of expansion after the nation had recovered from the war years. In all Faculties economies have had to be made in recent times. Each Department in the Faculty of Medicine has a savings target, and, if that has not been met, there is no University money available to fill the next post that becomes vacant. Meantime, too, the relative amounts of money that may be retained by all Faculties is being studied centrally with a view to re-distribution of the total sum if there is any injustice between Faculties. The intricate interweaving of University and N.H.S. interests and finances in the Faculty of Medicine make meaningful calculations difficult.

Salaries

The average British doctor considers that he is poorly paid, and this is true if the comparison made is with contemporaries in other developed countries or in certain areas of the Middle East. It must be said, however, that the salaries of most full-time members of staff in the pre-clinical departments or in other Faculties are so low as to be derisory. It is not helpful to Universities struggling to retain academic staff to have a Member of Parliament saying in a debate in the House (if correctly reported) that, in supporting the claims of University staff members, those in other political parties are "seeking to cash in on every grievance to make political capital" or that "Extra funds for education should go to the under-fives before University staff". The needs of the under-fives are obvious, and so, too, should be the plight of pre-clinical teachers and those in other Faculties.

At the moment, Lecturers in clinical departments are benefiting from the astonishing agreement that has been negotiated in such a way that some junior doctors receiving large overtime payments have a considerable fall in salary if they become Consultants. It is to be hoped that, in future, Lecturers and junior hospital doctors will receive an adequate basic salary and that, if promoted to Senior Lecturer or Consultant, their salaries will rise, not fall. Surely anyone who may read this number of 'Res Medica' in twenty years' time will find it difficult to believe that the present situation could have existed. If he is not surprised, then he is likely to have emigrated!

The writer of this article held House Posts in the days when these were unpaid. Since there was virtually no off-duty, expenses were low, but a laundry bill had to be paid to the Royal Infirmary. There were no students grants, apart from a possible £50 per annum that could be paid by the Carnegie Trust to Scottish students. It was possible to live as a student or House Officer on five shillings a week, and many did so. Some Ward Sisters still lived in rooms beside their Wards and worked a seven day week. In the writer's student days there was still in post a Ward Sister who had not had a holiday for twenty years. Fortunately, these days are over. There are, however, changes in the opposite direction. In an address to those graduating in 1855, Professor Sir James Young Simpson referred to an Edinburgh graduate of nine year's standing with an income of £5000 per annum. Income tax was the equivalent of 3½p in the £ and in the light of the cost of living of the mid-nineteenth century this was wealth indeed. It is unlikely that any Edinburgh doctor of today earns enough to meet the defence insurance premium of some American specialist surgeons.

It must be remembered, however, that many patients in Britain could not afford medical treatment prior to the introduction of the National Health Service.

Devolution

The differences between many aspects of administration in Scotland from those in England and Wales are, on the whole, beneficial to us. Scotland is sufficiently compact for the "faceless bureaucrats" to be real live people, often well known to the members of the University staff or to colleagues in the N.H.S. It is possible that a telephone message to St. Andrew's House along the lines of "For Heaven's sake, Willie, what are you up to this time?" could be sent from any part of the country. In England such a method of communication is unlikely, particularly from areas outside the metropolis.

The Scottish Medical Deans meet regularly, and jointly meet the Chief Medical Officer at St. Andrew's House to exchange views. Naturally, the Dean and Executive Dean meet daily. The Dean, the Post-Graduate Dean, the President of the Royal College of Physicians of Edinburgh and the President of the Royal College of Surgeons of Edinburgh are in constant touch with each other. The Deans have regular meetings with the Chief Administrative Medical Officer of the Lothian Health Board. On the other hand, there is no real desire amongst the majority for further devolution

in the Universities or in the National Health Service, and the break up of the United Kingdom by separation would be likely to lead to an exodus from Scotland of many members of the academic staff of the Faculty of Medicine if the opinions that have been expressed are to be believed. At the same time, the majority of staff and students want the Medical School to remain an international one rather than become a parochial institution. We are particularly well known abroad for our post-graduate activities.

Scottish Health Authorities Revenue Equalisation (the SHARE Report)

Recently a report has been published on behalf of a Committee established to review the allocation of revenue resources to the various Health Boards in Scotland, something comparable to what has been the subject of a report in England. There are 15 Health Boards in Scotland, with populations ranging from just under 20,000 to just over one million. In England the range is from about 1¼ million to just over 5¼ million. Accordingly, the English model cannot easily be transferred to Scotland. The calculations are complex and include weighting for various factors, including the numbers of undergraduate medical students that are being taught. The report is being studied widely at the moment and the Faculty of Medicine is giving its views, but, if implemented, the percentage share of money for hospital and community services in the Lothian Health Board area will be less, in Tayside much less, and in Ayrshire and Arran and in the Islands much more. Just what that will mean to our present medical students after graduation will depend upon the total sum available for Health Care. This report does not deal with building projects, and it must be stressed that just like the Universities, the N.H.S. is having financial problems.

Consultative Document on the Redeployment of 'Acute' Hospital Facilities

Another matter that is exercising the minds of those in the Faculty of Medicine is that the Lothian Health Board has issued consultative documents revealing their plans for redeployment of acute hospital services. This is mainly something for the future and it is hoped that it will not delay further the rebuilding of the Royal Infirmary and the Western General Hospital.

The suggested long-term plan is to have "acute" beds at five general hospitals, a suggested distribution being 687 at Edinburgh Royal Infirmary, 421 at the Western General Hospital, 420 at the

West Lothian General Hospital (Livingstone), 203 at a 'Southern General Hospital (possibly at Dalkeith) and 100 at Roodlands Hospital (Haddington). There will be 215 acute beds elsewhere. This is based on the expected distribution in population in 1996. Those of us who believed at one time that the rebuilding of the Royal Infirmary and Western General Hospital would have been completed by 1970 are naturally somewhat cynical about any programmes for the future, but, if these new plans are accepted, the pattern of teaching of clinical medical students will have to be altered to adapt to the new situation, and U.G.C. money will be required to match the N.H.S. building programme. No doubt, by the time this happens (if it does), the flow of North Sea oil will have ceased. From whence will come the money?

Peculiarities of the Edinburgh Medical School

It is obvious that this is a time of intense activity, and, because of its traditions and geographical position, Edinburgh is possibly more heavily involved than other cities. In many ways this is fortunate because it adds spice to life. The Faculty of Medicine celebrated its 250th anniversary in 1976, the Royal Infirmary celebrates its 250th anniversary in 1979, the Royal College of Physicians has its 300th anniversary in 1981 and the University of Edinburgh celebrates its 400th anniversary in 1983. Fortunately, the oldest constituent of the Medical School, the Royal College of Surgeons, is not about to celebrate anything in a major way. The others are setting up committees to organize their celebrations, and the Faculty has just recovered from its efforts.

Edinburgh is not a particularly large capital city, but it has unrivalled medical traditions and is known the world over. It is a favourite place for

medical graduates to wish to carry out their duties, but, because its population is not tremendous, the number of doctors that can be gainfully employed is limited. To this group there turns for co-operation and advice, international bodies, Government Committees, United Kingdom national bodies, overseas Medical Schools, the British Council, the Scottish Home and Health Department, the University of Edinburgh, the Faculty of Medicine, the Lothian Health Board, the Royal Colleges of Surgeons, the Royal Colleges of Physicians, the Royal College of General Practitioners, other Royal Colleges, specialist societies, the Area Medical Committee, the North and South Lothian District, the University Liaison Committee, Specialist Advisory Groups (covering Areas cooperating in our teaching programme) and a vast network of sub-committees spawned by each of these. It is unlikely that anywhere else there can be so many bodies dependent on one Medical School.

No mention is being made of the Dental School in this article, not because it is unimportant, but because it merits a separate account. Here, too, there is an interlocking of interests with other activities of the Faculty of Medicine.

It may be added that Edinburgh is believed to attract more postgraduate doctors than any other Medical School of comparable size, there being more than 1500 in any given year, although some are here to attend short Courses.

We have much to be proud of, not least the quality of our undergraduate medical students. Our entrance requirements are high, but our students are most excellent. As a result, our hospitals are staffed by first class House Officers and so the cycle of excellence is maintained. Despite all that is going on, or perhaps because of it, we can look forward to the future with confidence.

Floreat res medica Edinburgensis

From a dissertation read before the society

"Opium eating: its effects and mode of cure"

Robert Byers 1853

"In opium smoking, the first effect of the drug on the Chinese is to render them more loquacious and animated. Gradually their conversation drops, laughter is occasionally produced by the most trifling causes and to these effects succeed vacancy of countenance, pallor and shrinkage of the features."

Teviot Place then;

FIFTY-FIVE YEARS AGO

Sir Derrick Dunlop, M.D., D.Sc., L.L.D., F.R.C.P.E., F.R.C.P., F.A.C.P.
Emeritus Professor of Therapeutics, Edinburgh.

Having studied my preclinical subjects at Oxford and taken a B.A. degree in Physiology, I came home to Edinburgh in 1922 to do my clinical work. I thought it might be amusing and interesting to contrast our work, habits and behaviour at that time with what they are now, for the students of today are like everything else, different from what we were over half a century ago.

To begin with they are, on the average, undoubtedly of a higher intellectual standard. In my day almost anyone could become a medical student provided he was not so completely half-witted as to be unable to pass the simple matriculation examination demanded and provided his parents were ready to pay for him. Thus a number had indifferent intellectual qualifications.

Scottish universities were always more democratic than those of Oxbridge and in them there was invariably a sprinkling of lads o' pairs whose parents in humble circumstances had often made incredible sacrifices to send their sons to college, and Andrew Carnegie's scholarships helped many to maintain themselves in rather straightened circumstances. On the whole, however, most medical students in the university then came from middle class homes, often with a hereditary medical background. In Edinburgh too, at that time the extra-mural school was flourishing, comprising a very cosmopolitan collection of students for whom practically no academic entrance qualifications were required at all. Thus every year had a tail of "chronics" failing repeatedly at their examinations but allowed to continue indefinitely if they liked till they finally passed. A plough rate of at least 20 per cent at professional examinations was common and the bloomers of the "chronics" constituted the jokes and banter which enlivened the luncheons for the external examiners.

All those connected with the selection of medical students nowadays agree that today's students are far superior intellectually to what they were, resulting from their very stringent selection from a broader spectrum of society consequent on the elimination of the financial barrier. In Edinburgh, for example, 150 students a year are now carefully selected from over 2,000 applicants and the extra-mural school has vanished. No wonder they are very able young people! Practically no-one fails in professional examinations nowadays so that there is a feeling that they might be abandoned altogether in favour of progress reports. The acceptance of medical students depends almost entirely on the number of A and O certificates they have collected. This is reasonable for the State is now largely responsible for their education and there must therefore be no suspicion of nepotism, influence or final status. Acceptance by examination is free from such drawbacks and on the whole examinations do distinguish intelligent people from stupid ones. Nevertheless they do not necessarily select those who are kind, who have common sense and who are likely to have a deep interest in and sympathy for their future patients — qualities as important for a practising doctor as high intelligence. It has been claimed that if examination results are combined with an interview, that would go far to resolving this difficulty, but does it? A ten minute interview may tell us if a candidate is tidy and has nice manners, and should two candidates be indistinguishable academically it is better to choose the one who is clean and pleasant, but it does not give much more information. Indeed it may give an advantage to a flashy extrovert than to a decent introvert. At Harvard their likely candidates are taken for an observation weekend in the country. The encounters between them and their interlocutors must be very artificial unless the victims are plied with alcohol and their

veritas observed *in vino*. To judge from the excellent results our present system of selection seems to be most satisfactory. Nevertheless, to end this encomium of modern medical students on a rather sour note it is possible that they may not be quite so dedicated to their future profession as were some of their more doltish predecessors. For instance in my day I heard little chat about "overtime" or "industrial action"!

For many years after the first World War the University admitted some 250 medical students a year. There were also large numbers of extra-mural students doing their clinical work in Edinburgh. Apart from midwifery, paediatrics, infectious diseases and psychiatry, those hordes of students were all taught in the Royal Infirmary. Craigleith Hospital, as the Western General was then called, had been a poorhouse until converted into a military hospital during the 1914-18 war, but by 1920 it had again reverted to the parish and then to the municipal authorities. Many years elapsed, however, before it developed into the great teaching hospital it now is. None of the numerous other hospitals in Edinburgh or its environs were used for teaching apart from the Simpson, the Sick Children's, the City and the Royal Hospital at Morningside. Thus the wards of the Infirmary were overcrowded with students and in popular charges it was sometimes difficult to catch a glimpse of the patient being demonstrated.

Until the start of the National Health Service in 1948 the Royal Infirmary was controlled by a medical superintendent — usually a retired R.A.M.C. major-general or colonel — and a secretary and treasurer. These two men, with the help of a few clerks and typists, ran satisfactorily what was then the largest voluntary general hospital in the U.K., and there were very few committee meetings of the staff. Of course medicine has now become more complicated and the N.H.S. has bred many problems. Nevertheless the large number of officials required to control the hospital nowadays is surprising and the spawning of so many committees is regrettable as they occupy much of the time of the clinical staff.

Until the commencement of the National Health Service the staff of the Infirmary and the other hospitals in Edinburgh was an honorary one earning its living by private practice. Like so many Robin Hoods they mulcted the relatively rich so that for some hours a day they could look after the poor for nothing and have the prestige of being on the staff of a great voluntary teaching

hospital. The clinical professors got from the University what we would now consider derisory salaries of a few hundred pounds a year. The Professor of Therapeutics, the first of whom was appointed in 1920, was the only full-timer at £1,000 a year and had charge of the clinical laboratory. There were eight medical, eight surgical and three gynaecological charges besides the special subject units of E.N.T., ophthalmology, dermatology and V.D. Each charge was staffed by a chief, an assistant chief, a clinical tutor and a houseman, which seems modest compared with the modern mostly full-time staff.

Nearly all the work in a medical charge was done by the house physician under the direction of his chief. If the assistant physician was on good terms with his senior he was allowed to take part in the work of the ward and in the teaching of the students. Otherwise his work was confined to the medical out-patient department on the ward's waiting day and to deputising in the ward when his chief was on holiday or ill. I well remember one assistant physician looking into the ward for some purpose when his chief happened to be there. Seeing him the latter stopped his work, stalked down the ward, shook his assistant by the hand and said "Good morning Dr., and what can I have the pleasure of doing for you?".

The work of the clinical tutor on the medical side was confined to one or two hours teaching in the morning and service under the assistant physician in the M.O.P.D. On the surgical side he was more active, for besides teaching the students "bandaging and instruments" he usually assisted his chief at operations and often in his private practice. Though he got his keep the houseman worked without pay for 24 hours a day for seven days a week with a few interrupted hours for sleep. It was an eagerly sought appointment!

The chief would usually arrive at his ward between 10 and 11 a.m., see his patients, teach or operate and leave between 1 and 2 p.m. Apart from the waiting assistant surgeon who stood by for emergency operations the care of all patients in the great institution then devolved upon newly-qualified housemen . . . and the ward sister. The latter, in those days, were great ladies of considerable clinical experience. Their whole life revolved around their wards and indeed their sitting rooms and bedrooms opened on the ward corridors from which they popped out should anything unforeseen occur. Their salary was £80 a year and they often retired to penury. They really took the veil as they seldom married. The

honorary staff, the housemen, the nurses and students admired, feared and often loved them.

Just as the students were different in the 1920s so were the patients in the Infirmary. They were usually very poor people, ready to sit patiently, sometimes for hours, in ward corridors and out-patient departments in the hope of benefiting from the advice of the honorary staff. When admitted to the wards they were often dirty, malnourished and lousy. It must have been a traumatic experience for often gently nurtured probationer nurses to clean them up. The wards were redolent with the aroma of sassafras oil with which the patient's scalps were annointed. Even small shopkeepers felt it a little disgraceful to go to a charitable hospital and were prepared to expend their small savings on being treated in the Queen Mary Nursing Home in Chalmers Street or in a private ward at the Chalmers Hospital at two to four guineas a week. How different it all is now when patients feel that the state hospitals belong to them and rightly expect a degree of civil service from their staffs!

As students we certainly had plenty of theoretical instruction but owing to our vast numbers in the Infirmary it was important to become a junior houseman in order to gain practical clinical experience. Such positions, of which there were usually two or three to each charge, were eagerly sought. On the surgical side the "juniors" acted as dressers, shavers of abdomens, wheelers of trolleys and occasionally holders of forceps and retractors at operations. On the medical side we helped with case histories and with simple laboratory procedures, which are now all sent to central laboratories. These were often done in the side-rooms of the wards: red and white blood counts, haemoglobin estimations, sputum examinations, urine tests, test meals, occult blood in stools and so forth. Only Wassermanns, blood and urine cultures, blood chemistry (blood sugar curves and renal function tests were big science in those days) and the pathological examination of tissues were sent to central laboratories staffed by the University. Many of the results obtained by the housemen and their "juniors" were often most inaccurate. Doubtless the system provided good experience for them, though very time-consuming, but was not so good for the patients. On the other hand it is so easy now for housemen to send specimens with unthinking requests for every conceivable sort of biochemical, bacteriological and radiological examination that all these services are being over-

used at great cost in money and manpower.

Owing to the great number of students who had to be taught in the 1920s considerable regimentation was necessary, to which we were quite ready to submit. Like dumb driven cattle we knew just where we had to be from morning to night. We were lectured to perpetually — at least three or four times a day. Each professor attempted, usually very ably and personally, to cover in his course of lectures all the essentials of his subject during the time allotted to him in the curriculum. There we would sit poised over our notebooks to get it all down almost to the extent of the "good morning" with which the professor might greet us. If we were diligent note-takers, if the notes were legible and if we learned them thoroughly it was hardly necessary to read anything else to get through our examinations. This persisted up till the last war. I became a professor in 1936 and well remember how some pathetic little joke I made in a lecture would reappear in examination papers afterwards. On reading the scripts one felt a little like a dog returning to its own vomit.

Of course we were lectured to far too much and it is good that students are now stimulated to be more productive and less purely receptive, but the modern tendency to decry lectures altogether is excessive. There are many principles that can be taught as well to 100 people in a lecture theatre, and with a great saving of teaching time, as to five in a tutorial. Lectures should not attempt to replace textbooks, to comprehend the whole subject or to instil a mass of facts; they should attempt in the course of an hour to leave two or three important principles in the minds of their audience illustrated by examples, and they should amuse, stimulate and indicate what is important to read.

From the sawboneses of Dickens' day to the time when I was a medical student we were always regarded as the rowdiest, most drunken and disreputable of the students. Indeed in polite society one hesitated to confess to being of their number. People were often astonished by our rapid metamorphosis into respectable citizens after qualification. Our Saturday night frolics in which we made ourselves objectionable to the citizens were not, however, protests against authority — indeed we were rather obsequious to our seniors — but just high-spirited hooliganism like the Corinthians of long ago who rioted in the town and assaulted the watch. This tendency found full vent during the rectorial contests to elect some

notable statesman, admiral or general as Lord Rector, involving appalling combats with flour, eggs and soot. The subsequent address by the distinguished man we were supposed to have honoured by our suffrages was invariably made inaudible by our interjections and missiles, including terrified fowls projected from the galleries of the McEwan Hall. Not surprisingly we seldom saw the Lord Rector again. He at once appointed as an assessor some decorous Edinburgh W.S. who thereafter deputised for him at the University Court but had little or none of the contact with the students as is the case with the modern Rector. In respect of behaviour medical students as in other things have changed: they now seem to constitute the respectable "establishment" of the undergraduate population.

Another of the things which have changed greatly since the 1920s are the clothes worn, though this perhaps applies less to medical than to other students. I was at my old College at Oxford recently where some repairs to the roof were taking place and it was hard from their dress to distinguish the dons or the undergraduates from the labourers on the scaffolding. In my day we all wore suits at classes or in the wards – often seedy and shiny but conventional garments. I remember one Saturday morning going into the ward in plus four knickerbockers, being about to play golf in the afternoon, and plus fours were then the conventional uniform for that pastime. My chief, who was examining a patient looked up at me with the greatest distaste and said, "Sir, this isn't the gun room". It is hard to imagine such a remark these days.

It is difficult to believe that the inspired romanticism of the poems of Rupert Brooke was what then most appealed to the youth of the country. At the back of them was an old-fashioned patriotism. Patriotism seems to be a rather fuddy-duddy expression nowadays, to be discarded in favour of protests against the form, conventions and establishment of society (we did not indulge in protest marches in the 1920s!). Doubtless this tendency started before the last war when in the Oxford Union they passed the famous motion that they were no longer interested in fighting for King and Country. Yet within a short time the same students were piloting the Spitfires in the Battle of Britain, manning the Malta and

Murmansk convoys or among the soldiers of the Eighth Army at Alamein. Doubtless it would be the same now.

Then as now the Royal Medical Society played a great role in our undergraduate life. It was splendid when we held our meetings in the magnificent old Hall in Melbourne Place with coal fires burning at each end, in the middle the Senior President on a rather unsteady eminence, his officers below him resplendent in dinner jackets and the members on plush-covered benches to one side. The other rooms were hardly on the same plane: a cold common stair opening on some rather bleak rooms containing our great library. Its historic volumes were only very rarely consulted by some visiting scholar. Our exiguous undergraduate subscriptions were insufficient to insure or rebind them. Moth and rust consumed them and an occasional thief would break through and steal. Although we retained some of the library's gems – the dissertations in the youthful handwriting of famous medical men and the volumes particularly relating to Edinburgh – we were nevertheless much criticised for selling the library for which we got a considerable sum. Though I must take a considerable share of the responsibility for the sale I am confident that we were right in what we did.

I was a Junior President of the Society and for weeks before the Presidents' Annual Dinner, which was much as it is now, rehearsed the toast of the City of Edinburgh which I had to propose. Delivered without a note I hoped it would sound extemporary but it was probably more like a recitation. In our new, comfortable and convenient quarters we have many advantages, including the presence of women students. I am sure that when their admission was proposed I would have opposed it violently. How wrong I would have been! Besides being decorative and enchanting they have contributed much else. Apart from the splendid Hall of Melbourne Place the only thing I regret in our new home is the status of our noble bird who sits crouched on the floor like one in the zoo. Perched on the roof of Melbourne Place he surveyed the view with his eagle eye: to the north the Forth, to the south the Pentlands, to the west the Castle, to the east St. Giles and Holyrood. How lucky we are to study medicine in such a noble setting!

PRINCIPLES AND PRACTICE

MODERN MANAGEMENT OF DUODENAL ULCER

Alan Boyd B.Sc.

Introduction. Chronic peptic ulcer of the duodenum is a common disease. It causes the loss of over two million working days per annum in the U.K. In Scotland, its sufferers occupy over one hundred thousand bed days, and, along with benign gastric ulcer it kills almost four hundred Scots per year.^{1,2} By the age of fifty about ten per cent of the male Scottish population will have been affected by it.

If it is not rare, neither is it new. The term peptic ulcer was first used in 1882 by Quincke, believing that pepsin was the prime culprit. Bilroth first performed his operation in 1881, so we have nearly a century of operative experience to draw from.

Yet despite this, there is still controversy over how this condition should be managed. Until recently our drug therapy was ineffective in altering the natural history of the disease, and even now has little place in recurrent ulceration. And trying to untangle the mass of surgical literature with many surgeons each promoting the virtues of one of the various manoeuvres, with at least nine major and a multitude of minor variants on offer, is not easy.

And why should this be? Largely because we still do not fully understand its multi-factorial aetiology, when applied to the individual. Many factors have been implicated, most now well founded, but some still a little dubiously, but we are still not in a position to relate these to each patient, and treat his disease specifically, even if we had the means. And on the surgical side the differing emphasis placed on the balance between effectiveness and sequelae, both morbid and mortal, compounded by the natural variations between surgeons' techniques and abilities, as well as patient variables have served to muddy the waters for those seeking clear cut answers.

However, in the last few years new developments have arisen, both in the medical and surgical managements which promise to radically improve the outlook for our patients. The advent of Histamine H₂ receptor antagonists has given us a potent and specific means of reducing acid secretion, and the development of Highly Selective Vagotomy offers a less ablative approach with a marked reduction in the side effects so long associated with gastric surgery, and it is on these that I shall concentrate.

Uncomplicated Chronic Duodenal Ulcer

Conventional wisdom has it that the initial management of duodenal ulcer, in the absence of life threatening complications, should be conservative in all cases, and nothing has appeared in recent years to change this.

Admission to hospital is preferable, as bed rest still remains a corner stone of therapy and the release from domestic tensions and pressures may aid this. This alone is enough to bring relief of symptoms within a few days to many patients, a fact which must be borne in mind when assessing the efficiency of drugs. Eighty per cent of patients will remit symptomatically for a greater or lesser period without specific treatment.

Stopping smoking has been proven to speed healing of gastric ulcers, but the evidence in duodenal ulcer is less conclusive. Empirically, however it seems sensible and is retained by most clinicians.

As for diets, the milk-fish diet of the past has been discredited, with hourly milk feeding having shown to increase acid secretion, and no evidence of increased healing being found. Dietary advice should now be limited to avoiding those foods and alcohol which aggravate symptoms and to taking regular smallish meals.³

Drug treatment has evolved considerably in recent years, and there is now much evidence that healing can be accelerated as well as symptoms alleviated. The drugs available fall into five categories according to site of action.

1. Antacids. Providing purely symptomatic relief, these were the main stay of treatment until the newer drugs arrived. They remain useful adjuvant therapy for relief of symptoms, and should be allowed freely.

Total titration of gastric acidity is neither practical⁴ nor necessary. What is required is rapidity plus freedom from side effects, which is best achieved by balancing the cathartic and constipating effects of magnesium and aluminium compounds.

2. Anticholinergics. These are many and various yet differ little in their effects or side-effects. They are less effective than antacids for symptoms and have no evidence for a healing action.⁵ Since their role in maintenance therapy for the prevention of recurrence is also contested⁵ they must be of declining usefulness in today's treatment.

3. Antipepsins. These synthetic sulphated mucopolysaccharides eg. amylopectin are claimed to interfere with auto digestion by pepsin. They are very expensive and not generally available though they may have an effect on recurrence⁶, again disputed⁷ and requiring further evaluation.

4. Mucosal Barrier Fortifying Agents. The first of the new generation compounds, this group has three contenders. Carbenoxolone is a liquorice derivative, whose mode of action is not clear, but which may stimulate mucus production. When it first appeared in produced very poor results in duodenal ulcer (Doll, 1962), though effective in gastric ulcers, but it has recently been re-examined in the belief that effective concentrations had previously not been realised in the duodenum and now a degree of endoscopically proven healing has been shown.⁵ But it has serious disadvantages in terms of side effects producing salt and water retention and potassium loss. Conventional diuretics worsen the potassium loss and spironolactone blocks its therapeutic effect which must limit its use in duodenal ulcer.

Deglycyrrhized liquorice has not been shown to speed healing, but chelated Bismuth has, to a minor degree⁵

5. Histamine H₂ Antagonists. Histamine is thought to be an intermediate messenger in the acid and pepsin secreting pathway in the gastric mucosa both for vagal and gastrin stimulated

secretion. The receptor for this is pharmacologically different from that mediating bronchial and smooth muscle contraction and is designated H₂. The first drug to be developed was Burimamide which was shown experimentally on dogs to reduce acid secretion. However it lacked potency and could only be given parenterally, and was replaced by Metiamide which was put on trial. The largest published trial was the International Multicentre Trial⁸ which followed sixty seven patients with endoscopically confirmed duodenal ulcer in a metiamide v. placebo randomised controlled trial.

Ulcer healing in six weeks was significantly increased compared to placebo (Table 1). It also produced a statistically significant reduction in antacid consumption and daytime pain, measured by a self scoring system.

This difference was greater than has been shown for the other groups of ulcer healing drugs.

	% endoscopically proven healing at six weeks
Placebo	25
Metiamide 1g/day	62)
Metiamide 1.3g/day	73)
	}— 67

Table 1

However Metiamide had several side effects, the most serious of which was bone marrow depression which led to one death. This led to the toxic thiourea group being replaced by a cyano-guanidine group and the new drug cimetidine was released for trial.

The results published so far seem to indicate that cimetidine is both effective and free from major side effects though of course it will be some time before the latter can be stated categorically.

Pouder⁹ produced complete healing in all of a series of ten patients on cimetidine 800 or 1600mg/day, for six weeks. Heggie¹⁰ produced healing in seventeen of nineteen patients (90%), on 400mg t.d.s. Bodemar and Walan¹¹ showed ninety per cent healing in a series of forty-four patients, as against thirty-six per cent on placebo, on a regime of 200 or 300mg q.i.d. They also followed acid secretion, antacid consumption and self assessed symptoms and found a statistically significant reduction in all three. Marginally better results were found on the higher dose.

Cimetidine has undoubtedly been a great breakthrough. These series showed ulcer healing

and symptomatic relief in ninety per cent of patients, a far better result than has been achieved by other drugs. Antacids failed to heal ulcers faster than methyl cellulose, the control chosen for one trial.

However, one major problem still remains, namely that of recurrence, since the now standard six week course does not alter the natural history. In the series by Heggie¹⁰ seven of his seventeen patients with healed ulcers had a recurrence within a month of stopping treatment. Trials of continuous cimetidine as a prophylactic measure on a dose of 400mg/day, taken at night, are now under way, but early results indicate that this is not fully effective.¹²

Fortunately cimetidine, being as yet free from side effects, may, with long term therapy (for life?), offer an answer to recurrence for many sufferers, but evaluation of this is based on a few trials with small numbers of patients followed for relatively short periods, and an answer cannot yet be given.

Therefore, the treatment of recurrent or persistent ulceration is still surgical. The indications, which have not altered for some time, are reasonably clear. They are:

- a. intractable pain, or recurrence of pain with frequent loss of work
- b. complications — pyloric stenosis, perforation or bleeding
- c. presence for five years or more.

The last is a little more controversial but it has been stated that an ulcer present for five years is unlikely to heal and that the risk from complications of having an ulcer for five years is similar to that of an operation.

The present authors of "Bailey and Love" suggest that patients should "earn" their operation, since unless they have suffered from some pain or a complication they may be ungrateful if significant symptoms arise from surgery. But this may change at least in degree in future years if recent developments hold good.

Having decided on surgery the choice is wide and a short survey of the alternatives may be useful. The aim of operation is to reduce the amount of acid bathing the duodenum which can be achieved by bypassing it, removing a part of the secretory apparatus or by removing the stimulus to secretion both neural and endocrine.

The earliest operations were gastrectomies with duodenal or jejunal anastomosis. This was fairly effective but had numerous side effects and

a high mortality. Sectioning of the vagi at the oesophageal hiatus was introduced, thus removing both direct and gastrin mediated secretion. However the vagi control gastric emptying and gastric stasis was produced necessitating a drainage procedure either by pyloroplasty (at least four methods), gastrojejunostomy or antrectomy which also has the virtue of removing the gastrin mediated stimulus to secretion.

By the mid sixties many surgeons had become dissatisfied with these operations. Many variants had been tried but despite long experience few good results were obtained and new ways to deal with the problem were sought.

With titles like 'The Surgeon's Dilemma'¹ the papers of the period set out the problem. Partial gastrectomy had the lowest recurrence rate but serious side effects and a significant mortality. Vagotomy and drainage was safer but had a higher recurrence rate and a different though no less debilitating set of side effects.

This led to the development of a selective vagotomy to overcome of the post vagotomy symptoms by leaving intact the hepatic and coeliac branches, and, most recently, a highly selective vagotomy which leaves the antrum innervated as well, allowing normal gastric emptying so that no drainage procedure is necessary.

The reasons for dissatisfaction were not hard to see. Table 2 lists the incidence of side effects and recurrence found in four of the more popular procedures. Five hundred and eight patients were followed for five to eight years in the Leeds York trials.^{13,14} Uncharacteristically this series produced only one operative death (in the truncal vagotomy and pyloroplasty group) partly due to selecting out of high risk patients and partly due to the great experience of all the participants.

Similar results were obtained in Glasgow¹⁵ and in America by the Veterans' administration who followed 1357 patients.¹⁶ These results showed that only major gastric resection carried a higher mortality — nearly 2% as against 0.6% — 0.9% for other operations. With their low mortality they pointed towards truncal vagotomy and gastrojejunostomy or antrectomy as the best operations in experienced hands and called for a halt in the drift towards vagotomy and pyloroplasty which was steadily growing in popularity due in part to its more physiological approach.

Nevertheless this still produces a considerable and unacceptable burden of sequelae, even in the best hands.

	Vago- tomy and enter- ostomy	Vago- tomy and antrect omy	Sub- total gastrect omy	Vago- tomy and pyloro plasty
	n=119	n=116	n=107	n=164
Epigastric fullness	40.2	36.3	36.5	37.1
Early dumping	17.9	8.6	21.5	11.9
Late dumping	6.0	4.3	0.9	1.9
Nausea	12.8	17.2	23.4	17.6
Food vomiting	4.3	9.6	5.6	4.4
Bile vomiting	14.5	13.8	13.1	10.1
Heartburn	19.8	15.7	8.4	12.6
Flatulence	17.9	22.8	19.8	20.1
Dysphagia	1.1	0.0	0.0	0.6
Reflux	4.0	7.0	4.3	---
Diarrhoea	26.3	23.2	6.5	21.7
Degree of certainty of recurrence				
Proven	3	0	1	11
Suspected	4	2	1	7
Very dubious	3	4	3	5
Total	3-10	0-6	1-5	11-23

Table 2

The first major trial of selective vagotomy was by Kennedy in Belfast who followed one hundred patients with truncal vagotomy and drainage or selective vagotomy and drainage and produced a reduction in post operative diarrhoea from 30% to 8%, a statistically significant result (a rare event in most of the surgical papers on duodenal ulcer), with similar results for recurrence and other symptoms.

Most attention soon turned however to highly selective vagotomy which on a theoretical basis offered much by not interfering with gastric emptying and by not requiring the alimentary tract to be opened. It was first performed as early as 1957 by Griffith and Harkins on an experimental basis but they included a drainage procedure. Andrup in Copenhagen and Johnston in Leeds were the first to perform it without drainage. Soon many people were trying it and reporting their results which, often, were very poor for a number of reasons. But many of these bad early results pointed to errors of technique and procedure and are worth looking at.

One major early fault in technique was an incomplete oesophageal clearance and this was illustrated by poor results in a number of studies. Kronberg in Copenhagen¹⁸ produced excellent results for dumping, diarrhoea and epigastric fullness but a recurrence rate of 22%, after one year. Hellenbeck¹⁹ in America managed to reduce their incidence of recurrence from 15.4 to 6% (one

from seventeen) by increasing their oesophageal skeletonisation from two to seven and a half centimetres above the cardia. Similarly, another study by Kronberg²⁰ compared four techniques for the operation with lower recurrence when the oesophagus was adequately cleared, finally adopting the technique of Goligher which was superior for both recurrence and symptoms. Another problem, shown by Sohlaurg²¹ in Bergen passes a comment which is pertinent to most of what has been discussed so far, namely that good results depend on experience operators. The Bergen study included a large number of junior operators some of whom had only assisted at one such operation before undertaking it themselves. Though few of their results could be considered good, they steadily worsened with the increasing inexperience of the operators. It must be remembered that most of the good results both for the more established and the more recent operations have been obtained by very experienced surgeons with a special interest in, and performing large numbers of, the particular operation and so their results will be hard to repeat, though this is balanced, in part at least, by the fact that the new operation is young and should improve with age as has been the case with most procedures as further improvements in fine technique are developed.

In order to assess the place of highly selective vagotomy (HSV) in the modern management of duodenal ulcer, we must have the answers to three questions:

- i. Is it safe?
- ii. what are its post operative consequences?
- iii. is it effective?

Its safety is least in doubt. Johnston in Leeds²² sent a questionnaire to all the surgeons he knew to be doing HSV's and received replies covering 5539 patients. This showed an overall mortality of 0.31%, compared to 0.8% in 6490 cases of truncal vagotomy and drainage, and 1.6% in 1725 cases of truncal vagotomy and antrectomy from other collected series. The only specific mortality related to this operation was from upper gastric necrosis which accounted for five deaths (0.09%), and prompted Johnston to advocate the reperitonisation of the lesser curvature as well as careful preservation of vasculature not sacrificed necessarily in the procedure.

Reports of post operative sequelae vary, but largely agree that they are significantly less than for other procedures.

Grassin	787	1-6	1.1	0.4	0
Hedenstedt	465	0.5-7	1.0	2.0	0
Liarag	265	3-6	6.0	2.0	0
Goligher*	250	2	1.0	2.0	2.0
Holst-Christeson	160	1-4	9.0	Not severe	
Kennedy	112	mean 2.2	6.0	7.0	2.0
Lyndon*	100	5	1.0	—	—
Sayers*	84	0.5-4	1.2	1.0	1.0

Table 3 Taken from Andrup²³ except for *(24-26)

The figures in Table 3 for incidences of diarrhoea and dumping compare extremely favourably with those in Table 2. The problem of poor drainage leading to epigastric fullness and gastric stasis was anticipated, but reports vary enormously. Goligher puts epigastric fullness at 29%, Sayers at 8%, but Goligher claimed that all but one of his patients could eat a normal meal without discomfort. Johnston's mammoth collected series put gastric stasis, both early and late, at 1.3%, with a reoperation required to provide drainage in 0.8% Barium and other studies have shown that in general liquids drain a little faster than usual and solids a little slower.

The series by Lyndon also showed that, although all their patients gave a negative Hollander test one week post operation, this was rapidly changed to a positive rate of 94% after three years. However, the level of peak acid output on insulin stimulation was only 10% of the pre-op level, and offered no prognostic indicator for recurrence.

The incidence of recurrence with this operation in general is still not clear. Since it probably takes two to three years for a surgeon to familiarise himself with the operation and perfect his technique before he can reasonably compare it with his performance of more established procedures, and then takes at least five to ten years of follow up before reliable rates of recurrence can be established, and since no one has this length of experience, it would be foolish to make a final judgement on figures now available. Nevertheless some inferences can be drawn.

Table 3 also shows recurrence rates for most of the large series published to date and these vary

from 1 — 9%. Undoubtably these figures will rise with time as the follow up lengthens. The best result (1% at 5 years by Lyndon) compares very favourably with any other method but in general this has not been widely achieved. We can say for certain that it will not prove as effective as vagotomy and antrectomy or larger gastric resections but that it could equal results for vagotomy and gastro-jejunostomy and will probably be more effective than vagotomy and pyloroplasty. Comparisons with selective vagotomy and drainage are few, but four randomised controlled trials reported by Andrup²³ suggest near parity on recurrence but a strong advantage for the highly selective procedure as regards sequelae, though these again suffer from small numbers and a short follow up.

Thus, HSV offers an attractive proposition to those favouring minimal intervention in the first instance, being very safe and largely free from side effects, and who consider acceptable the possibility of a slightly higher incidence of recurrence perhaps necessitating a further operation at a later date. Those who consider surety as the prime consideration must opt for one of the established procedures with vagotomy, preferably selective, plus antrectomy offering probably the best choice. If it were I on the table, I would want a surgeon of the former kind.

Summary

On confirmation of the diagnosis of duodenal ulcer medical treatment should be instituted. This will consist of bed rest, stopping smoking, a minimally altered diet and drug therapy in the form of cimetidine 1.3 g/day in divided doses with additional antacids as required. This will produce healing in about 90% of cases within six weeks. Thereafter cimetidine 400 mg/day may be useful as prophylaxis. For persistent or recurrent ulcers (or for complications, with which I have not dealt here) surgical treatment is required. The choice of operation will continue to depend on the surgeons preference but the new operation of HSV, if it maintains or improves its reliability as it develops, must continue to grow in popularity, offering as it does both greater safety and greatly fewer post operative symptoms.

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PERIPHERAL ENTRAPMENT NEUROPATHIES

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The effects of peripheral nerve compression have only been appreciated for a century. Panas published the first description of tardy ulnar palsy in 1878⁽¹⁷⁾, exactly a hundred years ago, although Morton had preceded him by two years in his classical paper⁽¹⁴⁾ about the neuroma which may form in the forefoot after presumed pressure, repeated trauma or degeneration. Since that time many other peripheral entrapment neuropathies have been encountered and discussed^{(2) (10)} and the importance of early and effective treatment appreciated.

This paper will present a synopsis of the pathology and sites of such entrapment, excluding the lesions of nerve that may occur from proximal pressure secondary to vertebral disc, spinal or thoracic outlet pathology. The effects of ulnar nerve compression at the elbow will be discussed in some detail using data obtained from a recent retrospective review of 100 patients with this complaint.

Pathology

Mild but chronic nerve compression has been shown experimentally to cause partial obstruction of the vasa nervorum. This results in hyperaemia and oedema of the nerve trunk and gradual narrowing of the axons due to increased interstitial fluid pressure. The axons themselves may also increase in size, but this is again due to distention by oedema fluid. The axonal substance is displaced by this process⁽⁴⁾ and the nerve swells both proximal and distal to the site of compression^{(6) (25)}. Eventually the oedema fluid is invaded by fibroblasts and an irreversible fibrosis occurs which causes permanent loss of nerve conduction⁽²⁴⁾.

Although compression is probably the most common primary cause of these

changes, traction at sites such as the ulnar nerve in the post-condylar groove will also affect conduction. Paine⁽¹⁶⁾ quotes 19 possible mechanisms of chronic nerve injury at the elbow although most derive from nerve compression of one kind or another. The actual pressure to which the ulnar nerve is subjected was studied by Pechan and Julis⁽¹⁸⁾. Using fresh autopsy material they were able to show that the normal pressure within the "cubital tunnel" was 7mm of mercury when the arm is extended. This cubital tunnel is formed by the aponeurotic arch of the flexor carpi ulnaris muscle origin overlying the ulnar nerve just distal to the elbow joint and bridging the medial aspect of the proximal ulna to the common flexor origin. When the elbow is flexed to a right angle pressure around the nerve increases to approximately 20 mm of mercury, and increases further if the wrist is extended and the shoulder abducted. Pressures well over 30 mm of mercury have been recorded, similar to those observed in the carpal tunnel by Brain⁽¹⁾ and Tanzer⁽¹⁹⁾. The pressure required to impede flow in the vasa nervorum is not known, although in other tissues the capillary pressure is approximately 20 mm of mercury (Fronek⁹).

Diagnostic Features

The onset of symptoms secondary to compression of a peripheral nerve may be either gradual, intermittent or acute. Much depends on the underlying pathology and the site of the lesion. Pain is often a feature, although it is more accurate to describe this as paraesthesiae since pain in the hand is not, for instance, a constant feature of ulnar neuritis. Symptoms are present during both night and day, although they may be exacerbated by occupation or certain positions in which the limb may be held; thus the symptoms of ulnar neuritis may be worsened

by lying with the arm acutely flexed at the elbow, or the symptoms of meralgia paraesthetica (from compression of the lateral cutaneous nerve of thigh) may be worsened by adducting the thigh, for example when crossing the legs. It is said that symptoms from the carpal tunnel syndrome are more acute and continuous since the compression of the nerve is not intermittent, unlike ulnar neuritis where symptoms may be relieved by extending the arm. After symptoms have been present for some time there is usually blunting of sensation in the distribution of the nerve, although hyperaesthesia may be noted in the early stages. In mixed nerves, motor function may be preserved for some time, with no apparent loss of power. However muscle wasting often presents quite early and may be associated with a feeling of clumsiness in the hand or of subjective weakness in the leg.

Local tenderness at the site of compression may be acute, and it is often possible to exacerbate the distal symptoms by compressing the tissues at this site. A positive Tinel sign may also be elicited, indicating definite nerve injury. Infiltration with local anaesthetic at the site of tenderness may produce temporary relief and help towards the diagnosis. Steroid infiltration is also helpful and may give a permanent relief of symptoms in a proportion of cases, although it is never entirely successful. There are often associated syndromes affecting the limb, such as de Quervain's tenovaginitis and lateral humeral epicondylitis ('tennis elbow'). This led to the suggestion of a 'summation theory' which assumes that the nerve is subjected to mild and subclinical compression at a number of sites, such as the vertebral canal, in relation to areas of external pressure (the radial nerve in the spiral groove) and at the various osseofibrous tunnels through which the nerve must pass. Although individually the nerve compressions are insufficient to produce symptoms, the net effect is cumulative and symptomatic. Thus cervical spondylosis may co-exist with more peripheral compression lesions, and the resultant symptomatology may be confusing. Furthermore, release of an apparently convincing compression at a site such as the elbow or the wrist may not relieve symptoms entirely since the root compression proximally remains.

Sites of Compression

1. Upper Limb

(a) *Ulnar Nerve.* The nerve is rarely compressed proximal to the elbow, although it is occasionally

trapped in the elbow joint after a dislocation at that level. Entering the forearm by passing round the medial epicondylar groove, the nerve is normally free to glide at this level, thus preventing any stretching during flexion of the arm and abduction of the shoulder. If the mechanics of the elbow are distorted, particularly in cases of cubitus valgus resulting from a supracondylar humeral fracture, then the nerve will be liable to injury. This is particularly the case if adhesions form round the nerve trunk, binding it to the post condylar groove. Symptoms may present many years after the fracture, and this syndrome constitutes tardy ulnar palsy. Osteoarthritis of the elbow joint may also affect the gliding mechanism of the nerve, and osteophytes from a degenerating joint may compress the nerve just distal to the post condylar groove.

In 1957 Osborne described constriction of the nerve at the level of the flexor carpi ulnaris aponeurosis⁽¹⁵⁾. He noted a band of tissue stretching across the nerve in 13 cases, and observed that it was relatively fixed at the medial epicondyle but mobile at its olecranon attachment. Simple division of this band gave results which he considered to be comparable to those after the more formal operation of transposition of the nerve. A year later Feindel and Stratford described much the same lesion⁽⁷⁾, but stressed that a second constricting band was often present more distal to the flexor carpi ulnaris aponeurosis. This "Osborne lesion" or cubital tunnel compression syndrome accounted for approximately half the cases of ulnar neuritis followed up in a recent review by the author (Table 1). Other pathology which may produce compression includes constriction by the anconeus epitrochlearis muscle or by triceps hypertrophy, adhesions in the post condylar groove, a ganglion or a bony prominence such as a spicule or a loose body. The nerve may also be subjected to pressure if it dislocates anteriorly out of the post condylar groove. Childress⁵ found that the ulnar nerve could be palpated in this dislocated position in 16 per cent of the normal population, and that this was often a bilateral feature. The nerve may be at particular risk in these instances when there has been prolonged recumbency such as Woltman described in the chronically bedridden⁽²²⁾, or as may occur post-operatively when the patient uses the point of the elbow to move about in bed. In spite of certain of these clear cut causes of ulnar nerve compression, no cause is apparent in one quarter of the cases of ulnar neuritis that present

clinically.

TABLE 1		
	No. of cases	Percent.
'Osborne lesion'	50	46
Negative	25	23
"Adhesions"*	20	18
Anconeus Epitrochlearis	10	9
Triceps hypertrophy	9	8
Dislocated nerve	8	7
Ganglion	4	4
"Stretched"*	2	2
Bony spicule	1	1
Loose body	1	1
Total =	130	

Operative Findings in 110 Explorations

(*With or without "narrowing" or "thickening" of nerve)

Treatment of nerve compression at the elbow is best managed by anterior transposition deep to the flexor muscle mass⁽¹³⁾ although a number of surgeons still consider that a more superficial transplantation is sufficient. Simple decompression of the cubital tunnel will only suffice if the lesion is relatively acute and where there is clear cut evidence of compression of the nerve at the aponeurotic arch with a proximal neuroma but no adhesions in the post condylar groove. The longer the symptoms have been present the less likely is complete recovery of the nerve. Fortunately the majority of patients obtain reasonable symptomatic relief, with cessation of paraesthesiae in the hand and usually some gain in power of the fingers. A poor end result occurs in those cases where no pathology is evident, or where adhesions in the groove are present, and where only a release of the aponeurotic band is carried out. The nerve in these instances may still be trapped by some other pathology, and will not glide around the condylar groove on account of the adhesions, stretching presumably continues postoperatively and the symptoms are only slightly relieved, if at all. Anterior transposition is not free of unsatisfactory results either, but a direct comparison between this technique and simple release is difficult since the underlying pathology is often different, and the more chronic the lesion, the

more likely that transposition is chosen. If the results of either transposition or release are reviewed at least one year post-operatively it is found that poor recovery occurs if the symptoms have been present for more than one year, and that the best results are in those patients whose elbows are explored within three months of the onset of ulnar neuritis.

The ulnar nerve may also be compressed at the wrist⁽²¹⁾ in Guyon's canal and also at its deep branch in relation to the hook of the hamate. The latter lesion may occur after repeated compression of the nerve against the carpus, such as in cyclists or gymnasts.

(b) *Median Nerve.* The most common peripheral entrapment neuropathy of all involves the median nerve at the wrist. The nerve travels beneath the carpal ligament in the so-called carpal tunnel and is subject to compression. The size of the tunnel may be reduced following fractures of the carpal bones or a Colles fracture, in advanced hypertrophic osteoarthritis of the wrist, or if the flexor retinaculum is thickened. The volume of the other contents of the canal may increase, and this has been described with ganglia⁽³⁾, fatty infiltration⁽²³⁾, tendon bursitis, acromegaly, myxoedema and various other infiltrative conditions. Symptoms brought on by pregnancy or the menopause may also be due to water retention and increase in the size of the contents of the canal. In many cases, however, the onset of the carpal tunnel syndrome cannot be attributed to any obvious cause. It is most common in middleaged women, and like all compression syndromes may be bilateral. Some cases of carpal tunnel syndrome subside, while others may be minimally symptomatic for over 20 years. Diurnal symptomatology is common and symptoms may be exacerbated by dorsiflexing the wrists.

Release of the carpal ligament is almost always accompanied by complete relief of symptoms, and usually by recovery of any thenar motor loss which may have been present. Simple splinting of the wrist in a plaster for a few weeks may relieve symptoms in a proportion of cases, and injections of lignocaine and hydrocortisone are also advocated, but may only provide temporary relief.

The median nerve may be compressed proximally by fractures of both the humerus and the radius, and occasionally radiological evidence of such entrapment is present. The nerve may also be compressed by the ligament of Struthers which is present when a supracondylar bony spur is evident radiologically projecting from the distal humerus.

This spur is present in one to two per cent of the population and is connected by the ligament of Struthers to the medial humeral epicondyle. The pronator teres and coracobrachialis muscles may be attached to the ligament, which has also been noted to compress the ulnar nerve⁽⁸⁾.

The anterior interosseous branch of the median nerve may be compressed between the two heads of the pronator teres muscle, resulting in weakness of the long finger flexors. Tenderness is often present over the nerve at this level, but as in any other case where uncertainty exists about the level of the nerve lesion, a nerve conduction study may be of use. Digital nerve compression has also been described⁽²⁾ but is relatively uncommon and reasonably simple to diagnose. If symptoms become chronic, the digital nerve should be explored.

(c) **Radial Nerve.** The radial nerve is open to trauma as it winds round the spiral groove of the humerus. If a fracture occurs at the junction of middle and distal thirds of the humerus damage to the nerve is very likely since it is held against the bone at this site by the lateral intermuscular septum. However, non-traumatic palsies of the radial nerve may also occur in the groove, either from external pressure against the nerve or due to constriction from the fibrous arch of the lateral head of the triceps which bridges over the nerve. A supinator tunnel syndrome has also been described, in which the posterior interosseous nerve is compressed by the ligament of Frohse, resulting in weakness of the finger extensors and the ulnar extensor of the wrist. The extensor carpi radialis longus and brevis muscle branches come off the nerve before it enters this tunnel and therefore these muscles are not involved. Some cases of "tennis elbow" (lateral humeral epicondylitis) may be due to nerve entrapment, including the supinator tunnel syndrome, although this has not been established unequivocally. A compression of the radial nerve just prior to its division at the elbow has also been described but is rare. The cutaneous, terminal branches of the radial nerve may also produce painful paraesthesiae if trapped in scar tissue over the radial aspect of the wrist and this can prove difficult to manage surgically.

Other nerves may be compressed in the region of the shoulder, such as the supraclavicular nerve if it passes through the clavicle, the musculo-cutaneous nerve which may be entrapped as it passes through the coracobrachialis muscle, and the suprascapular nerve which can be compressed as it passes through the suprascapular notch⁽²⁰⁾.

2. Lower Limb

Meralgia paraesthetica. The lateral cutaneous nerve of thigh passes from the pelvis into the thigh beneath the inguinal ligament at its attachment to the anterior superior iliac spine. It may become wedged between this ligament, the iliac bone and the origin of the sartorius muscle, resulting in symptoms over the antero-lateral aspect of the thigh. A burning pain is described by the patient and this may be intermittent and positional. The condition appears to be less commonly diagnosed now and surgical release of the nerve does not always result in relief of symptoms. This may be due to the fact that the lateral end of the inguinal ligament is excised but the nerve may remain tented over the adjacent anterior iliac spine. Compression is therefore unrelieved.

The obturator nerve may be compressed by a hernia, tumour or abscess secondary to diverticular disease or appendicitis. Symptoms are often felt over the medial aspect of the knee but a proximal lesion must always be considered. The femoral nerve may be compressed by a haematoma of the posterior abdominal wall or by the lower edge of a plaster jacket at the groin. These proximal leg lesions are now less common than more distal lesions, the most clearly described of which are the tarsal tunnel syndrome, the lateral popliteal nerve compression, and Morton's metatarsalgia.

A **tarsal tunnel syndrome** may be produced by compression of the posterior tibial nerve as it runs under the lacinate ligament at the ankle⁽¹⁰⁾ ⁽¹²⁾. Symptoms may be produced by fatty infiltration, vascular engorgement, fibrosis, tenosynovitis, a valgus foot deformity, fractures of the ankle or calcaneum, or a neurilemmoma. There is pain over the instep and often an area of numbness over the distribution of the medial or lateral plantar nerves. Any weakness of the foot usually passes unnoticed. Eventually, however, the neuropathy manifests with weakness of metacarpophalangeal joint flexion and interphalangeal joint extension of the toes, resulting in clawing of the toes and a possible pes cavus deformity⁽¹¹⁾.

Treatment of the tarsal tunnel syndrome is once again surgical, with careful dissection and release of any fibrous compression involving the posterior tibial nerve or its medial plantar, lateral plantar and calcaneal branches. Conservative management using a medial sole flare or a foot brace to correct pes valgus may be tried prior to surgery⁽¹¹⁾ but neither this nor surgical release guarantee the relief of symptoms.

Lateral popliteal nerve compression is not a true entrapment neuropathy since it is usually an external pressure or a traction lesion which produces damage. The nerve is prone to injury as it commonly consists of one large funiculus and there is little in the way of connective tissue, this arrangement being less resilient than the more resistant architecture of multiple small funiculi ensheathed in a high proportion of connective tissue. It is for this same reason that the ulnar nerve is always so susceptible to injury at the elbow. However Kopell & Thompson⁽¹¹⁾ have drawn attention to a fibrous edge that de-limits the opening in the peroneus longus muscle through which the nerve passes. Compression may follow repeated inversion or combined inversion and plantar flexion of the foot, and thus they advocate the use of a lateral shoe wedge to keep the foot everted. If this conservative method fails they advise surgical exploration if prior lumbar myelography rules out sciatica from more proximal compression. More distal neuropathies have been encountered involving the superficial peroneal nerve if it is entrapped in the distal third of the leg where it penetrates the deep fascia and the deep peroneal nerve over the dorsum of the foot where it passes under the extensor hallucis brevis tendon and pierces the deep fascia.

Morton's neuroma is included in the list of peripheral entrapment neuropathies, although its aetiology is uncertain. The symptoms of pain under the forefoot, particularly in the web space between the third and fourth metatarsal necks, and of numbness in the associated cleft between the toes, are fairly characteristic. The patient often removes the shoe to massage the foot, and finds walking on hard ground extremely painful. Pain may also occur spontaneously at night. Trauma has been implicated in the onset of the symptoms, and at exploration a neuroma is found between

the third and fourth metatarsal necks. There are those who advocate injection with lignocaine and hydrocortisone to control symptoms, but this is usually only of temporary benefit and the use of a local anaesthetic is of principal value diagnostically. The thickening found in the nerve at surgery is histologically a neuroma, with considerable fibrosis around it. Some of these changes may be due to the anatomical arrangement of the nerve at this site, or may even be due to a congenital or degenerative cause.

Entrapment neuropathies have also been described at the subsartorial canal involving the saphenous nerve and in relation to the lateral malleolus involving the sural nerve. Digital nerve compression has also been reported, and thus virtually every nerve in both the lower and upper limbs, whether motor, mixed or solely sensory, can be compressed pathologically.

Summary

Simple release of the carpal tunnel usually relieves completely the symptoms of median nerve compression. It is only rarely, such as in cases of uncertain diagnosis or with associated cervical spondylosis, that the operation fails. Motor and sensory recovery is seldom incomplete. Regrettably such success cannot be guaranteed with nerve release at other site. The ulnar nerve, for example, may remain symptomatic after cubital tunnel decompression in approximately one-third of cases. Even after anterior transposition the more chronic ulnar nerve lesion will rarely recover completely. In the lower limb entrapment neuropathies are far less common but can also be dealt with surgically. Nerve conduction studies may be helpful in difficult cases, but the essence of diagnosis is accurate history taking, a knowledge of anatomy, and experience in dealing with these interesting neuropathies.

From a dissertation read before the society

"On Diabetes"

Frederick Wright 1860

Writing of sugar in the urine;

'It resembles grape more nearly than cane sugar and is usually called *glucose*. It forms with common salt a compound which crystallises with facility. Glucose may be obtained from its solution by evaporating rapidly in a water bath, when a thick syrup is produced, resembling treacle. This should be placed in a shallow vessel for a fortnight, when the crystallisation is complete.'

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MEDICAL JARGON – AN OVERVIEW

James O Drife B.Sc., M.B., Ch.B., M.R.C.O.G.

"They do certainly give very strange and new-fangled names to diseases" – Plato (427-347BC)

*"The Patient's Ears remorseless he assails,
Murthers with Jargon where his Med'cine fails"*
– Sir Samuel Garth (1661-1719)

That's all very well, gentlemen, but only laymen called it Jargon. The correct medical term is Correct Medical Terminology. We doctors can't go around calling Familial Dysbetalipoprotein-aemia "a touch of the nasties", now can we? Any more than we'd call *Erysipelothrix rhusiopathia* "a little bug". So just moderate your language, Sam; and as for you, Plato – run along and play with your friends.

Precision is vital to good communication, and medical men use jargon only to define exactly what they mean. Or do they? Occasionally, perhaps, there may be the tiniest hint of Jargon For Jargon's Sake – our profession has few other status symbols left nowadays, and sometimes it is regrettably necessary to subdue an uppity patient by blinding him with science. But under normal circumstances the use of jargon purely to impress people is limited to students and paramedical personnel, showing off their phraseology like a lance-corporal's stripe. Tyro jargoneers hold forth only to the awe-struck laity, since they remain uncomfortably aware that one slip will reveal their bluff and cause cruel hilarity to the initiated. In one hospital where I worked nobody had the kindness to correct a pleasant old nurse who for years referred to "urea and electric lights". (Another fond memory of nursing jargon: a successful enema is always said to have been "given with good result" – a merciful phrase which spares passers-by the details – and I remember a nurse exclaiming after an incontinent patient developed diarrhoea, "There was result everywhere!")

The more experienced the doctor, the plainer his speech. Older consultants tend to refer to stethoscopes as "tubes", physiotherapists as "girls" and paracoccidioidomycosis as "flu". They do this neither through lack of knowledge nor because their uvulas have calcified, but in order to guard against the age-old accusation levelled at medical jargon – that it is a cloak for ignorance. Sometimes it is: few of us know exactly what we mean by, say, "hypothalamus" or "S-I unit". Nevertheless, most of us retain a grasp of the broad outlines and when pushed can distinguish between melaena, melanoma and melarsoprol. Gone is the era when a physician's knowledge began and ended with his elaborate Latin terminology: in this scientific age a fairly complex word, like "Emiscan" or "lymphocyte" is likely to convey a much more complex concept. A few doctors remain adept in the ancient art of using jargon as armour. Dermatologists, for instance, have an array of wonderful Graeco-Roman words for things that you and I would call by the four-letter Anglo-Saxon "rash" or "spot". To watch a dermatologist in action, saying, "Aha, pityriasis rosea!" or "Go, bath in oatmeal!" is to appreciate medical gamesmanship at its best.

Though nowadays our jargon rarely hides out-and-out ignorance, it is still widely used as a disguise for woolly thinking, particularly by some of the newer specialties. It is generally accepted that a specialty is not a specialty until it has its own jargon, impenetrable to outsiders. For example, Immunology has rapidly grown a jungle of jargon by the natural process of naming new things as they were discovered. This is unavoidable, but specialties which are not in the discovery business, such as Administration or Social Work, have had to force their neologisms, a method which can produce some bizarre blooms. Patients no longer have friends, they have Interpersonal Relationships. Readers of *Res Medica* and *Private*

Eye will be amazed that the word "situation", despite the millions of gallons of ridicule poured on it, refuses to drown and continues to be an ongoing viable vocabulary-unit in the context of interdisciplinary communication at an Administrative level in the NHS. It occurs, in fact, across the board. Language like this is disconcertingly common even among doctors, especially those who want to seem up-to-date. The editor of the *British Medical Journal* has had to publish a list of 45 vogue words which contributors use "at their peril". It runs from "attitudinal" to "universalistic" via "grassroots" and "multidisciplinary". He should have offered a prize to anybody who knew what they all meant.

Most doctors, experienced, knowledgeable and far from trendy, would say that they use jargon only sparingly. The trouble is, they use it without realising it. Our training has drummed our obscure language so far into our subconscious that we cannot help thinking in jargon. Even the light-weight article that you are now reading would be heavy going for an intelligent layman, with its gags about electric lights and melaena. Our exclusive group-language sets us apart and makes it difficult to talk to non-medical friends without a string of patronising parenthetical explanations.

Of course, we have to talk to patients, and for this necessary chore a special terminology has evolved with a delicious jargon that never occurs in any other context. I pee, thou *passesst water*, he micturates. This strange half-world between curt everyday speech and polysyllabic professionalise is inhabited by people whose "bowels move", who may have "palpitations" and who (usually) have "back passages". My own specialty, gynaecology, requires euphemisms more than most and I keep being surprised that patients always know exactly where I mean by "down below". I recall as a houseman taking a hurried Systematic History from a foreign lady and asking briskly, "Any pain on intercourse?" "Pardon, please?" she replied, *intercourse* clearly not having featured on her Linguaphone record. I was temporarily non-plussed, able to think of only one synonym, which I hesitated to use in mixed company. Luckily the nurse chaperoning this interview was a resourceful woman and suggested making love. I'm sorry, I'll repunctuate that: she suggested "making love".

It is unfortunate that "jargon", like "hypocrisy" and "bestiality", is a harsh word with pejorative overtones, as some of its manifestations are far from ugly and a few are works of art. The graceful symmetry of "Wolff-Parkinson-White syndrome" deserves a Design Centre award. A place in the Tate should be reserved for the inspired "pseudo-pseudo-hypoparathyroidism", whose rhythmic undulations were built by an anonymous hand from an unpromising heap of Greek prefixes. These sophisticated creations are a world away from hand-blown artefacts of unaesthetic folksiness such as "hot dog headache", "Rocky Mountain spotted fever" or 'Salmonella thompson'. The profusion of medical eponyms – from "Addison's Disease" to "Zollinger-Ellison Syndrome" – can just be endured, if only through sympathy with the vanity of their dedicatees, though such hyphenated excesses as "Batten-Spielmeyer-Vogt Syndrome" are undeniably vulgar and probably of dubious mid-European origin.

We have no excuse, however, for tolerating the ambiguous inelegance of contractions and abbreviations. A phrase like "This woman needs 'scoping, doc" not only sets a sensitive registrar's teeth on edge but could subject the patient to the insertion of any one of a battery of metallic or fibreoptic gadgetry. "SCD" to the surgeon is Surgical Consultation Department, and to the gynaecologist is Something Coming Down. The physician's "DOE" is "Dyspnoea On Exertion" but the casualty officer's "DOA" is Dead On Arrival.

Such unnecessary conundrums are bad enough, but worse danger lurks in the notorious "hyper/hypo" combination. These antonyms, almost identical in speech and writing, cause potentially lethal confusion every day. Generations of students, introduced to them for the first time, have thought, "Hey, this is a bit silly", but they are perpetuated by inertia. Now that we have reorganised our administration and our system of measurement, we might think about re-organising our jargon, starting with these dangerous antiques. We could follow the suggestion made half in jest some years ago, and substitute "lower" for "hypo". "Lowpertenstion" "Lowperglycaemia". "Pseudo-pseudo-lowerparathyroidism". Clear and unconfusable. Could it be too sensible a change to be incorporated into our medical jargon?

AN INNOCENT IN NEW YORK

MICHAEL FERGUSON, B.Sc.

I can still remember the first words spoken to me in New York, the "Big Apple" as it has become to be known: "Hey Mac, you pullin' a fast one?"

I had made the error of following one of my friends through the check-in point at John F. Kennedy Airport. My error was that I had, in my innocence, written down the truth — that I was going to work in New York Hospital for six weeks without pay. Possibly it wasn't so unusual, but since my friend had also written that down under the heading "Purpose of Visit" the security guard decided something odd was going on. Nevertheless we got through, despite the fact that the third member of the intrepid Edinburgh trio had written down the same as his colleagues.

It was probably the sudden flurry of activity of the security guard as he searched through the "Undesirable Aliens" file that made me feel guilty and therefore jump when the second New Yorker in my life spoke to me: "Come over here! Don't dawdle already" barked the Customs and Excise Officer, his use of the unnecessary word "already" indicating that he came from Brooklyn and confirmed that we were actually in New York.

I clambered through customs, convinced I was going to die of heat exhaustion or from a bullet in the back. It was early July, and the start of what turned out to be the New York heatwave of the century. I suddenly felt very small — here I was in a foreign land with a missionary-type idea of doing medicine, and didn't have a clue where to start. Everyone around me was eying me with curiosity, snarling at each other when they collided because they were looking at me instead of where they were going. I had always thought of Americans as being pretty aggressive — my first few minutes of New York seemed to confirm it.

That was at the bus terminal on 38th Street: the hospital was up town on 68th Street, so a cab driver ushered my into a cab and headed off up town. The cab, somewhat dented, had few springs and a wire mesh separating me from the driver who permanently had one hand dangling out of the window. His other hand was a bit more active

and he pointed out all the sights on the way, lit his many cigarettes, waved to his colleagues, waved to his non-colleagues with one or two digits, and occasionally it touched the steering-wheel. Thank God that New York roads run in a straight north-south direction.

We arrived at New York Hospital, whereupon the driver stopped and held out his hand, demanding five dollars. I gave him the money and turned away despite the fact that his still lingered before me. A few mutterings were aimed at me and I gathered that his philosophy on British tourists was basic to say the least. Amazed to be still alive, I looked towards my place of work for the next six weeks. It was a grey building that stretched in every direction, especially up.

New York Hospital is 23 storeys high and measures two blocks by one block. It also contains about the same number of beds as Edinburgh Royal Infirmary. The reason it looks so big is because the "wards" are divided into rooms of four, two or one beds. The patients in the private wards, for America does not have the National Health Service, occupied single rooms on the upper floors named after someone called Baker. I worked in Baker 12A and 14, and on those floors a single room cost the patient, or his insurance company, nearly three hundred dollars per day. If the patient wanted anything done (like some medicine, or to say "Good morning" to a doctor), he had to pay extra.

Mr first day in New York Hospital changed my whole outlook on Americans. I found them courteous, kind and considerate. Maybe it was being in a special environment or because I was foreign, but I think not, for I travelled around after my six weeks in New York and found that most people were very kindly and I was welcomed wherever I went.

When I look back at my stay in New York I can only remember the good points, really. I suppose that if I concentrated I would remember my feelings about being expected to work seventeen hours out of twenty-four every third day

and twelve hours most other days. It was all good experience. The medical staff worked hard and had an enthusiasm which appears lacking in Britain. It was inspiring to hear juniors doctors quote recent journals rather than ageing textbooks. When I was there I looked forward to reading the latest information on the disease which my patients had. The whole New York drive and aggression had some good effects on one. As was said by one of the hospital doctors: "When I'm sick I want the technology to get me better, when I'm getting better *then* I want a sympathetic doctor".

Though I don't entirely agree with such a

doctrine, it might be useful to have a drive such as that within the New York Hospital to get the patient better — while still retaining the compassion to realise that a patient is not just the container of a disease.

‡

So I have turned from being the Edinburgh medic set out to impress New York into a medic who wants to shake up the apathy I find in Edinburgh. I can't help but feel that Edinburgh is resting too much on its laurels. It still has a lot to offer even to bustling (and hustling) New York, but I think that more enthusiasm and less apathy would better the high standard of Edinburgh.

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THE R.M.S. ABROAD

Hamish Maclaren

When Ted Duvall asked me to write a description of the Leiden trip, I went away and scribbled down the events as they occurred, in chronological order, right down to the last cup of coffee, the last *Bokma*. I did this because I was afraid that the events, put out of focus, even at the time, by the action of various euphoric agents, would in due course shift themselves beyond recall. Dutch *Geneva*, and another beverage which went down well with us — *Trapiste Triple* (Trapiste because made by Trappist monks, triple because about three times stronger than normal beer) — these were not solely responsible for the dream-like quality of our eight days in Holland. In fact, by our last day, we were all helpless with fatigue. It had all started on the night train from Edinburgh to King's Cross — not a sleeper, of course; that would have been contrary to the essential character of the trip. Most of us didn't sleep at all. We played Bridge till four and then stared disconsolately out into the grey murk, jealous of the slumbering Ailsa and her valium. (Although, to be fair, she did offer us all a fix.) It was even worse in London because we had to spend three hours of the early morning hanging around in Liverpool St. Station, shivering and looking more and more haggard. Finally, some of the party chose to live apart for the duration of the voyage from Harwich to the Hook of Holland. It was becoming clear that there were to be only two big disgraces on this trip — sleeping, and vomiting. (The rest of us relaxed on deck or in the bar, charmed, along with our cosmopolitan fellow passengers, by the colourful and extrovert behaviour of some of our fellow countrymen — who seem to turn up wherever you go — entertaining us with their stirring songs and quaint partisan chants.

So the fifteen refugees who lurched down the gangway at Hook were really in no fit state to appreciate fully the concentrated glimpse of Dutch medicine which followed, consisting of visits to four hospitals, four museums, a University, six

labs, a group practice etc., plus the crippling intensive social programme. (Not that we were complaining). The sheer precipitation of events somehow managed to keep us all going. We were also helped by the tireless efforts of our Dutch hosts, staff and students alike, to be with us on our various journeyings and to make our visit as fruitful as possible. We were all of us struck by the extent to which Dutch hospitality went. Some of the students on the *Dispuut* (a sort of Leiden small-scale RMS equivalent, if such a thing is conceivable) who were entertaining us, took the week off classes in order to accompany us, and to transport us around. Others somehow managed to combine socialising at three in the morning with continued appearances at their own nine o'clock lectures. Not that we, for our part, were doing anything less, but after all, we had gone to Holland in a state of morbid activity, on a High. But we got the feeling that Dutch student life, under normal circumstances, was not so very different from the frenetic social round in which we were now mixed up. We found ourselves wondering, particularly at half past one in the morning in the pub, what was wrong with Edinburgh medics that they felt the need to read medical text books all the time. Ought we to tell the Edinburgh medics about life outside, as we were now seeing it? Would they, in point of fact, believe us? It didn't seem to matter where we were, hospital, lab, pub, restaurant — our Dutch counterparts were always there and ready to ferry us on to the next engagement. The ferrying, usually by minibus, was perhaps a mixed blessing, especially with a fellow called Mark who would drive for long spells on the left out of deference to British *mores*, and with Peter who, to our chagrin, never fully comprehended the function of a clutch. They all displayed a wonderful, callous indifference to the well-being of their motor vehicles.

University and hospital staff were sociable too. We saw them not just during working hours but at innumerable less formal evening sessions. They

were relaxed and informal and, blessedly, like the students, spoke good English without exception. Even the Directors of the University Hospital in Leiden invited us to lunch — an almost embarrassingly opulent affair, a bizarre Dutch meal culminating in the eating of salad sandwiches with a knife and fork. We all watched our hosts covertly, to establish the protocol for each successive course. I remember the waiter removing my plate after the beef and mushrooms, replacing it with another, and pointedly laying my used cutlery by my side, violently, and with great deliberation, besmirching the virgin tablecloth. It was our last day in Holland. We sprawled around that table like an ad-hoc mixture of the lame, the halt, and the blind. The waiters' faces were quite without expression.

At this point I have to say something about Dutch medicine and medical research as we saw it during our short stay. After all, to see Dutch medicine was, at least ostensibly, the purpose of our visit. And indeed we saw a great deal. Yet it is very difficult to write about this because, at the end of the day, what impressed us most in what we saw were the *similarities* to what we were used to, rather than the differences. Not unreasonably, our hosts took pains to show us Good Medicine, and many of the things we saw were modern showpieces — the Leyenburg Municipal Hospital of the Hague, the Antonie van Leeuwenhoekziekenhuis (Cancer Centre) just outside Amsterdam, and the Burn Centre in Beverwijk, different, perhaps, from our own battered Edinburgh Victoriana, but nonetheless still familiar to us all as the spotless, antiseptic, perhaps slightly characterless face of modern Western medicine. I remember, in particular, in this respect our tour of the Hague's Municipal Hospital, at the heels of one Ms. Haitink who gave us a rigorous floor-by-floor account of the supreme functionality of the institution, meticulous to the last well-placed linen cupboard. The whole place bore an uncanny resemblance to Gartnavel General Hospital in Glasgow. Moreover, each floor bore an uncanny resemblance to the one beneath it. The top floor was fifteen. But the second top was numbered twelve. The omission of thirteen was a rather charming concession to the feelings of the patients, the omission of fourteen an altogether unforgivable capitulation to the feelings of the elevators' computer, which apparently could not understand that the floor above number twelve should bear an even number.

I suppose that the most especially Dutch item on the medical programme came right at the start — ominously enough, in the Anatomy Department.

When we entered the Anatomy Department of the Medical Faculty at Leiden, on a Monday morning, just after nine o'clock, some of us were more than a little apprehensive in case we should find ourselves listening to an Anatomy lecture. This would have been altogether too much. Indeed, on ascending the stairs and smelling that old familiar aroma emanating from the D.R. we half expected to see a few old familiar Edinburgh anatomists lurking round the next corner. However we need not have worried. This was to be a History lesson. In fact it was here in the Anatomy Department, in the Anatomy Museum and subsequently in the Boerhaave Museum, also in Leiden, that we were made aware of the immensely long tradition of Dutch medicine and its links with developing science, through such names as Leeuwenhoek and Boerhaave himself, and of the particular character of Renaissance European Medicine, as it was practised here in its hey-day, its links with religion and morality captured in these famous prints of the Anatomy Museum at Leiden, bedecked with skeletons, apocalyptic horses, and dire warnings about the passage of time.

Still, there *were* modern things to be seen which could not be seen in Britain. And one of these was *Eurotransplant*, a kind of central clearing-house for embarrassed kidneys which was a real live practical justification for what seemed to us to amount to the current Dutch medical obsession — the preoccupation of tissue typing for the HLA system.* *Eurotransplant* keeps a record on computer of the precise requirements of potential organ recipients (mostly it is kidneys that are dealt with) such that if an organ becomes available it can be typed, a suitable recipient can be selected, and the recipient and organ brought together in double quick time in an operating theatre. The system operates across a large portion of the European Continent, communications also existing, on a world-wide basis, with other similar organisations.

Plenty of our other visits do not stand out as being exotic or unique (although the Group Practice we saw certainly seemed a lot more opulent in its furnishings and appointments than any of us had ever seen in Britain) but nonetheless certain events stick in the minds of those of us who went to Leiden as being particularly worthwhile — the lecture on Complement Research given by Dr. Mohammud Daha — much appreciated by Third Year Students because it was

* of a remark of our mentor, Dr. Charles Swainson, Renal Unit RIE — "Oh, if we get hold of a kidney we just bung it in!"

actually of *use* to them, and the lecture at the Burn Centre in Beverwijk by Dr. R.P. Hermans. On the other hand, hardly anybody liked the REPGO–TNO Institutes at Rijswijk where they made monkeys neurotic; on the whole we were on the side of the monkeys. Perhaps the last event on the medical programme was the most impressive, a clinical conference, given in English for the occasion, in Leiden University Hospital, where a large number of doctors joined together for a discussion built around two case presentations. This was very entertaining, and it summed up for us a prevailing sense that people from all levels in the University had gone out of their way to be helpful to us.

Although the medical programme took up a large part of the day we were still able to move around the country and see places the more so since, unbelievably, the trains actually leave on time. We first realized this on boarding our first train at Hook, and we wondered then if it was unusual. Not at all, it turned out to be as ‘typically Dutch’ as the unmitigated flatness of the land you can admire from the carriage window, and the literally countless scores of effete windmills sitting gregariously in groups of three by the sides of the canals. Travelling by train for the first time from Hook to Leiden, we had been struck by the extreme compactness of a land which is, after all, no bigger than Yorkshire. But there is contrast too; we noticed it most strongly between Amsterdam and The Hague. The Hague is a very beautiful city with wide streets, trees and parkland and a clean swept municipal look about it, full of governmental buildings and art galleries which are, in turn, full of self portraits of Rembrandt leering at you from strange angles.

We went to Amsterdam primarily to visit the Antonie van Leeuwenhoekziekenhuis – the Cancer Centre looking rather more like an International Airport’s Hotel. I remember the discussion ‘over coffee’ we had here and how it emphasised for me a conviction that had been gaining footholds in my mind all week, as to the absolute futility of discussing anything ‘over coffee’. It is hard to concentrate on dysplasias, neoplasms etc., when a secretary at your elbow is politely enquiring as to whether you desire one lump or two, and when you are frantically trying to semaphore down to someone separated from you by twenty metres of mahogany table, in order that he post the milk up to you. The coffee was excellent.

Amsterdam, once our team of mad chauffeurs had led us there, turned out to have more of the

conventional grime of a city than The Hague. Amsterdam ‘pulsates’. It is impossible to give anything other than a personal view of this, and mine is probably coloured by the hangover of our morning’s trip round all these sinister concrete bunkers in the Ziekenhuis housing the deadly Cobalt and Radium sources, followed by a high speed tour of the Van Gogh Museum and these utterly extraordinary – and rather insane – pictures of golden cornfields which undermine your *joi-de-vivre* after a time, especially when you see a whole art gallery of them. It seemed to me that Amsterdam was a distinctly spooky place. At night you found yourself constantly looking over your shoulder. The buildings were beautiful but also grimy, the canals sullen and stagnant, the streets jammed with traffic by day, and, at night and in certain areas, with prowling and intent middle aged men, as much of a caricature as their assignations under the red lights. Along the length of virtually the entire canal system have been erected small iron railings, cheaper to instal than to continue to fish out the twenty or thirty cars which used to be driven into the canals every Saturday night. You couldn’t help feeling a sense of decadence hanging in the air. I kept a sharp lookout for the Amsterdam Hilton where John Lennon was reputed to stay in bed for a week for peace and also, recalling Amsterdam’s shady international reputation of the mid sixties, that other mysterious mythological symbol of faceless bureaucracy spawned in the days of late Beatlemania – the man in the mac. But I saw neither. I asked the Dutch medics what they thought of Amsterdam and it was quite obvious that they all had a great fondness for it, perhaps not unlike that totally irrational fondness a Glaswegian has for his own town. In particular they admired and even emulated – those who came from elsewhere – the Amsterdam character, typified by a kind of brusque no-nonsense attitude evident even to us. They had to agree that it was really quite a sinister place, but still insisted on describing it using words which seemed to me to be quite inappropriate, like ‘nice’ or ‘quaint’ and an apparently untranslatable Dutch word like *gesaelig* which happens to be the Old English precursor of ‘silly’. I thought of two members of our group taking pictures in the red light district and getting chased down the street by an outraged *madame*, of the forlorn automobiles slipping gently, lemming-like, into the murky depths of the canal every Saturday night – made even more murky by Mark’s insistence on the propitiousness of having a pee into the nearest public waterway

before we left; and of our one absurd brush with the law — a fifteen gilder on the spot fine for going down a one-way street the wrong way in the lewd quarter of town. Pretty silly.

I can't finish without at least mentioning *Minerva* — a student union in Leiden which made Teviot Row look like the Savoy Grill on a quiet night. They never let us take any pictures so perhaps it is going against the spirit of the place to describe it. Suffice it to say you would have felt at home there dressed in bear-skins, boasting about the latest dragon you've just slain, and quaffing vast quantities of Norseman Lager. They seem to

go in for a lot of all-night affairs. I asked a member of the Board of Management if the members ever slept and he replied, "You can sleep when you are dead." I think by this stage most of us were feeling about half-dead, but we had a concert to go to, given by an amateur orchestra rather alarmingly entitled "*Sempre Crescendo*". They were very fine. Then it was back to *Minerva* and on with the bear-skins again. And so on. It was marvellous but I don't think we could have stood another week of it. We had left Edinburgh on a Thursday night, and on Saturday week we limped off the boat again at Harwich, and slithered under the icy glares of the tired *douaniers*.

SYLLABUS FOR THE 242nd SESSION

1978/79

Wednesday 25th April	Dissertation Mr. Alan Boyd, B.Sc.
Wednesday 2nd May	ANNUAL EXTRAORDINARY GENERAL MEETING
Friday 11th May	PRESIDENT'S VALEDICTORY ADDRESS Dr. Edward Duvall



FORTHCOMING ATTRACTIONS — 243rd SESSION



Inaugural Address — Friday 19th October 1979 in the Hall of the Royal College of Surgeons at 8 p.m.
Professor M.F. Oliver, Duke of Edinburgh Professor of Cardiology at the University of Edinburgh.

Wednesday 7th November 1979

Air Vice-Marshal P.J. O'Connor, Former Consultant in Neurology to Royal Air Force.

Wednesday 21st November, 1979

Mr. P. Steptoe, Oldham, the gynaecologist whose technique produced the first "test-tube baby."

Wednesday 23rd January 1980.

Professor Bryan Jennet, Glasgow University, "Modern Dilemmas in Medical Care — Lessons from Head Injury."

Wednesday 6th February 1980

Dr. Hugh Jolly, Consultant Paediatrician, Charing Cross Hospital, London, "Why is Paediatrics Exciting?"

CHANGES OF OFFICE

LIBRARIAN

Dr. R. Traquair Thin retired as Honorary Librarian in 1978, and it is our pleasure that Dr. Jack Cormick (Olim Librorum Custos) has now accepted this position.

TREASURER

After the death of Dr. Malcolm Low in 1975, Professor D.C. Simpson saved the Society as Quaestor until 1978 when he retired due to the pressure of duties as Executive Dean of Faculty. We are glad to welcome Mr. Iain McLaren, F.R.C.S.Ed. as Honorary Treasurer.

OBITUARIES

Professor Norman Dott

The Dott Medal was struck in 1975 from a legacy bequeathed by the late Professor in 1973.

Dr. W.A. Alexander

Senior President 185th Session 1921-22. Retired as Quaestor 1964. Died October 1976.

Dr. Malcom Low

Senior President 212th Session 1948-49. Quaestor after Dr. Alexander's retiral 1965. Died April 1975.

Dr. D.J. Guthrie

Life Member of the Society and Editor of "History of the Royal Medical Society". Died June 1975.

Sir John Bruce

Elected Honorary Fellow 1971. Died December 1975.

Professor Sir Hugh Robson

Member of Society and Principle of Edinburgh University. Died November 1977.

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AN ATLAS OF TUMOURS
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CHILDREN IN HEALTH
AND DISEASE**

1978 · 892pp · 186 illustrations

**Brush, King Taylor/
ENDOMETRICAL CANCER**

1978 · 480pp · 183 illustrations

**Cossart/VIRUS HEPATITIS
AND ITS CONTROL**

1977 · 304pp · 17 illustrations · 8pp plates · 109 tables

Forgacs/LUNG SOUNDS

1978 · 80pp · 30 figures · 2 tables

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PROFOUND DEAFNESS IN
CHILDHOOD**

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PHARMACOLOGY**

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TUBERCULOSIS—A Journey
Down the Centuries**

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**Keith, Rowe and Vlad/
HEART DISEASE IN
INFANCY AND
CHILDHOOD**

1978 · 3rd edition · 1083pp · 478 figures · 120 tables

**Melmon and Morrelli/
CLINICAL
PHARMACOLOGY:**

**Basic Principles in
Therapeutics**

1978 · 2nd edition · 1146pp · 171 tables · 168 illustrations

**Speck/LOSS AND GRIEF IN
MEDICINE**

1978 · 175pp · 3 illustrations · Limp

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